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PROJECT BRIEF

Understanding Barriers to Facility-Based Births in Senegal

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Maternal mortality in Senegal remains unacceptably high with 273 maternal deaths per every 100,000 births, 4x as many as the Sustainable Development Goal of 70 or fewer per 100,000 births. Skilled birth attendants (SBA) are the most effective way to reduce morbidity and mortality among mothers, reducing serious health risks by about 20%. But low-income women and women living in rural areas are much less likely than their wealthier and urban counterparts to give birth in a facility, which is the only way to access SBA in Senegal. We conducted foundational research to understand the barriers to facility-based delivery (FBD) in Sedhiou and Kolda, two regions in southern Senegal.

Summary

Every day, approximately 830 women around the world die from complications related to pregnancy and childbirth. A whopping 99% of these deaths occur in low- and middle-income countries (LMIC), and most are preventable. A woman giving birth in Senegal is 23 times more likely to die than a woman giving birth in a high-income country.

Skilled birth attendants (SBA) are the most effective way to reduce morbidity and mortality among mothers, reducing serious health risks by about 20%. One reason they are so effective is that SBA are trained to recognize warning signs of obstetric complications such as hemorrhage and sepsis, which are difficult to predict and typically occur during or close to delivery.

Delivery with an SBA is rarely available outside of health facilities in Senegal. While Senegal has a relatively high rate of facility-based birth (78%), this masks significant socioeconomic disparities: low-income women and women living in rural areas are much less likely to give birth in a facility (53% and 69%, respectively) compared to their wealthier and urban counterparts (96% and 94%, respectively). Helping more women give birth in facilities would increase access to skilled birth attendants, reducing disparity and saving lives. That's why we focused on identifying behavioral barriers to facility-based delivery (FBD) together with our partners IntraHealth International and the Ministry of Health and Social Action in Senegal and funded by USAID as part of the Neema project, which aims to improve health for women and children in Senegal by strengthening health services and making them accessible to more people.

The bumpy road to facilities

We began by conducting a literature review, observing six health facilities, and conducting structured conversations and focus groups with 14 recent mothers and pregnant women and 12 health workers in Sedhiou and Kolda. This first phase of work revealed significant structural barriers to FBD. Access to facilities is limited in rural areas where narrow, bumpy dirt roads flood during the rainy season and close at night and where typical transportation options – donkey or horse cart and motorcycle taxi – are uncomfortable for women in labor and not always readily available. Facilities are hot, crowded, and offer little privacy, and quality of care is generally low due to severe understaffing, lack of training and supervision, and stock-outs. And while delivery itself is free, ancillary costs (transportation, bed fee, medications) typically add up to around 5,000-15,000 CFA (~$8-$24), a significant sum in a country where 38% of the population lives on less than $2 per day.

In spite of challenges with the quality of care, most of the families we spoke with said that it was preferable to give birth in a facility instead of at home. And despite structural barriers to access facilities, 97% of pregnant women in these regions attend at least one antenatal care visit with a qualified provider in a health facility. Although the cost of FBD may be prohibitive for some families, many families who choose a home birth reportedly spend significantly more money on a baptism ceremony soon after the birth. We concluded that structural barriers, while significant, were likely not the only barriers at play, and we returned to the field to dig deeper into the behavioral barriers preventing FBD for those with access to facilities.

Behavioral barriers

Focusing on villages within walking distance of health facilities in order to minimize structural barriers, we conducted additional conversations with 13 recent mothers and pregnant women, five husbands, seven mothers-in-law, and three health workers. We identified seven primary behavioral bottlenecks to FBD[1]:

Miscalculating the risks and benefits of delivering in a facility. We heard repeatedly from families that visiting a health facility for antenatal care or having given birth at home without issue in the past makes a home delivery safe – when in fact complications can arise during or after delivery regardless of precautions during the prenatal period, even for women who had successful home births in the past.

The perception that FBD is not intended for them. In some communities we visited, FBD is perceived as appropriate for wealthy women or for sick women – not for healthy, low-income women.

Negative associations with health facilities. Many families shared stories of unpleasant experiences with health workers, such as unwelcoming or impolite attitudes, restrictive birth positions, and prolonged financial disputes.

Lacking a clear moment to make a concrete decision about where to deliver, or lacking a definitive decision-maker. While deciding on the location of the birth is

> *"At the time, I felt okay about giving birth at home because I was going to the health post regularly for my medicines."*
>
> — Pregnant woman, Kolda

> *"The midwife was not very welcoming; the health workers are very harsh."*
>
> — Recent mother, Sédhiou

> *"The mother-in-law usually decides where a woman will give birth. The husband's attitude also matters—if he has several wives and a lot of kids, he may not want to pay for a facility delivery or prenatal care. The woman's pregnancy is that of the whole family."*
>
> — Midwife, Kolda

> *"No one can plan future birth, God decides that. I would like to give birth at the health post because now they say in the village that it's better to deliver there, but you can't plan the delivery."*
>
> — Pregnant woman, Sédhiou

[1] We describe each bottleneck as applying to the family as a whole, rather than just the mother-to-be, as decisions about where a woman will deliver are often made by or in conjunction with her husband, mother, grandmother, mother-in-law, or other family members.

one part of the birth plan that, according to national policy, should happen at antenatal care visits, in practice these plans are often skipped or soon forgotten. In many cases, the family members responsible for making decisions about the pregnant woman's health – typically husbands and mothers-in-law – are not present at antenatal care visits in order to hear about the benefits of FBD or partake in the planning. The vast majority of women we spoke with stated they did not discuss delivery location with other family members prior to the onset of labor.

> *"Even if women want to come to the health post, the mother-in-law will keep women at home and tell them to wait until the pain is very strong. Then they may wait so long that the baby is born."*
>
> — Midwife, Sédhiou

> *"Here in the community, women are proud of giving birth at home and unaided. Women brag about it among their friends and peers and tell them 'no one helped me give birth."*
>
> — Pregnant woman, Sédhiou

Not making arrangements to get to the facility before labor begins. Families may not make travel arrangements in advance due to ambiguity around the due date – many families do not use calendars, and some women track their pregnancy using the moon. Another reason why families may not plan their travel in advance is an external locus of control, sharing credos such as "Man plans, God decides."

Changing their mind about where to deliver when in labor. Families may change their mind once labor begins due to the hot-cold empathy gap – labor is painful and mentally taxing, perhaps making the immediate sacrifice of the comfort and privacy of home for the discomfort of travel in order to labor for hours in a hot, crowded facility feel like it's no longer the best option.

Waiting too long to leave home for the facility. Families may not leave for the facility in time due to a reliance on faulty heuristics. Recent mothers and midwives universally shared the heuristic of "strong pain in stomach" as the right time for women to come to the facility – but this threshold is often too vague, especially in communities where expressing pain is seen as weak. Additionally, some pregnant women worry about being cursed by co-wives or other negative spiritual outcomes that could result from being seen while in labor, preferring to wait until the last possible moment to leave for the facility.[2] Once they are certain that labor has begun, it may be too late to arrange transportation.

Takeaway

Most maternal deaths in LMIC are preventable, and helping more women access skilled birth attendants is key to reducing this health disparity. More skilled birth attendants are certainly needed alongside better transportation and lower costs, but in Senegal at least, SBA can only help those who come to the facility. That's why an effective solution in Senegal and other similar contexts will need to address both structural and behavioral barriers to facility-based delivery in order to succeed. Identifying and understanding the behavioral barriers to FBD is the first step toward designing a solution that will help women and their families make an active choice about where they will deliver and follow through on that decision—helping to reduce maternal mortality.

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[2] Polygamy is common in Sedhiou and Kolda, with about 40% of women in union reporting having one or more co-wives. https://dhsprogram.com/pubs/pdf/FR345/FR345.pdf