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When things fall apart: local responses to the reintroduction of user-fees for maternal health services in rural Malawi

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Abstract: *Despite the strong global focus on improving maternal health during past decades, there is still a long way to go to ensure equitable access to services and quality of care for women and girls around the world. To understand widely acknowledged inequities and policy-to-practice gaps in maternal health, we must critically analyse the workings of power in policy and health systems. This paper analyses power dynamics at play in the implementation of maternal health policies in rural Malawi, a country with one of the world's highest burdens of maternal mortality. Specifically, we analyse Malawi's recent experience with the temporary reintroduction of user-fees for maternity services as a response to the suspension of donor funding, a shift in political leadership and priorities, and unstable service contracts between the government and its implementing partner, the Christian Health Association of Malawi. Based on ethnographic research conducted in 2015/16, the article describes the perceptions and experiences of policy implementation among various local actors (health workers, village heads and women). The way in which maternity services "fall apart" and are "fixed" is the result of dynamic interactions between policy and webs of accountability. Policies meet with a cascade of dynamic responses, which ultimately result in the exclusion of the most vulnerable rural women from maternity care services, against the aims of global and national safe motherhood policies.* DOI: 10.1080/09688080.2018.1535688

Keywords: accountability, power, health systems, traveling models, maternal health policy, user-fees, home-birth fines, inequity Malawi

Introduction

In December 2015, a group of village heads marched into the office of a local non-governmental organisation (NGO) which worked to enhance communities' self-reliance in the areas of health, education, environment and advocacy. The village heads had just received news that from January 2016, women needed to pay for maternity services in the nearby health centre, run by the Christian Health Association of Malawi (CHAM). This reintroduction of user-fees contradicted Malawi's Presidential Safe Motherhood campaign of 2012–2014, launched by former president Joyce Banda and underpinned with substantial donor funding and political legitimacy.¹ Banda's renewed attention to an existing policy^{2,3} intended to reduce

Malawi's high maternal mortality ratio (497 deaths per 100,000 live births)⁴ by encouraging women to give birth in health facilities, banning traditional birth attendants (TBAs), constructing maternity waiting homes, and training community midwife assistants.⁵ Banda mobilised traditional leaders to promote institutional deliveries,⁶ which were free at the point of care in public and certain CHAM facilities. The user-fee reintroduction also contradicted service delivery contracts between the Malawian government and CHAM that were supposed to guarantee user-fee exemptions. The group village headman, leader of several other village heads in the area, asked the NGO's director for assistance to get the free services back and expressed his worries:

“It is a big problem, because women don’t have the money to pay for delivery, so they will give birth at home. Many women will die! The TBAs [Traditional Birth Attendants] will have to help them, but there is no clean room where they can give birth.”

In this article, we examine the reintroduction of user-fees, after several years of exemption policies, and its impact on service access through an analysis of the perceptions, experiences and actions of various local actors: health workers, village heads, and women. We situate this in the changing funding landscape, namely the withdrawal of donor funds, and relate it to two relevant policies, the Presidential Safe Motherhood Campaign and the Service Level Agreements (SLAs). We analyse how dynamic relationships of power and accountability at various interfaces interact with these policies and show how in a donor-dependent and under-resourced setting, different actors apply their limited agency to manage and “fix” services that are “falling apart” in relation to their own priorities. This generates a cascade of dynamic responses – behaviours and relationships arising from within and outside the health system – in relation to policies,⁷ which ultimately result in the exclusion of the most vulnerable rural women from maternity care services, against the aim of global and national safe motherhood policies. This ethnographic study supports a growing body of evidence regarding the inequitable effects of user-fees,^{8,9,10} problems in relation to “traveling models” (uniform interventions which “travel” from global to local levels) such as skilled birth attendance and user-fee exemption policies,^{11,12,13} and the role of multiple actors in the generation and mitigation of problematic policies and their effects. In this way, we illuminate processes leading to inequity, a central challenge to achieving the Global Strategy for Women’s, Children’s and Adolescents’ Health and the Sustainable Development Goals (SDGs).¹⁴

Power and accountability

Financing mechanisms, shaped by nation states, as well as non-state actors and donors, are a key determinant of health care access. After structural adjustment programmes were implemented, anthropologists¹⁵ and other scholars⁸ demonstrated how user-fees undermined public sector services for the poor. A review of the empirical literature shows an adverse effect on maternal and

child health, especially among the poor.¹⁰ In recent years, user-fee exemption policies have been widely implemented. A quasi-experimental analysis comparing three Sub-Saharan African countries with user-fee exemption policies, and seven without, has shown a modestly higher skilled birth attendance and lower neonatal mortality rate¹⁶ where fee exemption was implemented. Other reviews show that user-fees are an important source of facility revenue, and if not replaced, can negatively affect provider behaviour and quality of care.^{9,17}

An analysis of power is necessary to understand the events leading up to the temporary reintroduction of user-fees and its effects. Power dynamics are an under-examined but key feature of health policies and systems.^{18,19} Power manifests implicitly or explicitly at the global, national and local level, and is present at each actor interface, shaping actions, processes and outcomes.¹⁸ “Traveling models” are adapted or resisted by health providers, whose behaviour is strongly shaped by practical matters, informal norms, professional culture,¹¹ and power dynamics.¹⁹ Examining how policy works out “on the ground” requires a multi-level analysis of power relations and the reflexive, complex and dynamic responses of health system actors.⁷ Since health systems are deeply political and a core social institution, functioning “at the interface between people and the structures of power that shape their broader society”,²⁰ analysing power in health policy and systems improves our understanding of the underlying causes of inequity.¹⁸

Power is conceptually fluid, and often discussed in the context of closely related concepts, such as accountability.¹⁸ Accountability has three dimensions: *responsibility* (holding responsible, taking responsibility), *answerability* (providing information, justifying actions), and *enforceability* (sanctioning inappropriate actions).^{21,22} Just as sources of power are always relational and context-dependent,²³ so is accountability. Actors are involved in multiple accountability relationships or “webs of accountability”, which are uneven. The moral landscape that forms, enacted in a context of risk and under-resourced systems, affects behaviours, interactions, health systems functioning and the quality of maternity care,²⁴ as discussed below.

Methods

The analysis draws on the first (HP) and second (BdK) authors’ research on maternal health in

Malawi, and, specifically, HP's ethnographic fieldwork in Mangochi district between May 2015 and August 2016. This was part of a broader project looking at interactions between international NGOs and local communities in attempts to reduce teenage pregnancies. Problems related to payments of service contracts and their consequences on the quality of maternity care overall emerged as an important theme. Between October 2015 to February 2016 and July to August 2016, HP conducted participant observation in the semi-rural area where she lived with her experienced research assistant and third author (GF) and where the health centre referred to in the introduction section was located. HP and GF investigated what happened over time, how the health centre dealt with financial setbacks, and how midwives, village heads and women responded to events and each other's actions. HP, accompanied by GF, interviewed and had follow-up conversations with a programme officer of the Catholic Health Commission (CHC), the director of the local NGO, the chair of the civil society organisation (CSO) network, nuns and midwives at the health centre, the local councillor, community health workers known as Health Surveillance Assistants (HSAs), and village heads and their advisors in two villages. HP also interviewed the then Minister of Health, examined the village birth register book, collected statistics on the uptake of services at the health centre and discussed patterns with the head midwife.

Core to the ethnographic method was the informal conversations and observations, which emerged from daily participation in the village, long-term interactions with families, and repeated visits to the health centre. HP and GF asked whether women and girls in the village had heard about the reintroduction of user-fees. Worries or stories they had heard were shared with the researchers. HP and GF also asked women with new-borns where they had given birth and why. Observations in the village, for example during meetings at the chief's house, or discussions between women, were informative in understanding general discourses. Observations during visits at the health centre before and after the reintroduction of user-fees confirmed a reduced uptake of services. GF continued data collection between late February and June 2016 while HP was away from the field and had weekly phone conversations with HP to discuss findings.

The National Committee on Research in the Social Sciences and Humanities in Malawi and

the Norwegian Social Science Data Service provided ethical approval. Following local ethics approval, HP obtained permission from the District Commissioner, the Traditional Authority, the Group Village Head and the Village Head to conduct research in the area. She obtained oral informed consent for interviews and household visits and introduced the research aims during a village meeting. The interview with the Minister of Health was recorded. HP and GF took detailed notes during all other interviews and transcribed them as soon as possible thereafter. They registered informal conversations and observations in digital field journals. Interviews were conducted in English. GF translated informal conversations and interviews in the village from *Chiyao* and *Chichewa* into English. NVivo Pro was later used to organise data in a database.

Data collection and analysis were part of an iterative and inductive ethnographic process, which built up to a rich contextualised analysis. HP and Bdk analysed actors' perceptions and dynamic responses to the unfolding events and each other's actions. Discussions between the authors, Bdk's knowledge on Safe Motherhood policies in Malawi and her work on power and accountability,²⁴ as well as data triangulation across multiple sources and perspectives, facilitated a nuanced analysis that considers multiple perspectives. Study limitations are the absence of data on the number of women who gave birth at the district hospital and at home, and the limited geographical scope as actors in other villages might have responded differently.

Findings and discussion

Global-national: dynamics around policies and funding

Presidential safe motherhood campaign

A key strategy of Banda's campaign was to "empower" and "sensitize" traditional leaders on the importance of improving maternal health.⁶ Consequently village heads developed various strategies,¹ in Mangochi together with NGOs, as explained by the chair of the CSO network:

"We showed statistics -morbidity reports- to communities. We started recording maternal deaths. Because we made this public, people got scared to give birth at home. And we gave regular updates to the communities.

I was one of the people who were involved in developing by-laws [local rules enforced by village heads]. NGOs discussed with the chiefs [village heads] what to do. They said that the women should pay a goat when delivering at home [...]

The other rule is that village heads should report deaths to the group village head, who reports to the TA [Traditional Authority]. The TA holds the chief accountable, and the chief has to pay money to the TA for every death.”

In Mangochi, local implementation and monitoring of the Safe Motherhood campaign thus entailed the following: NGOs linking homebirths to mortality; initiation of an upward accountability system for maternal deaths, following the chiefs’ hierarchy; and encouraging women to give birth in health facilities through by-laws and home-birth fines (including a letter confirming the home birth and paid fine). Several actors were involved in implementing these by-laws, as explained by a midwife:

“The rule is that the women who deliver at home are supposed to pay 1000 kwacha [US\$1.5] to the chief, and the chief should give 500 [US\$0.75] to the hospital. [...] The chief should also write a letter, which the woman should bring to the hospital.”*

In 2015–16, 91% of women gave birth in health facilities.⁴ However, when Banda lost the presidency, the Safe Motherhood Campaign went back into “invisibility” at the national level, NGOs stopped focusing on the issue, there were no headlines in the newspapers anymore, and the continuation of local enforcement depended on individual village heads who had their own motivations to enforce the bylaws or not (B Chinsinga and P Mvula, professor and senior researcher, personal communication, January 9, 2018).

Service level agreements

The temporary reintroduction of user-fees contradicted SLAs between the government of Malawi and CHAM, which provides 75% of health services in rural areas.²⁵ In Mangochi, four out of fifteen CHAM facilities had a SLA,²⁶ where CHAM provides maternal and newborn health services free of charge and the government reimburses the costs. The government pays staff salaries and essential medication. District councils and CHAM signed

SLAs for geographical areas where needs were greatest.²⁷ Targets (based on expected user numbers) are reviewed and adjusted annually. The SLAs have substantially increased access to services.²⁸ Nationally, CHAM and the government were in ongoing negotiations over a new memorandum of understanding.²⁵

Starting in July 2015, “our” health centre was experiencing financial problems because of delayed government payments. According to the Minister of Health and the CHC programme officer (operating ten CHAM facilities in Mangochi, two with a SLA), several other health centres encountered similar problems. This is supported by a newspaper article.²⁹ This financial situation resulted from complex webs of accountability between donors, national and district government, and CHAM, intertwined with actors’ different priorities in under-resourced settings. Malawi depends in large part on donor funding. Donors financed 63% of the health budget in 2013/14 and 54% in 2014/15.³¹ This drop in donor funding was due to corruption. In 2013, Banda’s administration was involved in the “Cashgate” scandal and subsequently lost the elections. Donors have suspended budget support during every Presidency.³² Through the Health Sector Joint Fund, several donors earmarked money to safeguard the payment of the SLA and utility bills of hospitals, but the suspension of budget support indirectly influenced the payment of SLAs.

Our study found that the government and CHAM accused each other of respectively over-invoicing and delaying payments, which has been noted by others.³³ The then Minister of Health commented:

“There has always been a disparity between what is claimed and what is owed. [...] There are two problems that normally come with that. Let me say this that on average we are corrupt. [...] That normally happens even at facility level. [...] So then, the problem becomes that the government ends up spending a lot more money on reduced service delivery. [...] On the other side, we are not particularly good as government on ring-fencing monies. [...] You find that DCs [District Commissioners] have run out of money for [e.g.] education and they go and take from the SLA money. [...] I cannot say with certainty that the DC took money from the SLA. But I will be surprised if it has never happened in Malawi.”

According to the CHC programme officer, the result was that the District Health Officer (DHO) received less money than planned for and had to choose which issues to prioritise:

*According to the exchange rate on January 1, 2016

“They [DHO and District Council] were unable to pay the private clinics and meet their part of the contract. They prioritized operational costs at the district hospital and argued they can’t pay for the SLA while patients in the district hospital don’t have food.”

This ultimately resulted in the health centre reintroducing user-fees to cope with the financial setback. We will now discuss how health workers, village heads and women dealt with this “falling apart” of the SLA.

At the health centre: balancing institutional viability and maternity care

The primary health centre served a population of 50,000 in a large geographical area. The nearest public hospital with a maternity ward was 20 km away. The relationship between the surrounding villages and the CHAM facility appeared good: village advisors and women mentioned its good quality of care. The maternity ward included a four-bed pre-delivery room, a two-bed delivery room, a ten-bed post-delivery room, a private room for those who paid extra, the HSAs’ office, and a separate building for antenatal care (ANC). The health centre offered only basic obstetric care (including post-abortion care): there was no surgical theatre and they could not perform caesarean sections. Most complications required referral to the district hospital.

Midwives and HSAs implemented the Safe Motherhood policies. They encouraged women to give birth in health facilities and registered the place of delivery, thus enacting accountability through monitoring and evaluation. According to the midwives and HSAs, policies and interventions (awareness campaigns, SLA, by-laws with associated home-birth fines) were initially successful, with more women delivering at the health centre. However, multiple developments converged and conspired against trust and service use – including the way in which by-laws were implemented, financial shortages reducing the quality of care and ultimately the reintroduction of user-fees.

The midwives explained that by-laws were no longer “effective”:

“The laws are no longer effective [...] the way in which the letter [from the chief] is written implies that the rule is coming from the hospital. So women think that the hospital is punishing them for home delivery. [...] We think a lot of chiefs don’t follow up on the women who delivered at

home. So we stopped asking for the letters. [...] Because the chiefs don’t care, the women think that the hospital wants money.”

According to the midwife, the way in which chiefs implemented the by-laws appeared to affect women’s trust in the facility, so they stopped enforcing the policy.

Furthermore, the deteriorating financial situation resulting from funding problems with the SLA influenced the quality of maternity services. Midwives complained they had to use examination gloves instead of surgical gloves and they could not test haemoglobin levels. The government had not provided folic acid and iron tablets, so women had to pay to obtain these. They now also had to pay for services not directly related to pregnancy, but that used to be free to pregnant women. The midwives seemed to fear that the declining quality of care and payments for certain services affected their relationship with women and might stop them from coming to the health centre. A midwife complained:

“Women are used to free services. Even if they can afford to pay, they still refuse to come, because they expect a free service.”

In balancing its mission to provide health care to the poor and the financial situation, the health centre continued to offer most services free of charge for a while. In addition, as the nun in charge explained, they wrote a monthly letter to the DHO, thus holding him accountable for the situation, because: “The DHO is supposed to supervise the SLA”.

The programme officer at the CHC said they had regular meetings with the DHO, set ultimatums and threatened to terminate the SLA. However, these attempts to regain government funding were unsuccessful. In December 2015, the health centre announced the termination of free services, hand-written in *Chiyao* on posters in the ANC room:

“Notice: From January 16, all women who are going to start antenatal care and those who are going to deliver will be paying money”

The other CHAM facility under the CHC in Mangochi did the same. Women had to pay MK7500 [Malawi Kwacha] (US\$11) for delivery, MK1000 (US\$1.5) for ANC registration, and MK1000 (US\$1.5) for a post-delivery check-up. In case of complications, they paid extra and MK10,000 (US\$15) for ambulance

transport to the district hospital. Yet, the health centre's management intentionally asked less than their actual expenses, according to the nun in charge:

"150 women give birth in our facility every month. It is a disaster. We were no longer able to provide good services. We ask women to pay 10,000 kwacha [US\$15], so we can buy medication and gloves. But this 10,000 is not enough for us. But for the women here it is probably too much."

During ANC, the midwives and HSAs advised women to save money for delivery or for transport to the district hospital. Yet this was challenging, as the changes were announced only a few weeks in advance and it was in the midst of the "hunger season". Women went to great lengths to access the free services, sometimes tricking nurses into helping them. One of the midwives described:

"Women pretend to have money, but after helping them it turns out, they don't have it. Or the case is so urgent (at point of delivery) that we can't refuse to help the women and can't even ask about money until after delivery."

Four women jointly "escaped" from the maternity ward during night-time. A village advisor and one of the midwives explained they had put their babies in food baskets and walked out without paying. Because of the false payment promises, the management had decided there would be a strict "paying-up-front" policy. The interaction between women's and midwives' actions and dynamic responses to sharpen the health centre's policy could have contributed to critical situations and possibly maternal deaths.

Unless they were in labour or in critical condition, midwives had to refer women to the district hospital if they were not able to pay up front. Village heads, advisors and women told us about women giving birth on the side of the road, in the maize field, or at home. Others could not reach the referral hospital, or reached it too late. A midwife told us how a woman delivered at home, because she could not afford to pay the fee. As she was bleeding, she came to the health centre. Although she was referred to the district hospital, she died. A village advisor mentioned another situation:

"There was a woman and child who had to be transported to the district hospital by ambulance. The child was born premature at 6 months. The midwife

said they had been calling to the hospital the whole night to request an ambulance, but it didn't arrive in time. It arrived in the morning. The woman couldn't manage to pay 10000 [US\$15] to use the health centre's ambulance. There are two ambulances, which have been donated. But there is no fuel."

The Minister of Health gave instructions to the Ministry to settle all payments accumulated between July and December 2015 by January 31, 2016 to facilities who had their finances in order. This was secured through the African Development Bank.²⁵ On January 18, 2016, CHAM and the government signed a new memorandum of understanding, which was effected on July 1.²⁵ According to the CHC, the government still owed the health centre MK9 million (US\$14,000) in July 2016. Nationally, unpaid invoices had accumulated to MK400 million (US\$614,000) by March 2016.³⁴ In total, 16 out of 69 CHAM facilities with a SLA suspended the agreement in 2015.²⁵ In December 2016, a year after the reintroduction of user-fees, HP received a message from a midwife that services were offered free of charge again.

Village heads: local enforcement of policies and fines

As mentioned, village heads were key in the local enforcement of by-laws. They had the power to ask for fines, or not. The group village headman said:

"Women who deliver at home are charged 4000-5000 [US\$6-7.5], the equivalent of four/five chickens. Because the hospital is near and women are supposed to be ready all the time [to reach the hospital]. [...] My job is to guide the chiefs who are under me. [...] They are supposed to tell their people, but not all of them do. [...] That is why some who live close to the hospital still deliver at home."

Just as with the by-laws, the reintroduction of user-fees generated various responses amongst chiefs. The group village head went to "Mr. [NGO]" because he had helped them before and he said,

"I know that when they have money they will spend it to help the communities. The other organizations don't do that."

There was, thus, a relationship of trust. The group village head followed up on the NGO's advice to involve the councillor, who then wrote a letter to

the DHO. He tried to seek help from more powerful actors who could help him to get the free services back, but his power was constrained:

“It is a decision from the government, and I don’t have enough power. But I hope we can do something by talking to the radio. We have to tell others what is going on.”

The NGO had experience with using the media to hold the government accountable.

One of the village advisors, who was a HSA volunteer, explained they had lifted the MK1000 (US \$1.5) fine for home deliveries:

“Because we understand why it is complicated for women to pay for the hospital or travel to the district hospital.”

Considering it unreasonable to expect women to travel 20 km to the district hospital, and understanding financial struggles, the village leadership was responsive towards the situation of women. Another village advisor responded to the reintroduction of user-fees by emphasising women’s responsibility to use family planning during a public speech:

“They [the government] said [...] you should be using family planning methods, [...] but you don’t use it, that’s why there is not enough land to cultivate and also a lot of hunger. [...] Now giving birth [at CHAM] is 7500 [US\$11]. Are you going to manage? [...] From the past, the hospital was not free, but after helping you, they were giving the expenses to the government to pay for you. So don’t say that the Catholics have started bad things, no, but the government doesn’t have money to pay for you and it will take time to be sorted out. So be careful and tell each other.”

Village heads and advisors thus responded in various ways. Despite the midwives’ experiences of village heads “not caring about hospital deliveries”, in these two villages they did appear to care about women’s health and access to maternity services. According to one of the village’s registration books, which was updated to June 2015, nearly all women had given birth at CHAM. Village leadership tried to manage and “fix” the situation and hold the government accountable through the following means: involving more powerful actors (the NGO and councillor); social accountability initiatives (radio); holding women accountable by promoting family planning methods; or refusing to do so by lifting the fines. In the meantime, some

tried to maintain the trust relationship with the health centre by telling women that it was the responsibility of the government and not of “the Catholics”.

Women: accessing services and inequity

How did the reintroduction of user-fees affect women and their experiences of exclusion and inequity? Data from the health centre indicated that the number of skilled deliveries and ANC visits decreased by approximately 50% immediately after the reintroduction of user-fees. A midwife commented:

“We used to have eight-ten deliveries a day. Nowadays there is only one, two or three a day. Most women stopped coming. The same goes for antenatal care. Today there were less than 20, while previously the number was close to 70.”

The programme officer at the CHC mentioned:

“There is some sort of ‘natural selection’, the ones who can’t afford it go to the district hospital.”

A midwife thought more women delivered at home because of worse quality of care:

“Reasons I have heard are that many people deliver there, they are not attended properly, they deliver on the floor, and they are not being assessed until delivery.”

Some women married to “businessmen” for example, could afford deliveries at the CHAM health facility. Others could not save enough money. A woman explained:

“I didn’t have money and I couldn’t do anything but give birth at home. There is no food in the house, no door at the other side of the house, not enough clothes, even torn blankets. How can I pay 7500 [US\$11] to the hospital?”

According to a midwife, multigravida women, in particular, stayed away, whereas younger women and girls still came to the health centre. She said that parents tend to help their teenage daughters. For example, the mother of a pregnant 15-year-old conveyed her worries regarding her daughter’s delivery. She was making mats and started saving money to pay at the CHAM facility; since they lived nearby, they could come and provide their daughter with food and other support.

From information in the postnatal register, one of the midwives inferred that women who had given birth at home returned less often for

postnatal care than women who had given birth at the CHAM facility or the district hospital. The woman described above who gave birth at home had decided not to take the baby to the health centre for postnatal care, afraid that the nurses would shout at her and hold her responsible and accountable for not complying with the advice to travel to the district hospital. Instead, her mother had protected the baby with traditional medicine. For other women seeking postnatal care after home delivery, they would still need to pay user-fees, as explained by a midwife:

“The ones who give birth at home and then come in for check-up still have to pay 7500 [US\$11]. This is because we check a lot of things: vital signs, checking the baby, weighing the baby, iron, blood pressure, temperature, the uterus, tears etc. The women who [do] come in after home birth are the ones who experience problems. Like losing a lot of blood or tears etc. We are still charging this 7500, because we are afraid if we reduce it, we will encourage home delivery.”

This practice of the health centre, partly based on continued enforcement of the Safe Motherhood policies, affected poor women’s access to services even further.

Conclusion

This article contributes to literature, marginal in public health, that places globally designed “traveling models”, such as user-fee exemption policies and skilled birth attendance, in the broader context of the day-to-day functioning of health systems and public health policy.^{11,35,36} Our analysis shows how dynamic responses and accountability relationships²⁴ can help explain problems with the implementation of policy^{36,37} and their inequitable effects when confronted with broader malfunctions of health systems.^{12,13,35} This article contributes to understanding processes leading to inequity, which is a central challenge to achieving the Global Strategy for Women’s, Children’s and Adolescents’ health and the SDGs.¹⁴

Global attention to maternal health has contributed to holding governments responsible for maternal mortality and improving health systems’ capacity to provide services. This and other research from Malawi shows that Safe Motherhood policies can affect women through punitive means.^{5,6,30,38†} Both home-birth fines and user-fees place the burden on poor women and increase

health system inequity, as confirmed by a long-standing and growing body of evidence on the negative implications of user-fees,^{8,9} and the recent studies on home-birth fines.⁴⁰ We showed that different actors are frustrated about user-fees and their impact on the poor, especially because in Malawi non-institutional deliveries have become strongly associated with maternal deaths.⁶

Our analysis highlights issues of intersectionality, with different social locations, power relations and experiences converging to shape inequity.⁴¹ The falling apart of SLAs especially affects women in rural areas, where access to care is already minimal. In addition, the poorest rural women struggle most to pay user-fees, and would have to travel to the district hospital. If village heads did not suspend the home-birth fine, women would end up in an impasse, having to pay the fine or user-fees.

Actors’ dynamic responses highlight issues of trust between health workers and women, which were negatively influenced by the local implementation of “traveling models”.⁴² Damage of trust seemed to be the reason midwives stopped enforcing the fine and letter system. User-fees eroded trust between women and health workers. Some women “escaped” without paying or were afraid of being shouted at when accessing postnatal care after home delivery. A village advisor tried to maintain the trust relationship by telling women not to blame CHAM for the situation, placing the responsibility with the government. Reduced trust in health workers and the government might have broader consequences of trust in public services and society more generally.⁴³

Our analysis has shown the need for considering aspects of power, health systems functioning and financing at the global, national and local level⁴⁴ to understand how health policies are implemented and what the consequences may be. We have shown how actors’ priorities play a role in the “falling apart” of services, starting with the discontinuation of donor funding and the (de)prioritisation of Safe Motherhood at the national level. In attempts to manage and “fix” the “falling apart” of services, dynamic responses are informed by actors’ different priorities and constrained by limited power within a constantly

[†]See also ³⁹ for how financial incentives as part of results-based financing for maternal and newborn health affect Malawian women.

under-resourced health system. This draws parallels with research on “street-level bureaucrats”, who manage policy implementation and “broker” project demands in the context of resource constraints.^{45,46} Local actors’ inability to hold powerful actors to account demonstrates that webs of accountability are uneven. Only when we analyse power relations from the global to the local level, and how these dynamically interact with policies, can we understand how inequities are shaped. Following other scholars,^{7,11,36,43,44} we make a couple of suggestions towards more equitable health systems. First, utilising ethnography can generate a better understanding of the complex interactions between policy and dynamic power relations. Second, policy reforms can start from the frontline, and should strengthen trust between women and health providers. Lastly, policy implementation should be monitored long-term, while being attentive to a possible cascade of dynamic responses and unintended consequences. This evaluative learning can feed back into improving policies.

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Résumé

En dépit d'une forte priorité accordée à l'amélioration de la santé maternelle ces dernières décennies, il reste encore beaucoup à faire pour garantir aux femmes et aux filles de par le monde un accès équitable aux services et à la qualité des soins. Pour comprendre les inégalités largement reconnues et les lacunes dans l'application des politiques de santé maternelle, nous devons analyser de manière critique les rouages du pouvoir dans les systèmes politiques et sanitaires. Cet article examine les dynamiques de pouvoir en jeu dans la mise en œuvre de politiques de santé maternelle dans le Malawi rural, un pays qui enregistre l'une des charges les plus élevées de mortalité maternelle du monde. Plus précisément, nous analysons l'expérience récente du Malawi avec la réintroduction temporaire des frais d'utilisation des services de maternité en réponse à la suspension du financement des donateurs, une réorientation dans le leadership et les priorités politiques, et des contrats de service instables entre le Gouvernement et son partenaire d'exécution, l'Association chrétienne de santé du Malawi. Sur la base d'une recherche ethnographique réalisée en 2015/2016, l'article décrit les perceptions et les expériences de la mise en œuvre des politiques parmi différents acteurs locaux (agents de santé, chefs de village et femmes). La manière dont les services de maternité « s'effondrent » et sont « réparés » est le résultat d'interactions dynamiques, qui aboutissent en dernier ressort à l'exclusion des femmes rurales les plus vulnérables des services de soins de maternité, à l'encontre des objectifs des politiques nationales et internationales de maternité sans risques.

Resumen

A pesar de un importante enfoque mundial en mejorar la salud materna durante las últimas décadas, aun falta mucho por hacer para asegurar acceso equitativo a los servicios y calidad de la atención para las mujeres y niñas del mundo. Para entender las inequidades ampliamente reconocidas y las brechas entre las políticas y la práctica en salud materna, debemos analizar críticamente el funcionamiento del poder en las políticas y sistemas de salud. Este artículo analiza las dinámicas de poder en juego en la aplicación de políticas sobre salud materna en las zonas rurales de Malawi, país con una de las cargas más altas de mortalidad materna del mundo. En particular, analizamos la reciente experiencia de Malawi con la reintroducción temporal de tarifas de usuario para servicios de maternidad como respuesta a la suspensión de financiamiento de donantes, cambio de liderazgo político y de prioridades, y contratos inestables de servicio entre el gobierno y su socio ejecutor, la Asociación de Salud Cristiana de Malawi. Basado en investigaciones etnográficas realizadas en 2015/16, el artículo describe las percepciones y experiencias de la aplicación de políticas entre diversos actores locales (trabajadores de salud, jefes de poblados y mujeres). La manera en que los servicios de maternidad “se derrumban” y se “arreglan” es el resultado de interacciones dinámicas entre políticas y redes de responsabilidad. Las políticas se encuentran con una cascada de respuestas dinámicas, que a la larga causan que las mujeres rurales más vulnerables sean excluidas de los servicios de maternidad, lo cual va en contra de los objetivos de las políticas internacionales y nacionales a favor de una maternidad segura.