



Assessment of the impact of the free delivery and caesarean section policy in Morocco

New tools, new knowledge



OVERVIEW

In 2008, the Ministry of Health implemented a plan for accelerated reduction of maternal and infant mortality (PRMMI) encouraging deliveries under medical supervision.

The PGAC, the key measure of this plan, is intended to be available to any woman giving birth regardless of her socio-economic status. It entitles her to benefit from a package of services in public hospital facilities.

The objective of the FEMHealth research was to evaluate the PGAC through analysis of its design, funding and implementation at the local level and effects on the six

KEY MESSAGES

- 1** The free delivery and caesarean section policy (PGAC) was effectively implemented with a clear formulation of its overall objectives. However, at the outset there was a lack of clarity about the definition of the package of targeted activities and the population, stakeholders and their responsibilities.
- 2** The PGAC has probably contributed to an increased use of hospital maternity wards, significantly alleviating the financial burden of women giving birth on their families. Certain expenses are still borne by
- households, such as the prescription at the time of discharge (median cost of 313 MAD), inter-facility transfers for some women, and transport from home (between 50 and 150 MAD).
- 3** Although socio-economic disparities in access to health care according to categories have been reduced, this cannot be exclusively attributed to the PGAC.
- 4** The coverage of emergency obstetric needs is adequate. It was noted in the study site hospitals that care for the mother is acceptable technically, but needs improvement in terms of relationship with patients. Care for the newborn is less satisfactory.
- 5** The workload generated by the PGAC is perceived to have increased by staff and is a source of dissatisfaction.
- 6** Sustainability of the PGAC depends on its compatibility with the move towards general provision of universal coverage and its integration in the regionalization process. The plan for accelerated reduction of maternal and infant mortality (RMMI) absorbs 2.8% of the overall budget of the Ministry of Health. This is an element conducive to the sustainability of the policy. Sustainability of the PGAC is also dependent on the degree of ownership by health professionals.

functions of the local health system. This evaluation also looked into the effects of the PGAC on the reduction of the financial burden for households, on the quality of care and on the governance of the local health system.

This research was carried out over three years by a team of multidisciplinary national and international researchers. Innovative tools were developed and used to assess the effects of the PGAC.

The PGAC was one of the first policies of the PRMMI to be introduced and therefore preceded other accompanying measures which might have prepared the ground for its implementation. Its implementation has been characterized by a very limited involvement of local providers and the community. Thanks to the PGAC, women enjoyed exemption from delivery and caesarean section fees in hospitals. However, other delivery costs are still borne by households.

One of the expected results of the policy was improved accessibility for the poor. Both the rate of deliveries with medical supervision and caesarean sections rates increased, in the same upward trend from the mid-2000s, and this evolution cannot be attributed to the PGAC alone.

The quality of care offered is satisfactory from a technical viewpoint. However, efforts are needed to improve the relationship between providers and women and also the quality of care for newborns.

MAIN PROBLEM

Maternal and neonatal mortality is a priority issue in Morocco. In 2003, the national population and family health survey (ENPSF) revealed that the maternal mortality ratio was 227 for 100,000 live births, and the neonatal mortality rate was 27 for 1,000 live births. The main obstacles to access to emergency obstetric care services were financial barriers (for 74% of women), distance to a health facility (60%) and transport (46%).

To reduce these barriers to access, Morocco introduced the PGAC in December 2008.

It should be noted that deliveries were already free at basic health care facilities, and that in hospitals deliveries and caesarean sections were also supposed to be free for the poorest (women with a certificate of indigence).

Table 1: Different delivery-related fees paid by households

	Pay	Do not pay	Cost (MAD)
Antenatal		X	
Home-hospital transport	X	X (if SAMU OR)	50 to 150
Caesarean section		X	
Medicines on the essential list (Oxytocin, Magnesium Sulphate, etc.)		X	
Prescription upon discharge	X		350
Lab test	X (before 2012 circular)	X (after 2012 circular)	
Transfer	X (if no diesel oil)	X	100 to 150
Newborn care		X	
Complications (Haemorrhage, eclampsia, abortion, etc.)	X (at the beginning of fee removal)	X	
Other intra-hospital costs	X		177

To obtain evidence on the effects of the PGAC, Morocco participated in the FEMHealth project along with Benin, Burkina Faso and Mali. The objectives of this project are to strengthen the scientific evidence on the effects of the removal of fees and to guide strategic decisions. Supporting the establishment of the Community of Practice on "Financial access to health services" (CoP AFSS) was an innovative approach as part of this research to promote interactions between researchers and decision-makers.

This document sets out how in Morocco the PGAC was developed and implemented, and what its effects have been on household spending, on the local health system and its six functions, the workload of staff, quality of care and equity of access to care.

METHODS

FEMHealth is a research project combining several evaluative cross-sectional studies, mixing quantitative and qualitative tools.

This project analysed the national level in terms of the design of the policy, funding of the removal of fees and changes in access to delivery with medical supervision and to caesarean section.

The research project was conducted in six provinces and their referral hospitals, selected on the basis of criteria relating to the context of the population (poverty, geographical accessibility), and level of use of the services prior to the introduction of the removal of fees (rate of caesarean sections and deliveries with medical supervision). The study lasted three years. Several tools, of

which some are innovative, were used. Data was collected through a literature review, interviews, questionnaires and observations.

The targeted audience includes policy-makers, managers, providers, expectant mothers and their families.

A comprehensive report and several thematic reports have been produced.

MAIN FINDINGS

The decision to introduce the PGAC in late 2008 resulted from centralized decision-making and implementation, with no effective involvement of the local level. Community participation has also been partial and mostly informational.

Communication about the PGAC was done through circulars and posters. Meetings to provide information and support were related to the PRMMI as a whole.

An additional grant was awarded to hospitals (68 million MAD in 2009 and 75.5 million MAD in 2010). An increased number of delivery kits and life-saving medicines was provided. This was one of the strengths of the PGAC.

The strengthening of human, material and logistical resources was insufficient. There was no PGAC-specific information system.

The sustainability of the services offered is not assured, mainly because of the shortage of human resources.



Stewardship has not been strengthened by the PGAC.

Managers at local level have readily adopted the PGAC since it introduced little change to their current practices.

The workload has increased slightly, although the health personnel perceive it as burdensome and affecting the quality of care.

An upward trend in access to emergency obstetric care started 10 years ago, particularly for the poorest sector of the population, but substantially also for the middle quintiles. This evolution cannot be attributed exclusively to the PGAC.

Households sometimes bear expenses which should be covered in principle by the policy, such as inter-facility referrals. Other non-targeted costs increase the financial burden of households, such as the prescription when discharged from hospital, transportation from home to the hospital and expenses for accompanying persons.

For the majority of the poorest households (88%), delivery costs have accounted for more than 15% of their overall spending in one month. Almost half of these households had to ask for help from their family or borrowed money.

During the course of the study, 39% of women had a near-miss during hospitalization. Appropriate interventions are not systematically undertaken for the management of all women in labour, and particularly for newborns.

Overall, women were satisfied with their hospital stay. However, they didn't enjoy their stay in the delivery room, especially because of poor hygiene. The quality of personal care also needs to be improved in some maternity hospitals.

DISCUSSION

A delivery fee exemption policy on its own remains insufficient to ensure equitable access to health services. In Morocco, the upward trend in deliveries under medical supervision and caesarean sections emerged 10 years ago, including for the poorest category and cannot therefore be attributed exclusively to the PGAC.

It should also be noted that the increase in caesarean section rates in the private sector for the wealthy, has created a false

impression of inequity between categories.

The PGAC was introduced centrally without effective accompanying measures (for example, without instructions and information for staff responsible for implementation). The policy was however generally adopted by managers and providers firstly, because policies are usually executed in this way (through strong central power), and secondly because the staff seem convinced of the importance of removing fees for the population, and because this policy has introduced little change in the current practices of local providers.

The elements covered by the PGAC package have not been able to eliminate all costs related to delivery and caesarean sections. The prescription at the time of discharge from hospital and transport still remains a major costs borne by households. The technical quality of care is satisfactory for the mother but is yet to be improved for the newborn. In the absence of historical data, these results cannot however, be attributed to the PGAC.

Work load is perceived to have increased according to staff, with a negative effect on the quality of care.

Under the PGAC, no incentives of any sort were introduced for staff.

RECOMMENDATIONS

The target group of this research includes policy makers, researchers and care managers.

Some recommendations from the results of the research have already been included in the 2012-2016 action plan of the Ministry of Health. Nevertheless, we would like to stress the importance of the following recommendations

For decision-makers:

- Strengthen interventions focused on vulnerable populations and implement interventions specifically for the poor, particularly in remote areas.
- Strengthen the PGAC pending the general introduction of universal coverage. The current targeted policy guarantees the management of delivery for women who are not eligible for the other modes of health coverage during this transition period.
- Ensure a clear formulation of the policy and well established implementation and accompanying procedures.

- Strengthen stewardship and define mechanisms for monitoring and evaluating the implementation of the policy, and its effects on the local health system.
- Give newborns more importance through targeted actions, focused on competent human resources and properly equipped facilities.
- Include the prescription charge in the care package.
- Make local delivery centres attractive (providing technical quality, comfort, and privacy), in order to address the bypassing of the local care sector.
- Ensure arrangements are made for safe and speedy transfer when required, from all delivery homes to specialist care, with support from skilled staff.
- Increase the number of drugs and supplies covered by the policy, and organize ongoing training for all staff involved.
- Increase and repeat awareness-raising relating to the PGAC services among expectant mothers, local managers and health professionals.

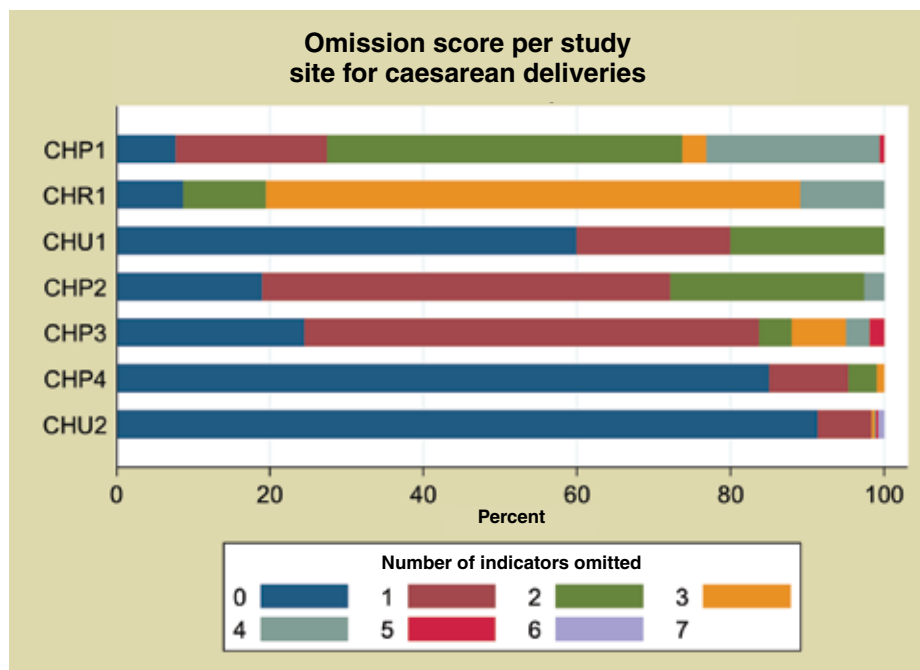
For care managers:

- Improve the entry of information in the medical records and complete records systematically.
- Ensure the quality of the information system at all levels.
- Develop a database on near-miss cases to be used especially in clinical audit.
- Involve professionals and the population to continuously address their concerns. Improve the patient-provider relationship and ensure good practices are introduced and followed.
- Train care providers in personal development and interpersonal communication.
- Improve inter-facility coordination to reduce unnecessary referrals.
- Improve the availability of services through the enforcement of the decree on duty periods, particularly in settings where gynaecologists do not live on-site.

For researchers:

- Conduct further studies to improve the production of quality indicators using the routine information system, and test them in different contexts for increased validity.
- Conduct studies to examine the use and provision of services (such as caesarean sections in private facilities).

Table 2



CONTACT

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KEY RESOURCES

- FEMHealth report (2014) "Assessment of the impact of the free delivery and caesarean section policy in Morocco, new tools, new knowledge".
- Report on "Interviews with parturient women upon discharge".
- Report on "Interviews with care providers".
- Report on "Monitoring of financial flows".
- Report on "Qualitative interviews with actors".
- Report on "Assessment of the implementation of the policy".
- Report on "Mapping the effects of the policy".
- Report on "Effects on the use and quality of maternal and neonatal health services".

All available at:
www.abdn.ac.uk/femhealth

