Evidence from Immpact evaluations: demand-side barriers to maternal care

Too far, too costly, too unfamiliar

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Overview

1. Intersection of different types of barriers

2. Distance barriers

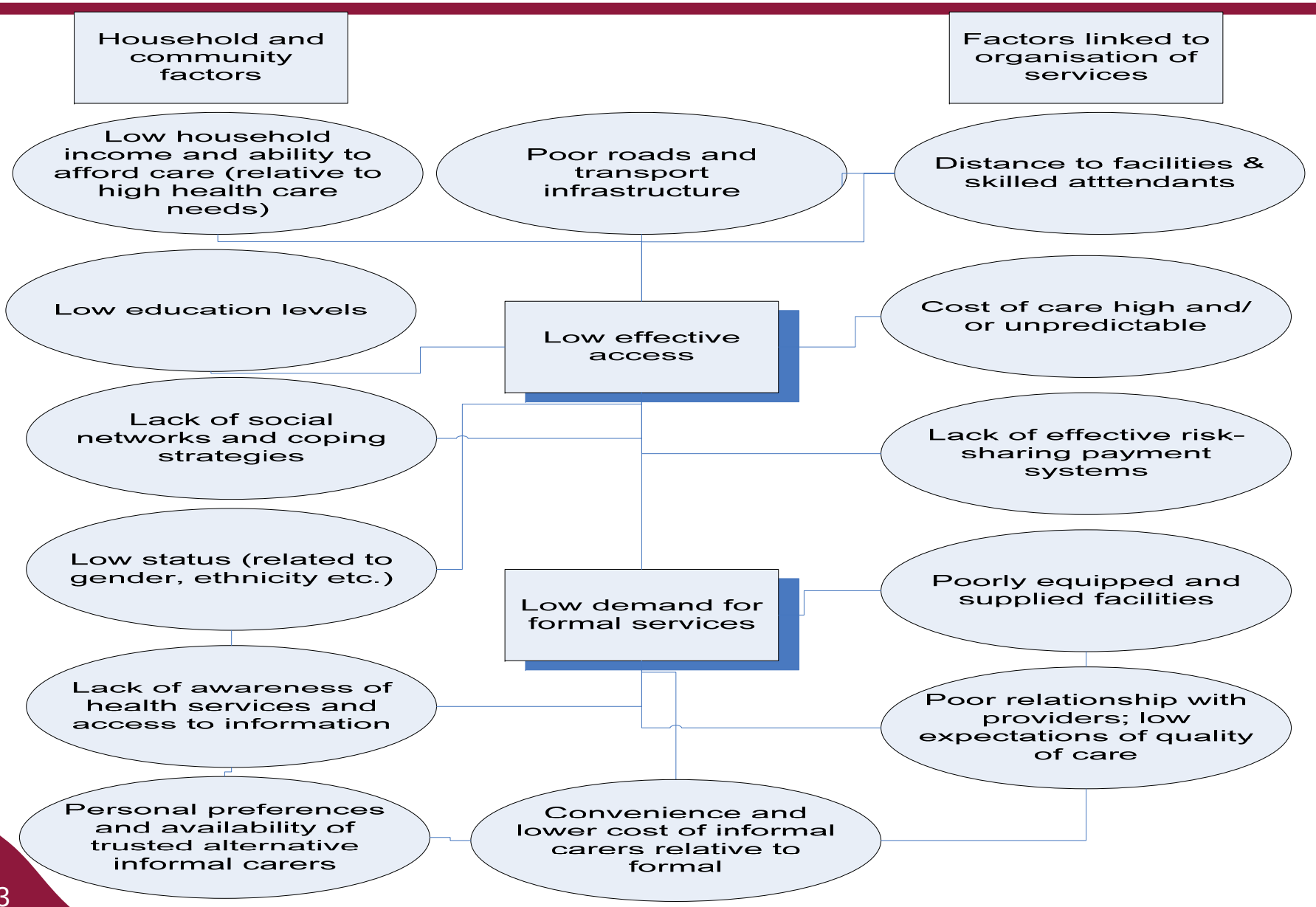
3. Cost and poverty

4. Gender and cultural barriers

5. Policy implications of research findings

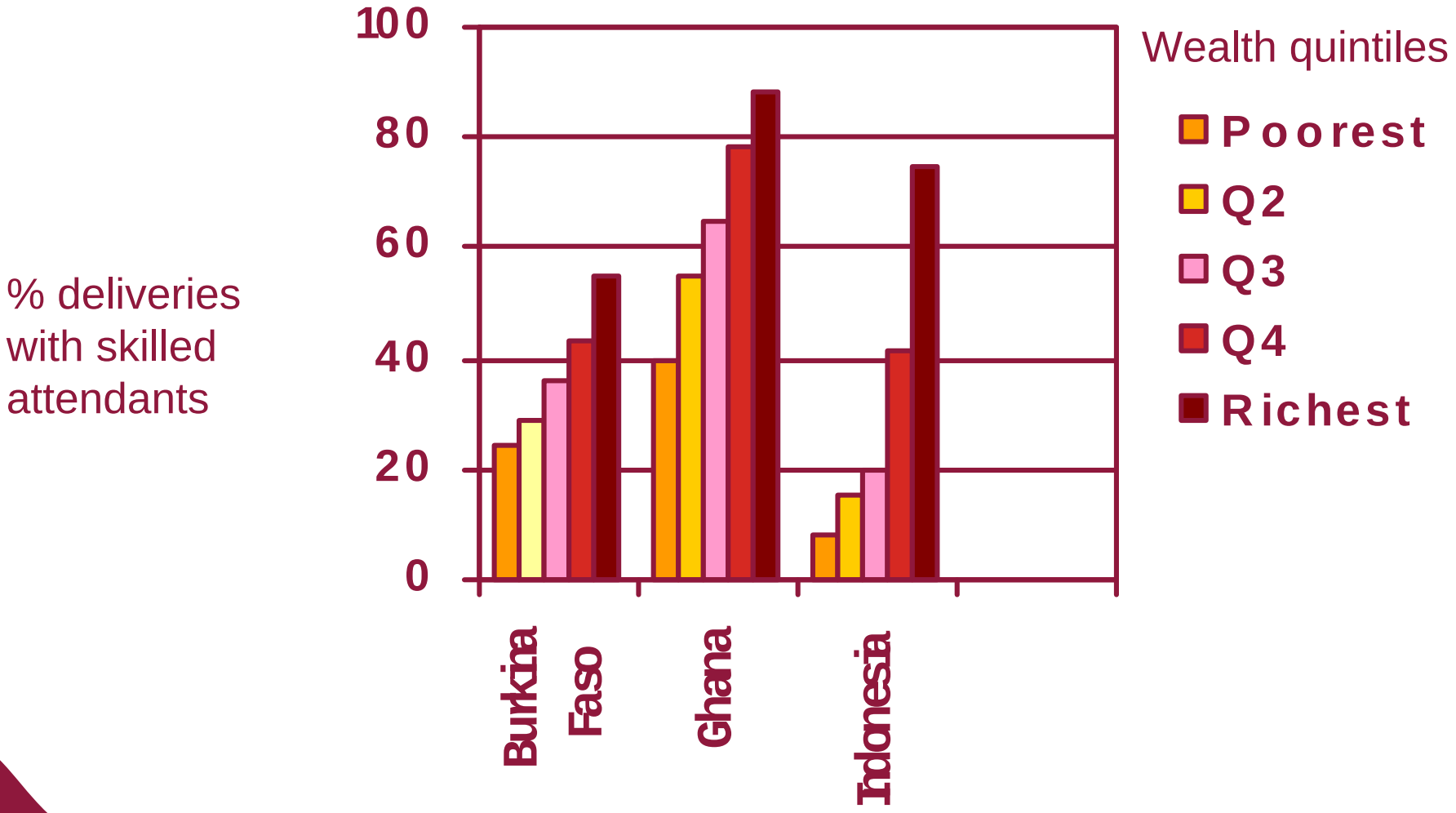
- Demand-side strategies
- Supply-side strategies

Barriers usually interconnected



Many barriers linked to poverty

Coverage of skilled care at delivery from Immpact sub-national data



Distance

Distance to facilities matters:

- SCI evaluation in **Burkina Faso**: 77% of births in households living within 1 km of the health centre took place in a facility, compared to 18% for births more than 10 km from the health centre
- **Senegal** exemption scheme favours urban poor over rural poor

Access to skilled providers matters:

- **Indonesia**: only 29% of villages have midwife, despite Bidan di Dessa programme
- Presence of midwife associated with higher skilled attendance
- Three or more midwives per village associated with half the risk of maternal mortality compared to villages with fewer

The average costs are high for households

Average cost of care to mothers in US$

	Normal delivery	Caesarean section
Indonesia	99	425
Ghana	43	229
Burkina Faso	39	124

Low affordability for poor of maternal health services

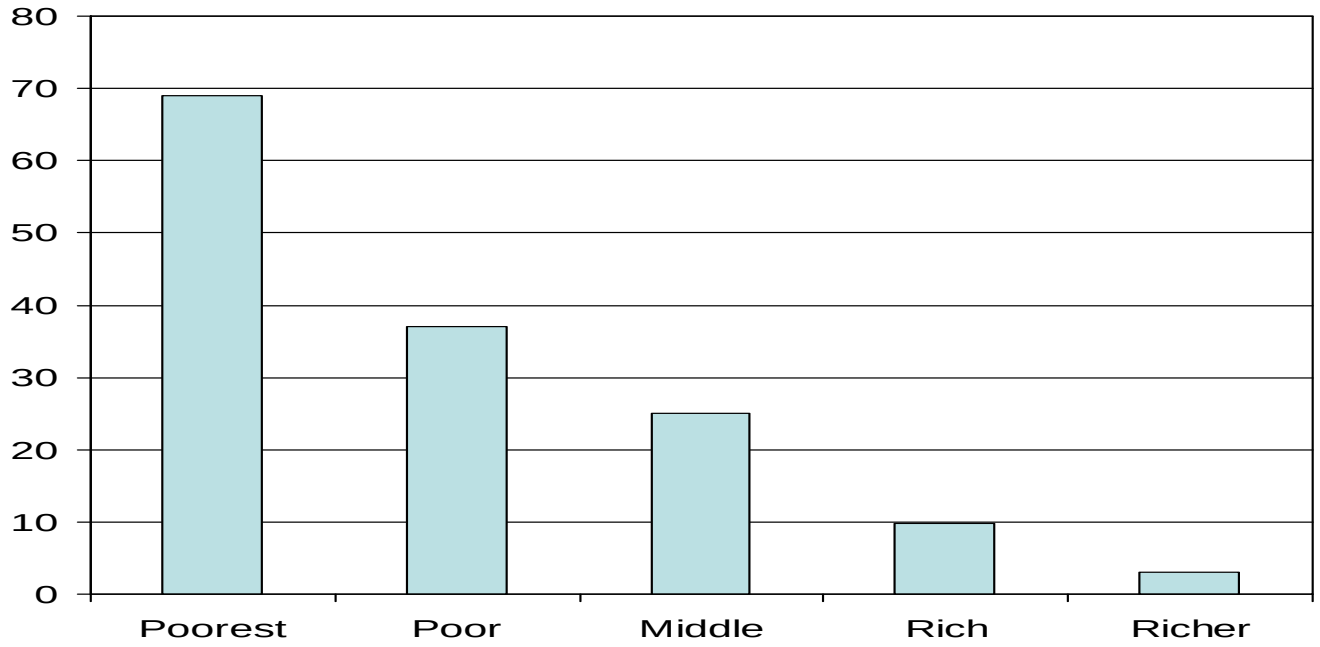
- In Burkina, the average cost of normal deliveries represents 43% of annual per capita income in poorest households

- C-sections **138% of annual per capita income** in poorest households

Catastrophic payments are much more common for poor

Indonesia sub national: % distribution of catastrophic payments* for care in obstetric complications by wealth quintiles

*40% or more of a household's disposable income



Immpact 2006

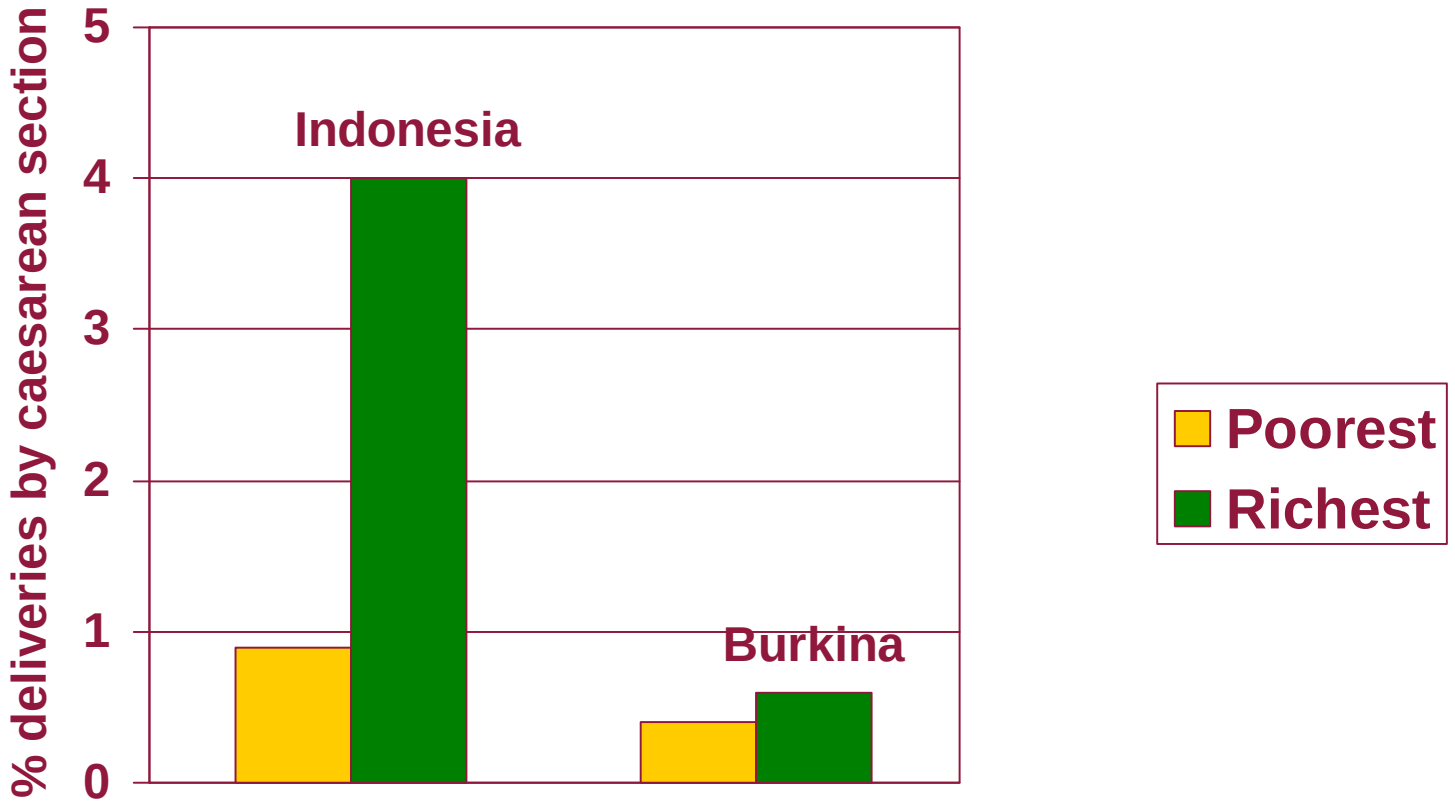
Low affordability for all of emergency care

- Median cost of comprehensive emergency obstetric care without hospitalisation costs in Burkina was $70, compared to GNP per capita of $300

- These are **catastrophic** payments

Confirmed by differential use of emergency care between rich and poor

Indonesia & Burkina Faso: Poor-rich gap in caesarean sections (sub-national, Immpact data)

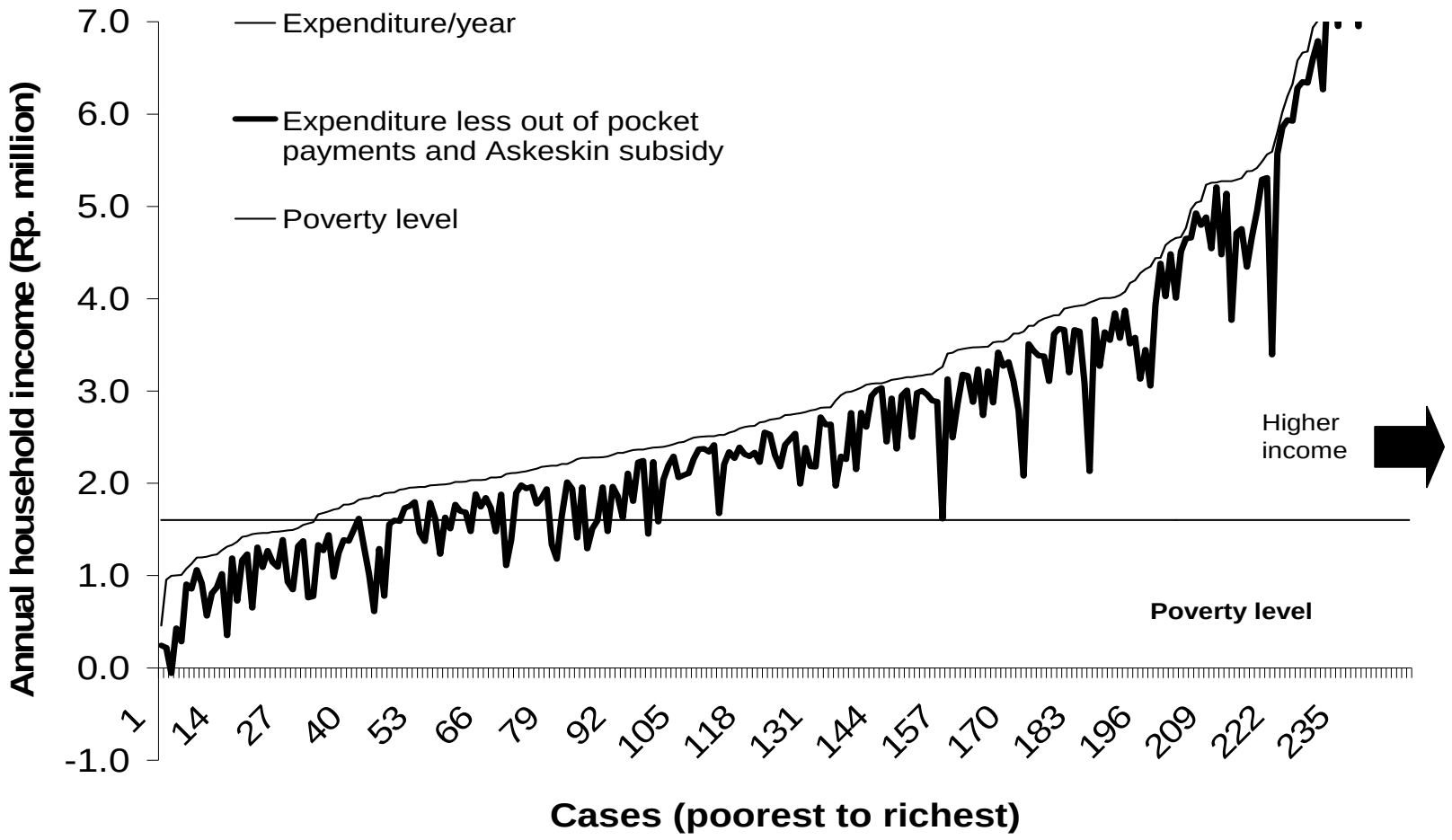


Official protection schemes only partly effective

- Even with the support of Askeskin (social insurance for poor) in Indonesia, 20% of families had to borrow to pay for their normal delivery costs, and 46% for costs of near misses

- Barriers to registering for schemes targeted at poor: lack of awareness, mistrust, shame, quality concerns

Case of Askeskin in Indonesia and payments for hospital-based delivery care



Payments for health care have lasting adverse consequences

Immpact findings in **Burkina Faso**:

- Poorest women had highest level of asset sales
- Poorest women spent least on care in absolute terms, but largest proportion of household income
- All women with near-miss complications reported frequent spending of savings, borrowing, & sale of assets
- 8% of women with normal deliveries reported borrowing to meet the cost of care

Gender and cultural barriers

- Lower WTP found amongst women in Burkina, even after allowing for lower income and education status – limited capabilities?
- Preliminary work suggests strong correlation of gender index with maternal mortality
- Evidence of influence of traditional taboos in Burkina
- Traditional rites performed by TBAs in Indonesia and Ghana
- Senegal: antagonism of husbands to (male) ICP – only skilled provider at health centre level
- Senegal: dominance of mother-in-law, even where woman pays for own care

Importance of maternal education

- In multivariate model of determinants of caesareans in Burkina study areas, only distance and maternal education significant
- 0.4% overall CS rate; for women with secondary or higher education, 2.4%
- Inequalities in access by educational quintile linked to but often more extreme than income inequalities (e.g. Central Region, Ghana)

Policy implications: demand side

Too far?

- Assistance with transport and other direct costs outside facilities

Too costly?

- Encourage communities to save for predictable maternal costs
- Enhancing women's decision-making role
- Poverty reduction

Too unfamiliar?

- Community mobilisation (e.g. SCI in Burkina)
- Education

Policy implications: supply side

Too far?

- Targeted investment in facilities and physical access, especially in remote areas

Too costly?

- Reduce costs, especially for the poor and for emergency care for all
- Increase predictability of costs
- Increase effectiveness of risk protection schemes
- Increasing package of care on offer in public facilities can reduce direct payments (elsewhere) by households

Too unfamiliar?

- Improve relations with providers and increase convenience and acceptability of services