Research Brief

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BEYOND MATERNAL MORTALITY: SURVIVING AN OBSTETRIC COMPLICATION IN BURKINA FASO

80%

The percentage of the direct cost of treatment covered by the subsidy.

The policy to heavily subsidize care does not reach the poorest households.

Globally, the number of maternal deaths have decreased by nearly one-half over the past two decades.[1] However, there are still adverse consequences for women experiencing near-fatal complications during pregnancy or childbirth. For many women, emergency obstetric care is a catastrophic expenditure that may potentially contribute to a cycle of poverty and poor health. This brief summarizes findings from one study that qualitatively examines how some women in Burkina Faso fared after such "near miss" life-threatening experiences.

To reduce the financial barriers to maternal health care services, Burkina Faso adopted a policy to subsidize deliveries and emergency obstetric care (see box, page 2). The subsidy is 80 percent of the total cost of treatment but does not cover nonmedical expenses such as transportation. Additionally, the policy fully exempts the poorest women from paying for obstetric care.[2] The uncovered costs represent a substantial proportion of some women's income—as much as seven days of income earned, and health care workers are often unsure which women are fully exempt. For these reasons, many poor women do not benefit from the subsidies as they should. The policy was adopted in 2006 and will be in effect through 2015.

In 2008, Katerina Storeng and her colleagues conducted repeated in-depth interviews with 64 women who nearly died of a pregnancy-related complication in Burkina Faso between 2004 and 2005, just before Burkina Faso's nine-year policy was implemented.[3] This qualitative study was part of a larger epidemiological investigation that followed 1,000 women for four years after their near-miss complications.[4] These women's experiences illustrate the possible health consequences faced by those not protected by such policies.

Burkina Faso Maternal and Child Health Indicators

	2005/2006	2010
Maternal mortality ratio (per 100,000 live births)	370†	300
Neonatal mortality rate (per 1,000 live births)	39†	38
Percentage of births attended by skilled health personnel	54*	67
Antenatal care coverage (percentage of women)	85*	95

Notes: † Estimate from 2005. * Estimate from 2006.
Source: World Health Organization, Global Health Observatory Data Repository, accessed at http://apps.who.int/ghodata/, on Aug. 2, 2012.

Findings

LOSS OF CONTROL OVER ONE'S BODY

While women considered themselves lucky to have survived a life-threatening obstetric complication, they recalled feeling as if they had no control over their bodies. Many feared that they or their baby would not survive the event and were confused about why they were subjected to certain types of invasive procedures to help with delivery. Many also felt that they received inadequate information from medical staff about what was happening to them. Others felt confused and scared when staff would speak to them in a language they could not understand. Some women even reported that staff would hurt them physically.

Women believed that after giving birth, they had "one foot in the grave" until 40 days passed. Women in Burkina Faso tend to return to regular activities within a few days of childbirth. Women who experience a

"near-miss" event experience a longer delay in resuming productive and domestic duties, which in turn can negatively affect economic conditions at the household level and cause social tensions.[5]

A common belief among interviewees was that loss of physical strength, whether associated with excessive work, illness, or childbearing, was both a cause and a consequence of pregnancy complications. For women, recovering from an obstetric complication is a lengthy and difficult process filled with economic hardships. For some, the unaffordable cost of follow-up care prolonged illness and injury that delayed their ability to return to domestic or agriculture work.[6] Others were told by their health care provider to rest and recover from delivery, but they did not follow this advice because women feared losing their role as a significant economic provider within the family.

DISRUPTION OF HOUSEHOLD ECONOMY

Obstetric complications produce economic hardships for many of the women surveyed because they pay at least some portion of the direct costs for essential life-saving care, and they also forfeit earnings when they must wait weeks to return to productive and domestic duties. Those who survived obstetric complications generally described living in severely impoverished conditions, having fallen into deeper poverty after paying for life-saving but extremely expensive health services. The policy to heavily subsidize such care doesn't reach the poorest households because both poor women and health care workers lack knowledge about the policy's provisions, particularly about who is fully exempt from fees. Many women had acquired debt: borrowing money from family members, neighbors, and money-lenders to pay for obstetric treatment. Some even sold property to pay the fees, further contributing to long-term anxiety and tension within the family.

To restore their position within the household and to mitigate the economic burden from obstetric emergency, some women continued working despite knowing the risks to their recovery. Others refrained from asking for additional health care.

Unmarried women, who tended to be the poorest, experienced the most severe consequences of surviving an obstetric complication. Twenty-five percent of the women in the study were unmarried and required assistance from their family to cover the cost of treatment. Many unmarried women became unemployed and lived in severe poverty for up to a year after giving birth.

COMPROMISED SOCIAL IDENTITY AND STABILITY

The severity of obstetric complications also compromised the social status of interviewees. Many reported experiencing deteriorating relationships with others in their social network, particularly women living in the same compound with co-wives, mothers-in-law, and sisters-in-law who were also affected by using a large share of the family financial resources for the emergency. Some husbands punished their wives for not producing a child. A number of marriages ended in divorce, forcing women to live alone without financial support from their husband.

It was common for women to attempt to have another child soon after the "near-miss" event. While women understood that they were advised by health workers to wait two to three years before attempting another pregnancy, their role as wives did not align with this recommendation. Women who were in polygamous relationships feared that if other wives were producing children and they were not, their position in the relationship would weaken. Some women felt so strongly compelled to become pregnant again that they risked their immediate health and future fertility. This risky behavior contributes to a cycle of repeated obstetric complications, ending either in maternal mortality or depletion of financial resources.[7]

In some cases, husbands supported their wives' use of contraceptives and encouraged them to wait until they had recovered properly from an obstetric complication. To delay another pregnancy, some women admitted to using contraceptives discreetly—preferring injectable contraceptives that could not be easily detected by their husbands. For some women, having their husbands find out about their contraceptive use would result in the husband's taking another wife, being unfaithful, or ending the relationship.

Major Strengths and Weaknesses of the Policy to Subsidize Obstetric Care in Burkina Faso

Strengths

- Political will, including funding in national budget.
- Integration into the health system and community-based management.
- Subsidy for direct costs of treatment, hospitalization, and transportation for obstetric emergencies.

Weaknesses

- Fixed rate of reimbursement for normal deliveries too high.
- Ambiguity regarding some elements of the policy.
- No criteria to define eligibility for free care.
- Lack of resources for policy support activities: communications, technical documentation, and evaluation.

Adapted from: Valery Ridde et al., "The National Subsidy for Deliveries and Emergency Obstetric Care in Burkina Faso," *Health Policy and Planning* 26, supplement 2 (2011): ii30-40.

Implications

The findings highlighted in this brief indicate that prior to the implementation of Burkina Faso's national policy to reduce user fees associated with the provision of obstetric care, the costs associated with care were a considerable burden for poor women. In addition, for poor women, the financial shock associated with obstetric care extended beyond the immediate cost of care. The implementation of subsidized obstetric care can reduce much of the cost for many women and objectives of the national subsidy are certainly worthwhile. Clearer communication of the policy's provisions regarding full exemptions would ensure that the benefits extend to even the neediest women.

Under the current national policy, there is no clear definition of which patients should be eligible for free care, a lack of resources for communicating the policy on subsidies to patients, and little training of health care workers in how to implement the subsidies (see box, page 2). These factors limit the benefits to the poorest women. Establishing a clear fee structure that identifies who receives free services, communicating the fee structure to patients, and training health workers how to apply these fees could direct more resources toward the poor.

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References

1 World Health Organization, *Trends in Maternal Mortality: 1990 to 2010* (Geneva: World Health Organization, 2012).

2 Valery Ridde et al., "The National Subsidy for Deliveries and Emergency Obstetric Care in Burkina Faso," *Health Policy and Planning* 26, supplement 2 (2011): ii30-40.

3 Katerini Tagmatarchi Storeng et al., "Beyond Body Counts: A Qualitative Study of Lives and Loss in Burkina Faso After 'Near-Miss' Obstetric Complications," *Social Science & Medicine* 71, no. 10 (2010): 1749-56.

4 Véronique Filippi et al., "Health of Women After Severe Obstetric Complications in Burkina Faso: A Longitudinal Study," *The Lancet* 370, no. 9595 (2007): 1329-37.

5 Katerini Tagmatarchi Storeng, Melanie S. Akoum, and Susan F. Murray, " 'This Year I Will Not Put Her to Work': The Production/Reproduction Nexus in Burkina Faso," *Anthropology & Medicine* (forthcoming).

6 Katerini Tagmatarchi Storeng et al., "Paying the Price: The Cost and Consequences of Emergency Obstetric Care in Burkina Faso," *Social Science & Medicine* 66, no. 3 (2008): 545-57.

7 Katerini Tagmatarchi Storeng et al., "Mortality After Near-Miss Obstetric Complications in Burkina Faso: Medical, Social, and Health-Care Factors," *Bulletin of the World Health Organization* 90, no. 6 (2012): 401-76.

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