Partnership for Reviving Routine Immunisation in Northern Nigeria; Maternal Newborn and Child Health Initiative

FINANCIAL BURDEN OF PAYING FOR EMERGENCY MATERNAL HEALTH CARE

The true costs of paying for emergency maternal health care hold implications for poverty reduction and health improvement.

The Challenge

Women and babies are dying in Northern Nigeria because women delay seeking treatment or are unable to access it at all. Many of these deaths are entirely preventable. Affordability of care is a particular problem in the case of emergency maternal health care where costs of a birth complication can be crippling for poor households. Sixty-one per cent of the population in the North West zone and 65% in the North East zone live on less than one US dollar a day.

In the PRRINN-MNCH states, around 15% of pregnancies result in complications. The birth of a child – a time of joy and celebration – can quickly turn to a time of hardship, difficult decisions, and even tragedy.

Some northern states have committed to introducing free maternal, newborn and child health services. To build consensus around and to support free care, state governments needed evidence to back up the policy. In response to this, PRRINN-MNCH designed and implemented a survey that examined the financial burden of emergency maternal health care. The following brief reviews the findings of the survey.

The Evidence

The Financial Burden of Emergency Maternal Health Care Survey[1] was implemented in Katsina, Yobe and Zamfara in December 2009. The survey was implemented in 28 communities in eight Local Government Areas (LGAs) across the three states with a total of 1485 respondents.

The survey aimed to gather evidence on:

The costs of Emergency Maternal Care incurred by households

How households raised money in the event of a maternal health emergency

The short and long-term impact on households of financing maternal emergencies.

The costs of Emergency Maternal Care

- Households spent an average of US $103 when seeking treatment for a maternal emergency.
- The majority of expenditure went on the direct costs of treatment, but indirect costs (e.g. transport, firewood, food) were also high with an average spend of $26, while the maximum amount reported was $183.
- The average cost of blood transfusion and a caesarean section was $47 and $40 respectively, but some people paid considerably more than this.
- The cost of different treatments varied considerably across the states, and between cases.
- Families are often dissuaded from seeking care because of unknown, potentially substantial costs.
- The average sum spent on transport was $12, with the maximum amount reported as much as $164.
- Paying for food when a patient was admitted was costly. On average, families paid $17 for the woman and for the family members that had accompanied her.
- Hard to reach communities were more likely to incur very significant costs to access emergency maternal care – 33% of these respondents incurred costs over $134.

In Katsina and Zamfara, 22% of household heads earned a monthly income more or equivalent to $97.50 - the average cost of dealing with a maternal complication. In Yobe, this figure was 15%.

The average cost of a maternal complication was therefore more than the average monthly income of 78% of household heads in the three states.

For those individuals who paid more than the average cost of a maternal emergency, affordability was even lower.

Any health care expenditure that forces a household to reduce its expenditure on food, on schooling, or on other essential items over time can be defined as catastrophic (i.e. likely to deepen a family's poverty). For many people in the three states, a maternal complication is a financial catastrophe.

1 The full survey can be found on www.prrinn-mnch.org

How households raised money

Many households used a mix of strategies to pay for a maternal complication, including use of personal savings, sales of livestock, farm produce or land, and borrowing money from family, friends or money lenders. Of the household heads interviewed who are traditionally male:

32% sold farm animals or produce in order to raise funds.

15% took out a loan from family, friends or money-lenders

3.3% were forced to sell land.

Of the female respondents interviewed:

21% contributed from their own savings

21% sold either animals or farm produce to raise cash.

"I have had to sell my produce so now we just eat anything that is available. Of course we thank God that she is alive, but I would not want to find myself in this situation again."

Male household head

The short and long-term impact

Sales of produce, land or livestock often attract lower than market value and many households are unable to recover assets quickly. Among the household heads surveyed:

68% who sold farm produce, 43% who sold land, and 39% who sold livestock or smallstock obtained lower than market value.

58% who sold land and 44% who sold livestock took more than a year to regain their assets.

21% who sold livestock felt that they would never be able to replace the livestock;

25% had no livestock or smallstock. Half of these respondents belonged to the lowest income group and faced very serious problems when needing to respond to a maternal emergency.

Overall the survey found that the additional financial burden of a maternal complication in a context of poverty can cause both short and long term hardship. One maternal complication can be the trigger that forces many households deeper into poverty.

Implications for Policy Makers

Increasing the affordability of emergency maternal health care should be a key priority within state poverty reduction plans.

Free maternal, newborn and child health programmes need to be adequately funded by the states. The public must have the confidence to seek timely treatment for a maternal emergency without the fear of financial burden.

State intervention must address the indirect and the direct costs of emergency maternal health care. Careful consideration will be needed on which strategies can be used to this end.

PRRINN-MNCH community systems can address some of the financial barriers of access to emergency maternal health services. Some LGAs have blood donor groups, subsidized emergency transport (led by the National Union of Road Transport Workers), and community loan and saving schemes.

States need to plan for how they can roll out and scale up this work so that other communities can participate.

The Financial Burden of Emergency Maternal Health Care Survey report can be obtained from PRRINN-MNCH.

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