

HEALTH

# Enticing Pregnant Women in Liberia to Give Birth in Health Centers

By ANERI PATTANI JULY 3, 2017

GANTA, Liberia — Evelyn Dolo saved a teenage girl's life, but not out of good will alone, she admits.

A traditional birth attendant for more than 15 years in the small Liberian village of Zahmbooyee, Ms. Dolo was summoned one night to help the teenage girl deliver her baby. Ms. Dolo rushed the girl to the nearest hospital, about 25 miles away, where she was immediately taken into surgery.

A cesarean section saved both her and her baby's life, said Zlangbah Dahn, head of obstetrics and gynecology at Ganta United Methodist Hospital.

Ms. Dolo's objectives in the case were twofold: She was racing to save the girl's life, but she was also compelled to rush to the hospital under the rules of her village. Rather than deliver women's babies at home, birth attendants in many villages are required to bring pregnant women to health centers or face penalties. In Ms. Dolo's village, failure to comply would have meant a payment to the town elders of 5,000 Liberian dollars (about \$50), a gallon of palm oil and a tub of cooked rice.

The local policy essentially forces women to give birth in health centers by threatening financial penalties — a practice aimed at curbing maternal deaths. In Liberia, 725 women die for every 100,000 live births — among the highest rates of maternal mortality in the world.

The practice is not a national policy regulated by the Ministry of Health, although the Liberian government does encourage women to give birth in health facilities as part of its push to lower maternal deaths in childbirth. Instead, it varies from one community to the next. In some villages, the fine is much lower or offenders must pay in cattle. In others, the nearest health clinic levies the fine rather than the town leaders.

Local clinicians say they are seeing more women deliver in hospitals as a result. “It’s working,” Ms. Dahn said. “Home births still happen in the village, but more birth attendants are bringing women here.”

But American experts fear the practice might deter those who deliver at home from visiting a hospital or a clinic for other health care. It is also unclear if the practice actually saves more mothers’ lives.

“This is a very complex issue and something like a penalty is a blunt instrument,” said Lynn Freedman, the director of Columbia University’s Averting Maternal Death and Disability program. “I don’t think it gets countries or their populations where they want to be.”

Coercive measures can set up negative associations with the health care system, she explained. It could make mothers who deliver at home reluctant to bring their children to clinics for vaccines or other care, fearful that they might be treated as delinquents who broke the rules.

The idea of using fines to enforce certain maternal health behaviors is not a new concept, but it is fairly rare. Punitive measures to get women to deliver in hospitals have also cropped up in villages in Zambia, Tanzania, Malawi and the Philippines, Ms. Freedman said.

Other countries, including Nepal, Cambodia and India, have incentive programs rather than coercive measures. In India, where the government gives women cash to deliver in a hospital or a clinic, institutional deliveries increased to 49 percent in 2010 from 20 percent in 2005.

The goal of these programs is twofold: to ensure a woman has easier and quicker access to a C-section if she needs it, but also for her to be assisted by a trained midwife rather than a traditional birth attendant.

While traditional birth attendants have historically played an important role in supporting pregnant women in rural areas, they may be untrained and may sometimes follow dangerous practices. In Liberia, some birth attendants will roll a pestle on the mother's stomach to try to push the baby out, said Eunice Josiah, a registered midwife at a health clinic in Boegeezay. The practice can rupture the woman's uterus, endangering the lives of both the mother and child.

Another problem is that birth attendants do not have the surgical tools that a health center can provide. For example, if a woman is in obstructed labor, where the baby cannot exit the uterus, a birth attendant cannot perform a C-section. By the time the woman reaches a hospital, it is often too late.

That was the case for a woman from a rural village called Yarnee. She had gone into labor on a Friday and continued laboring at home for three days before someone suggested she needed to go to a hospital, said Dr. Mamady Conde, the only full-time practicing physician in that county. That was when she and her brother began the nearly two hour walk through narrow footpaths in the forest, followed by an hour and half canoe ride to Cestos, the city where the nearest hospital was. By the time the canoe reached the shore, the woman had died, Dr. Conde said.

Dr. Jeffrey Smith, an obstetric gynecologist who is the vice president for technical leadership at Jhpiego, a nonprofit health organization at Johns Hopkins University, said women and their babies who arrive at a clinic can get better access to ambulances that can take them to the nearest surgical center.

"You have a minute, maybe three minutes, to resuscitate that baby if it's not breathing at birth," he said. "Being in a facility reduces the critical response time if there is an emergency."

But these theoretical benefits do not always translate to the field. In India, facility deliveries spiked after the cash incentive program, but there was no meaningful difference in maternal mortality rates.

Facilities cannot just exist as buildings, Dr. Smith said. If more women are coming into clinics, then those places need to have increased staffing and supplies to care for them.

“If you double the workload but don’t change the number of staff or the capacity of the health system, you have the potential to anger people and increase instances of disrespect and abuse toward the patient,” he said.

A clinic in Boegeezay is working to address that concern. While it fines birth attendants 750 Liberian dollars (\$8) for a home delivery, it is also trying to provide better care to make women want to deliver there.

The clinic has a maternal waiting home, where mothers can stay near the end of their pregnancy, eliminating the risk that they will go into labor in a village too far from emergency care. Each woman is given her own room and bathroom, as well as meals, at no cost.

The clinic also works with community health workers who are trained to help expectant mothers develop a birth plan that details how they will save money and arrange transportation to reach the clinic in advance of their delivery.

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