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Overcoming Operational Policy Barriers to Essential Safe Motherhood Services

The term "safe motherhood" refers to efforts to prevent maternal and infant death and disability through improved access to healthcare and other supportive services (White Ribbon Alliance, 2005). Sadly, women in the developing world experience a 1 in 61 lifetime risk of dying from pregnancy- or childbirth-related complications (World Health Organization, 2003). This is compared to a 1 in 2,800 lifetime risk for their counterparts in developed countries.

Common causes of maternal and neonatal mortality and morbidity are excessive bleeding, obstructed labor, infections, and hypertensive disorders. They can occur suddenly, often with little warning. However, negative outcomes can be greatly reduced with proper nutrition throughout the pregnancy, skilled assistance at delivery, and access to regular antenatal checkups, emergency obstetric care, and postpartum care.

Effective operational policies are essential for ensuring access to maternal health services, especially for underserved and hard-to-reach populations. Operational policies are the rules, regulations, codes, guidelines, and administrative norms that governments and organizations use to translate laws, policies, and resources into programs and services on the ground (Cross et al., 2001). These policies and guidelines affect all aspects of service quality and accessibility. Examples of operational barriers include unreliable supplies of medicines, unnecessary restrictions on the types of services that can be performed by various healthcare providers, high user fees for services, and inconsistent resource allocation and staffing plans that neglect rural health facilities.

In working to reduce maternal and infant mortality, policy and program planners must pay appropriate attention to the systems and guidelines that will operationalize services and, ultimately, determine whether services are accessible to those most in need. The remainder of this brief explores common operational policy barriers to maternal health services. It also offers recommendations for overcoming policy barriers, including using data on policy issues to promote awareness and encourage evidenced-based decisionmaking regarding maternal health services. The brief concludes by demonstrating how data, advocacy, and civil society engagement combined to influence policy norms and service access in Peru.

COMMON OPERATIONAL POLICY BARRIERS

To promote improved access to essential safe motherhood services, the POLICY Project has undertaken studies to identify and better understand common operational policy barriers to service access, quality, and use. Three common barriers and their impacts are discussed below.

Barrier 1: Mismanagement of User Fees and Exemptions

With constrained budgets and competing socioeconomic development priorities, governments are increasingly turning to user fees to help recover costs and alleviate the burden on public health resources. Such mechanisms have received considerable

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international attention as a means for addressing resource shortfalls, and some countries have reported encouraging results. The instituting of user fees, however, has also raised concerns that such an approach will further limit access to services for the poor. In response, countries have adopted fee waiver and exemption provisions. While charging fees to those who can afford to pay and exempting those who cannot is a good idea on paper, effective implementation of the approach remains a challenge. One study of maternal healthcare user fees and exemptions/waivers—conducted in Egypt, Kenya, India, Peru, and Viet Nam—revealed that, despite government efforts to promote access to maternal healthcare services, use of services remained low (Sharma et al., 2005). The study also found that:

(1) Subsidized services are not properly targeted to women most in need; instead, many women, regardless of poverty status, access free public sector services. This deprives the government system of needed funds while at the same time using up resources intended for poor women.

(2) Poor women incurred high costs for accessing maternal health services, including fees for services that should have been covered by the waiver system (e.g., lab tests, medicines) or "informal" payments to healthcare providers for "higher-quality care, shorter waits, or as a general condition of service" (Sharma et al., 2005, p. 39). Women reported that these out-of-pocket expenses represent a barrier to service access and use.

(3) Many women—and, in some cases, providers—were not aware of what services were covered or not covered by waiver and exemption programs. Lack of publicity and unwillingness of providers to inform clients of the waivers were common problems. In other cases, information on the waivers was not available or accessible to illiterate women.

Evidence from the study has been used to influence policy change within countries. For example, the data regarding implementation of user fees provided additional evidence that was used to successfully advocate for revising the user fee policy in Kenya. The revised policy streamlines the system of waivers and exemptions by specifying target groups, eligibility criteria, and appropriate administration procedures. The groups now accorded top priority include sexually active students ages 12–21, school dropouts, street families, the poor, the mentally and physically challenged, recruits in the armed forces, teenage parents, widows, and survivors of sexual assault requiring emergency contraception and post-exposure prophylaxis. In India, the study results informed the development of government orders and operational guidelines for improving the implementation of user fee systems. For example, the Uttaranchal state government issued an order to establish Medicine Management Committees in public sector hospitals. These committees have the authority to implement cost-recovery mechanisms, such as targeted user fees and other strategies, to generate funds to help ensure high-quality, sustainable services and improve access for the poor. At the global level, the study has contributed to policy dialogue regarding user fee programs, in general, and has inspired groups on both sides of the debate to consider the benefits and challenges of user fee mechanisms. Additional policy recommendations for addressing the challenges in implementing user fees and exemptions are presented in Box 1.

Barrier 2: Limited Access to Emergency Obstetric Care in Rural Areas

Due to limitations within health systems and because of cultural preferences, most women in developing countries give birth at home—often without the assistance of a skilled attendant. The majority of maternal deaths occur immediately following or within one day of delivery. It is critical, therefore, that women have timely access to services to address any complications that may arise. Countries cannot make progress in reducing maternal mortality without improved access to emergency obstetric care. Basic emergency obstetric care includes capacities such as administration of antibiotics, oxytocics, and anticonvulsants; manual removal of the placenta; and removal of retained products following miscarriage. Comprehensive emergency obstetric care would also include a 24-hour referral system, Caesarean section, and safe blood transfusion (United Nations Population Fund, n.d.). Rural women have limited access to maternal health services, particularly when compared with their urban counterparts. The "Maternal and Neonatal Program Effort Index" (MNPI) uses key informant information to rate the strength of various aspects of maternal and neonatal health programs. The 2002 MNPI, which covered 55 developing

Box 1. Improving implemenations of user fees and exemptions

- Generate awareness among low-income clients about the availability of free services.
- Enforce payment of user fees by those who can afford to pay to help generate sufficient revenue for quality improvements and cross-subsidization for the poor.
- Encourage rational spending on health services, including allocating sufficient resources for services provided, targeting resources to those most in need, and reducing waste.
- Permit health facility administrations to retain and use revenues collected at the facility level.
- Minimize informal payments to make services affordable to a larger number of clients.
- Revise insurance schemes so that they include all aspects of antenatal and delivery care.

Source: Sharma et al., 2005, p. viii.

Table 1. Selected Indicators of Rural and Urban Access to Various Maternal Health Services across 55 Developing Countries as per the 2002 MNPI

	Rural Access	Urban Access
District hospitals open 24 hours	55.8	81.9
Antenatal care	59.6	79.1
Delivery care by trained professional	47.2	75.3
Postpartum family planning services	41.4	64.5
Treatment for postpartum hemorrhage	39.3	68.4
Management of obstructed labor	38.1	69.8
Treatment of complications of abortion	37.2	68.5

Source: Ross and Begala, 2004.

countries, found that rural access to maternal health services received a mean score of 42.4 out of a possible rating of 100, compared with a score of 69.0 for urban access (Ross and Begala, 2004). The rating considered essential aspects of emergency obstetric care, such as treatment for postpartum hemorrhage and management of obstructed labor (selected indicators are presented in Table 1). The gap between rural and urban access was even greater in some individual countries.

Lack of access in rural areas—due to inequitable geographic distribution of facilities, lack of trained personnel available 24 hours a day, shortages in supplies, limited transportation, and other causes—constitutes an operational barrier to emergency obstetric care. In Kenya, for example, the majority of antenatal care clients cited "distance to the facility" as the decisive factor in seeking or not seeking services (Sharma et al, 2005, p. 25).

Ideally, maternal healthcare services must be provided in locations where women live. Emergency obstetric care should be available at the lowest-level health facility (e.g., not just at a district hospital) and should be supported by the presence of skilled providers and all necessary medications and supplies. Where it is not possible to offer emergency obstetric care at the community level, standards and protocols must be put in place to help birth attendants or healthcare providers assess high-risk pregnancies early on and to promptly refer cases when complications arise.

Barrier 3: Healthcare Provider Attitudes

Women in the five-country study of user fees (Sharma et al., 2005) and from a study of operational barriers to maternal healthcare services in Peru (POLICY Project, 2005) noted that provider attitudes can sometimes deter women from seeking services. Negative provider attitudes may relate to the clients' cultural practices, poverty status, or language. In Peru, the majority of women who did not seek professional healthcare at delivery "cited lack of respect for local customs and cultural practices as a reason for preferring to deliver at home" (POLICY Project, 2005, p. 12). Some of the health facility restrictions that went against local customs included not allowing the husband in the delivery room and not allowing the woman to have a hot beverage immediately following childbirth.

To be acceptable and appropriate, maternal healthcare services should strive to be more client- and family-centered and respectful of traditional practices. Providers, including physicians, midwives, and nurses, should receive pre- and in-service training to become more tolerant and conscientious of sociocultural practices when they are considered safe for the mother, fetus, or newborn. If these practices are harmful, providers should respectfully offer and explain the alternatives.

PROMISING PRACTICES FROM THE FIELD: REFORMING MATERNAL HEALTHCARE POLICIES IN PERU

Peru has one of the highest maternal mortality ratios in the Latin America region at 185 deaths per 100,000 live births. In low-income regions of Peru, the maternal mortality ratio can reach as high as 500 deaths per 100,000 live births. Additionally, approximately 75 percent of pregnant women in rural, low-income areas deliver at home—often with no skilled attendant present.

These conditions have persisted, despite the government's efforts and policies to provide free antenatal and delivery services through the government Integrated Health Insurance (SIS) scheme. Moreover, Peru's healthcare system is being decentralized to the regional level, bringing new stakeholders and implementers to the service delivery scene. Therefore, important stakeholders include not only the Minister of Health and the Director of the SIS at the central level, but also members of the Regional Health Council and Regional Health Directorate (DIRES).

A mother and trader in the Urubamba Valley of Peru carries her child during a day at work, 2005. © Anja Lendvay, Courtesy of Photoshare.

In 2002, the POLICY Project initiated an activity to identify and devise policy strategies to address operational barriers to the provision of essential safe motherhood services in Peru. In particular, the project sought to determine whether the current insurance system was sufficient to ensure that all women have access to antenatal care and delivery services. The research phase identified several operational barriers to maternal healthcare services, including: (1) arbitrary and inconsistent application of the SIS, leading to confusion and uncertainty for pregnant and postpartum women who are entitled to free services; (2) SIS restrictions on the provision of delivery services to certain provider types at tertiary facilities (because the insurance only reimburses services provided by physicians and not midwives, who attend the majority of all births); (3) exclusion of home delivery and transportation to facilities for cost reimbursement by the SIS; (4) lack of consideration for local customs and culture at delivery facilities; (5) poorly organized health networks, negatively affecting the referral system; and (6) lack of appropriate personnel at facilities to match client volume and needs.

To disseminate research findings and plan next steps, POLICY conducted workshops in two regions, Piura and San Martín. The workshops enabled local stakeholders to explore findings, determine the barriers that should be given a priority, and propose potential solutions. The final phase of the project consisted of providing small grants and technical assistance to groups in the two regions to implement, with DIRES support, the proposals that emerged from the workshops.

As a result, in Piura, the DIRES issued a normative document containing specific guidelines for the redistribution of staff among the health centers to ensure adequate availability of providers. The Multisectoral Maternal Health Committee of Piura also issued a Maternal Health Plan directed at reducing maternal mortality and morbidity in the region by addressing the main barriers to maternal healthcare services that were identified during the project's research phase.

In San Martín, the DIRES issued a resolution mandating the creation and implementation of new prenatal and delivery protocols that incorporate cultural practices. These protocols were subsequently included in the 2005–2006 operational plan for San Martín as priority interventions.

While these policy changes represent groundbreaking steps to overcome operational policy barriers at the regional level, improving access to maternal healthcare will also require policy dialogue and advocacy at the national level. In particular, the SIS and its implementation procedures need to be revised to increase reimbursement rates for maternal health services such that they cover all the actual costs of service delivery; allow reimbursement to tertiary facilities for services provided by midwives; and ensure consistent application of the SIS, with special attention to the services covered and eligibility requirements.

CONCLUSION

Countries are increasingly recognizing the need to take concrete steps to reduce maternal and neonatal deaths and disabilities. Any effort to improve maternal health policies and programs must closely consider the operational barriers that may hinder service access and use. Appropriate operational policies can ensure that national maternal health policies and plans are translated into high-quality, accessible, and affordable services for women around the world. As shown above, strategies such as using data for evidence-based decisionmaking, strengthening the advocacy capacity of local groups, and promoting involvement of a range of stakeholders can help to raise awareness of operational policy barriers and issues. Through policy dialogue, data analysis, and meaningful participation, local stakeholders can devise policy solutions—such as improved healthcare provider sensitization, changes in insurance schemes, allocation of resources to underserved areas, and better targeting of user fee exemptions—to expand access to high-quality maternal health services.

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Cover photo: A girl holds a younger child in the Visayas region of central Philippines, 2000.
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