Soins Obstetricaux Gratuit – The SOG Program: Examining Haiti's Maternal Health Care Services

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1. Executive Summary

Despite the restoration of democratic rule in Haiti in 2006, life for many Haitians is still characterized by poverty, violence and uncertainty. This is particularly the case in the capital Port-au-Prince where much of the population live in the city's slums, where access to affordable health care is virtually non-existent despite urgent needs, particularly among pregnant women. This situation is especially alarming given the extraordinary prevalence of eclampsia, an acute and life-threatening complication of pregnancy that is very common in Haiti.

Historically, medical services in public hospitals have been too expensive for expectant mothers, with a normal delivery in a state hospital costing a minimum of USD 7.50 and a caesarean USD 62.50. This did not include the cost of medication with could significantly increase the cost of institutional delivery. These expenses, coupled with the physical barriers to health services caused by insecurity and poor transportation have left the majority of expectant mothers in PaP in extreme danger; Haiti currently has the highest level of maternal mortality in the western hemisphere (670/100,000).

It is within this context that MSF opened an emergency obstetrics program in March 2006. The MSF program offers free obstetric care at a centrally located hospital as well as ambulatory ante and post-natal services in three slum locations in PaP. In March 2008 the World Health Organization (WHO) and the Pan American Health Organization (PAHO), in collaboration with the Haitian Ministry of Public Health and Population (MSPP) launched their own response to the maternal health care crisis in the form of the SOG program: Soins Obstetricaux Gratuits. This program, which aims to offer a free comprehensive maternal health care package to all pregnant women in Haiti, is funded until March 2010 by the Canadian International Development Agency (CIDA). As MSF services struggled to cope with excessive patient demand, it was decided to conduct an evaluation of the impact of the SOG program in PaP April and May 2009.

Methodology

This report is the culmination of interviews in PaP with representatives of UN bodies (WHO, UNDP), non-governmental actors in the health sector and national MoH staff. In addition, 328 women were interviewed regarding their experiences with the SOG program and maternal health in PaP.

The SOG Program in Theory

The SOG program was launched in 46 institutions across 10 health departments in Haiti, with 5 hospitals implicated in PaP. The program has 4 main objectives: Increased access to services, improved quality of services, sensitization of women to institutional delivery and the reinforcement of MoH structures.

These objectives are addressed with a number of activities, but the core of the program is to provide *free* services for women in public institutions by offering reimbursement of their transportation costs to/from the hospital, as well as by eliminating user fees and providing free medication (SOG hospitals are given USD 28.00 from WHO for each women who delivers to compensate for the elimination of user fees and to stock necessary medication). There is also a small incentive offered to traditional birth attendants, to encourage them to refer their patients to hospital.

The SOG Program in Practice: Assessment Findings

The 5 public hospitals in Pap under the SOG program manage a combined 1300 deliveries/month. In the Western health district, of which PaP is a part, there has been a 10% increase in the number of women who chose to deliver at hospital, indicating a change in health-seeking behaviour. There have, however, been significant shortcomings in the SOG program as well.

The greatest accomplishment of the SOG program has been the elimination of user fees. According to MSF's assessment, 100% of women interviewed who delivered at a SOG hospital did not pay a fee for delivery.[1] Unfortunately, the SOG program has so far failed to provide free medication – 98% of the same women paid significant sums for medication or medical supplies during their deliveries at SOG hospitals. The average cost of medication/materials (vaginal & caesarian) reported by the women interviewed is a staggering USD 51.25 – this is more than 25 times the minimum daily wage in Haiti. In most cases the purchases of medication/materials were made from the private pharmacies that surround the hospitals.

There are several explanations offered for the failure of the hospitals to provide free medication. The maternity directors of the 5 SOG-implementing hospitals claim that the USD 28 reimbursement per patient provided by WHO is not sufficient to cover the cost of medication. Another explanation could be corruption: the sale of medication may be an income generating activity in a health system plagued by lack of regular salary payments. The notion of corruption came up frequently in focus groups, in interviews with health staff and in conversation with residents of PaP. The prevalence of corruption was referenced not only in relation to health services, but in many aspects of Haitian life.

Several other aspects of the SOG have also fallen short: The incentive program for traditional birth attendants is not functioning in any meaningful way, nor is the reimbursement of transportation for patients. Knowledge about the SOG program is very low, with only 40% of the women MSF interviewed having heard of the program. These factors combined with the legacy of staff strikes and shortage of qualified personnel that characterize many Haitian hospitals mean that while accessibility to health services for vulnerable pregnant women has improved, there is still a long way to go.

1 This is particularly important as before SOG women were not allowed to leave the hospital until they were able to pay their service fee, causing a lot of women to fear institutional delivery.

Recommendations

MSF calls upon the WHO, PAHO, CIDA and the MSPP to push for the full implementation of the SOG program. This must include better information dissemination so that women are aware of the program, and the benefits to which they are entitled. The issue of transportation reimbursement and incentives to traditional birth attendants should also be addressed.

The most critical element is the provision of free drugs. As it stands, women are paying exorbitant amounts for drugs that are meant to be free under a program that is donor-funded. This must be investigated immediately. Until pregnant women in Haiti have access to truly free and quality maternal health services, this group remains at tremendous risk.

2. Introduction

Background

Haiti has experienced decades of violence, political unrest, dictatorship, economic hardship and environmental degradation, leaving it the most impoverished country in the Americas. In early 2006 democratic rule was restored, but bitter political divisions persist, and stability remains fragile. Rising food prices, chronic unemployment and lack of improvements for the poor continue to generate unrest and uncertainty. Much of the population of the capital Port au Prince (estimated at 3.25 million)[2] live in deplorable conditions in the city's growing slums with few people arriving every day to join their ranks.

The Ministry of Health (MoH) is ill equipped to meet the urgent health care needs of this population whose access to services is further hampered by poverty and violence. Private medical facilities with a higher level of care flourish throughout the capital to address the needs of the wealthy minority of the population while international NGOs try to respond to the needs of the majority of the poor.

Maternal Health in Haiti

Pregnant women are particularly vulnerable in this context, where they have little, if any choice, when seeking health care. Until recently medical services in public hospitals were too expensive for the majority of expectant mothers: Before the SOG program a normal delivery in a state hospital cost a minimum of 300 HGT[3] (USD 7.50) and a caesarean cost at least 2,500 HGT (USD 62.50).[4] This did not include medication, which significantly increased the total cost of institutional delivery. Until these fees were paid, women were not permitted to leave the hospital with their babies. In addition to these financial barriers, when women arrived at the hospital they often found staff absent or a lack of adequate supplies and infrastructure.

2 Population estimation used by MSF sections in Haiti, no recent national census.

3 HGT = Haitian gourde, the local currency.

4 According to MoH Obstetrics Department Directors.

These factors, combined with cultural norms and physical barriers to health services created by ongoing violence and poor transportation, have resulted in a situation whereby over 75% of Haitian women deliver at home, often with the aid of a traditional midwife, or *matron*.[5] Unfortunately, due to the extraordinary prevalence of complicated pregnancies in Haiti, this decision (often the only option available) can be a death sentence; Haiti currently has the highest level of maternal mortality in the western hemisphere (670/100,000).[6]

MSF in Haiti

MSF opened the Jude Anne Hospital in March 2006, just off a busy road in central PaP. This emergency obstetric hospital quickly became a major provider of health care for pregnant women, managing well over 1000 deliveries per month in peak periods. Three years after opening Jude Anne, MSF has re-focused on high risk and complicated pregnancies, and is now managing an average of 500 deliveries per month. Services have been moved to a better location at the new Maternité Solidarité (MS) in Cite Solidarité.[7] The caseload clearly indicates a large and on-going need for affordable emergency obstetric care for women living in the slums of PaP. In order to better reach the target population, MSF-OCA started a program of ambulatory ante and post-natal services in three locations (Pele Simon, La Saline and Solino) where it conducts an average of 1520 consultations per month.[8]

Introduction to the SOG Program: Soins Obstetricaux Gratuits (Free Obstetrics Care)

In March 2008 the World Health Organization (WHO) and the Pan American Health Organization (PAHO), in collaboration with the Haitian MoH launched their own response to the urgent need for improved access to health care for pregnant women; the Soins Obstetricaux Gratuits (Free Obstetrics Care) program, or SOG, funding through 2010 by the Canadian International Development Agency (CIDA). SOG is an ambitious program that aims to offer a free comprehensive maternal health care package to pregnant women across Haiti. This program covers *all* pregnancies, including complicated conditions such as pre-eclampsia and emergency deliveries.

Given that the SOG program aims to improve access to health services for pregnant women, MSF OCA was very interested in monitoring its implementation and impact. A successful SOG program could reduce or render redundant the need for MSF OCA's activities in PaP. However, in the months following the launch of the SOG program, MSF OCA did not see a reduction in patient numbers, and informal reports from personnel at SOG-implementing hospitals as well as from patients were ambivalent regarding the success of the program. As such it was decided to conduct a formal assessment of the program. This report is the result of that research.

5WHO/PAHO SOG proposal.

6 WHO (WHOSIS: WHO Statistical Information Systems)

7 Average over 6 months, December 2008 – May 2009.

8 MSF Monthly Medical Reports 2009.

3. Methodology of the Report

This report was researched during the months of April to June 2009. It is the culmination of interviews in Port au Prince with officials from the World Health Organization, the United Nations Development Fund, the national Ministry of Health and local hospital staff.[9] In addition semi structured questionnaires were administered to 299 women concerning their experiences with the SOG system and maternal health services in PaP in general. Finally focus group discussions took place at MSF post natal clinics. The groups were selected and interviewed as follows.

Group 1: Women who were transferred from MSF's Maternity Solidarity to SOG-implementing hospitals for delivery.[10]	
Description of group	Women who presented at MS for delivery but who did not meet admission criteria. These patients were then transferred by MSF ambulance to a SOG-implementing hospital.
Reason for interview	The follow up surveys were initially started in order to ensure that women transferred from the MSF hospital were able to access adequate care upon arrival at the referral site. This was prompted by a tightening of the MSF admission criteria at MS in March 2009[11] and a subsequent increase in the number of women transferred to SOG implementing hospitals.
Total # of women interviewed	254 (delivered March – June)
Methodology	Interviews were conducted in the first week of the month following the date of transfer. Therefore all interviews were conducted within 1 to 5 weeks after transfer for delivery. Each month a minimum of 20% of the total number of women transferred were randomly selected to participate in a telephone questionnaire.[12] . In order to increase the sample size for this report, all women were selected for interview in May (93 women). The women were contacted using the telephone number supplied on their transfer form. If there was no contact number or it was impossible to reach the woman on the number supplied, then the interviewer was instructed to take the next individual, on the list. Where the mother was not available (e.g. due to hospitalisation or death) but a family member answered the phone, the interviewer was advised to administer the questionnaire with the next of kin. The questionnaire was administered the same national staff person who accompanied

9 See Annex 1 for a complete list of meetings and contacts .

10 ''Transferred'' = patients taken by MSF ambulance to SOG hospitals for delivery.

11 Before this time MSF was delivery any woman who arrived at Jude Anne in Labour. This was largely due to the fact that many of the national hospitals were suffering from staff strikes. The new (or newly-enforced) criteria restrict admission to women who are in active labour and who have serious complications.

12 See sample in Annex 2.

	the women in the MSF ambulance for transfer. Data was entered into an excel database in using a numeric code to identity the women. All women were asked to give verbal consent to participate in the survey after the purpose of the interview was explained. The interviewer and the MSF data-entry secretary received training in protocol and data tool use.
Possible bias	We interviewed women we could reach by telephone. Telephone numbers are registered for all transferred patients, but those women who own their own phone (as opposed to those who use their neighbours' or relatives) are easier to reach. They are also potentially better-off financially. Home visits were considered, but the idea dismissed as nearly impossible in the densely populated slum areas of PaP. The fact that a MSF staff member from the transferring hospital (MS) was conducting the interview may have biased the responses of the women.

Group 2: Women who attended MSF mobile clinics for post-natal consultations who did not deliver at MS.	
Description of group	The women in group 2 came to MSF clinics for post-natal consultations, but delivered at home, or at a non-MSF health facility (some at SOG hospitals, others not).
Reason for interview	This group was selected as a source of information regarding services available in SOG hospitals, as well as maternal health-seeking behaviour in general.
Total # of women interviewed	45
Methodology	The MSF researcher attended mobile clinics regularly over a 6 week period; during these visits the attending midwives referred all women who presented for post-natal consultations to the MSF researcher who conducted the interview with the help of a translator.[13] The questionnaire was voluntary, and verbal consent obtained.
Possible bias	An effort was also made to ensure that the patients understood that participation was in no way obligatory, or a requirement for further access to services. However, it is always possible that patients felt compelled. In the case of both group 1 and 2 it is also possible that

13Questionnaire can be found in Annex 3

	patients may have inflated the costs they incurred in the hopes that MSF would compensate them. There is a possibility of selection bias given that women interviewed were those seeking post natal care with MSF. It is not clear if this group is significantly different from those not receiving PNC or those receiving it in the public or private sector.

Group 3: Women who delivered at MS, interviewed in MSF OPD following post-natal consultations.	
Description of group	Women presenting for their first post-natal consultation at the MSF OPD following delivery at Maternity Solidarity.
Reason for interview	This group was consulted in order to gain insight into maternal health care services, and health-seeking behaviour in PaP. A secondary objective was to gauge the level of satisfaction with the care provided by MSF OCA in MS.
Total # of women included	29 women in 4 focus groups over 2 days
Methodology	Four focus group discussions were held using convenience samples of women who waiting for post natal consultations in the OPD of the Maternity Hospital. Participation in the focus group was voluntary and participants consented verbally. They were advised that participation would not impact on the services they would receive. The focus groups were led by the MSF researcher assisted with a translator.
Possible bias	As above, the participation in interviews was consensual (verbal) and every effort made to make this clear. However it is always possible that patients, interviewed in an MSF structure by an MSF staff member may feel compelled to give answers they guess will please the interviewer. Similarly to group 2, there is a possibility of selection bias as the groups were composed of women choosing to access PNC with MSF.

Group 4: Matrons (traditional birth attendants) who work in the MSF catchment areas.	
Description of group	Matrons are untrained members of the community who provide home births. They charge a fee to assist with a delivery. In some cases matrons receive some basic training from various NGOs, but have no official relationship with MoH hospitals.

Reason for interview	We were interested in better understanding the role of matrons in maternal health care provisions, as well as to assess their involvement in the SOG program.
Total # of women interviewed	25 matrons were interviewed in the 3 slum areas in which MSF works: Pele Simon, Solino and La Saline.
Methodology	MSF community health workers identified from their knowledge of the community, the matrons working in the identified slum areas. he purpose of the group was explained, and all individuals consented to participate. There were no refusals, however some matrons were unable to attend due to their work commitments. The focus groups were led by the MSF researcher assisted with a translator.
Possible bias	The identity of the focus group leader as part of an international NGO working in the formal health sector may have influenced the responses.

4. The SOG Program

4.1 The SOG Program in Theory [14]

The SOG program has a budget of USD 4,222,403 and was launched in 46 institutions across 10 health departments in Haiti, with five hospitals implicated in PaP. It has as aims the reduction of maternal and neonatal mortality, improvement in the quality of life of pregnant women and newborns and poverty reduction. The SOG program has 4 main objectives and related activities.[15]

1. **Increased access to services.** This is meant to be achieved by the funding of all costs related to 4 antenatal consultations, free delivery (including medication), and 1 post-natal consultation. Geographic access is addressed by providing transportation reimbursement for pregnant women as well as for matrons who bring their clients to the hospital for delivery.

2. Improved quality of services is addressed by providing technical training to health care staff in the Perinatal Information Systems (PIS) used in participating hospitals.

3. Sensitization of women to institutional delivery. This objective is addressed through information dissemination over the radio regarding the SOG program and free institutional deliveries. In addition, matrons are provided with an incentive to encourage women to deliver at the hospital and to accompany them there.

14 WHO/PAHO SOG Proposal

15 As stated in the SOG proposal. .

4. Reinforcement of MoH structures. The SOG program uses a strategy of decentralized budget and information management that form the basis from which payments are made to implementing institutions. The following table illustrates exactly what the SOG program covers, and the associated budget.

	DETAILS	OBJECTIVE OF INCENTIVE	TOTAL INCENTIVE HTG	INCENTIVE (USD)
Financial support to institutions	Caesarean or normal delivery + 4 antenatal consultations + 1 post natal consultation	HGT 810 /delivery + HGT 40 /visit ($21.83 /delivery + $1.08/visit)	**1050**	**$28.00**
Transport pregnant women	Rural	HGT 140 return x 6 trips ($3.77 return)	**840**	**$22.64**
	Urban	HGT 55 return x 6 trips ($1.48 return)	**330**	**$8.89**
Transport matrons	Rural	HGT 140 return x 2 trips ($3.77 return)	**280**	**$7.55**
	Urban	HGT 55 return x 2 trips ($1.48 return)	**110**	**$2.96**
Incentive matrons	Women accompanied to SOG hospital by a matron	HGT 300 per woman delivered in institution ($8.09 per woman delivered in institution)	**300**	**$8.09**

As can be seen in the table above, the SOG program reimburses implementing health structures 1050 HGT (USD 28) per patient. This includes pre/post natal consultations, and vaginal or caesarean delivery.[16] In its offer the WHO intended that the maternal health care package be completely free for the patient, but did not intend to cover all those costs itself; the idea was to offset the revenue lost by the elimination of user fees. The balance of the budget required to implement SOG (normal institutional running costs, staff salaries, etc) was to be provided by the Haitian health care budget.

5. The Case of Port au Prince: The SOG Program in Practice

There are 5 hospitals in PaP that are now operational under the SOG program: The General Hospital (HUEH), Maternité Isaie Jeanty (MIJ), Hospital La Paix, Choscal and Carrefour. Combined these hospitals account for more than 1300 deliveries a month and the number of

16 Although the ante/post natal consultations are listed separately in the table (HGT 40/visit), current WHO practice is to pay the full reimbursement of HGT 1050 whether or not the patient presents for all the ante/post consultations. This is due in part to workload associated with calculating the thousands of reimbursements, and the desire to make timely reimbursements. Information from to Dr. Evelyn Degraff, WHO.

institutional deliveries in the Western health district[17] has increased by 10% since the advent of SOG. The caesarean rate in SOG hospitals in PaP is reported to be 10%. We have no detailed information regarding the number of complicated or emergency cases.[18]

The implementation of the SOG program in these 5 institutions has been staggered over the past 15 months; the HUEH, for example, has only been fully operational since March 2009. Implementation delays were attributed to a number of factors by those we interviewed: regular staff strikes (common in PaP), unwillingness of hospital staff to increase workload, a lack of drugs and supplies, and mismanagement of the initial WHO start-up budget.

5.1 Practical Challenges in Implementation

In interviews with the maternity directors of the SOG institutions in PaP, a few common practical challenges were identified. Firstly, there is a significant bureaucratic workload inherent in the reimbursement system. In theory, when a patient arrives for their first consultation (whether for ante-natal or for delivery), a SOG file is begun for them. This file should stay in the patients record at the hospital, and is completed after the patient has delivered and been discharged. At the end of the month, all completed files, along with a monthly report are sent to the MoH's district health department central office for review, and then on to WHO for approval and reimbursement.

At la Paix, Choscal and Carrefour hospitals this system seems to be working well, and the reimbursements from WHO arrive quickly. MIJ is also managing, although the director of the maternity service said that they struggled with the system at the start. However, for the HUEH, the busiest of the 5 hospitals, the system is proving very difficult to implement. In fact, since HUEH started the SOG program in March 2009, it has yet to send a single file to WHO for reimbursement.

The different degrees of success in working with the SOG system seem to stem from a number of factors: La Paix, for example, is a semi-private hospital with only 18 maternity beds and greater physical and human resources (computers, staff).[19] It is also located in a middle-class neighbourhood where more women are likely to seek out private hospitals, and thus patient numbers are lower. Choscal hospital is supported and co-managed by Médecins du Monde – Canada, and this relationship may have facilitated the implementation of the SOG program.
MIJ and HUEH, on the other hand, are overwhelmed and under-funded public hospitals; staff strikes seem to affect these hospitals more than others, and HR management, particularly at the HUEH is very poor.

17 The Western department covers an area of 4,827 km² and a population of approx 3,6 million people. The department is divided into five arrondissements: l'Archaie; Croix-des-Bouquets; La Gonâve; Léogane; and Port-au-Prince (www.floridahaiti.org).

18 WHO independent SOG survey, conducted by the Bureau de Recherche en Informatique et en Developpement Economique et Social (BRIDES) (www.brides.ht). BRIDES interviews 1067 women in 46 districts every month. The interviews are conducted after delivery in SOG institutions. BRIDES & WHO report 10% caesarean rate,

19 La Paix was the special project of Aristide, built to showcase Haiti's commitment to health care.

5.2 Physical Accessibility

Transportation

The SOG program calls for the reimbursement of patient's transportation costs, with a fixed amount of 330 HGT (USD 8.89) to cover 6 trips to hospital in an urban context. According to WHO this amount should be paid to the patient at the time of consultation, and no proof of payment for transport (i.e.: receipt) is required. The transportation reimbursement should be paid by the administrative department at each SOG hospital; however this is not taking place with any degree of regularity – possibly because most women are simply not aware that they are entitled to it. When asked why the reimbursements were not being made, all of the maternity directors claimed that it was 'impractical'.

Despite a significant improvement in the security situation in PaP, transportation continues to be a real problem. Severe traffic jams, poor road conditions and lingering security concerns mean that women have limited options when it comes to reaching health centres. Ambulance services are virtually non-existent and public transportation does not function during the night. As such, many women who deliver at home cite lack of transportation as a key element in their choosing a home delivery.[20]

It seems that in general it is availability rather than cost of transport that poses a barrier for women. Of the 45 women interviewed in post-natal consultations at MSF mobile clinics (group 2), 32 had delivered at hospital (71%, a much higher than the Haitian norm, possibly linked to the fact that women choosing to attend post natal care are more likely to have accessed other health services for their pregnancy). Of those who delivered at hospital, 7/32 (21%) had used public transportation to arrive, and 100% reported having had the means to pay for the transportation.

Coverage

With regards to the coverage of the program, it is difficult to assess whether the five SOG institutions in PaP have the capacity to cover the needs of the population. Certainly there are instances in which MSF has been told that hospitals are ''full'' and cannot accept referrals; similarly, interviewed women often spoke of crowded wards and staff shortages. If one takes the population of PaP as roughly 3.25 million, and the Crude Birth Rate quoted by UNICEF for 2007 of 28, we can estimate approximately 7583 births per month. The SOG hospitals currently manage over 1300 deliveries per month (combined), and have a bed capacity of about 260[21]. This means that SOG hospitals in PaP are covering approximately 17% of all deliveries. This fits with information from UNDP who report that nation-wide 13% of all deliveries are now taking place in SOG institutions.[22]

20 From interviews with women in Group 2: 6/13 women who delivered at home cited transportation as a key obstacle to reaching hospital. Also a common factor cited by matrons in focus groups when asked to list the top 3 reasons that women deliver at home.

21 According to MoH obstetrics directors. MIJ 80 beds, HUEH 90 beds, Carrefour 40 beds, Choscal 30, La Paix 18.

22 Michel Brun, UNDP.

The most important point for MSF is that 90% (228/254) of the women in group 1 who were transferred to SOG hospitals from MS were received for care. HUEH had the most refusals, but also accepted the most transfers[23], while MIJ also occasionally refused transfers. However, an important point is that MSF only transfers women to these 2 hospitals, and so we have no information regarding refusals at La Paix, Choscal or Carrefour. The most common reasons for refusing transfers have been a lack of staff or shortage of beds. I gather we are not worried about the 10% who got refused? They were seen elsewhere??

One factor which continues to hamper the ability of women to access maternal health services is overnight coverage and specialised neonatal care. At the time of writing, none of the SOG hospitals in PaP had surgical capacity at night, and none had a truly functioning neonatal unit. While all are supposed to offer 24 hour services, overnight staffing is quite irregular. This is an area that requires close follow up and monitoring in the future. Conversely, all of the SOG hospitals in PaP do offer robust antenatal services and the clinics are always very busy.[24] Voluntary counselling and testing for HIV (VCT) is available at all 5 institutions and PMTCT services are in various stages of implementation at each.

5.3 Economic Accessibility

According to the WHO, poverty is the determining factor when it comes to a woman's ability to seek health care in Haiti, with over 70% of the population living on less than USD 2/day.[25] This imperative plays out in the arena of maternal health care where, among the poorest Haitians, only 24% of women give birth in hospital versus 78% of the most wealthy.[26] It is within this context that the SOG program was conceptualized.

Before the introduction of SOG, maternity departments, along with most other aspects of the Haitian public health care system, were largely funded by user-fees. The cost of delivery (fee paid per delivery) and drugs made institutional births prohibitively expensive for the majority of women. In SOG-implementing hospitals today, 100% of the women interviewed in group 1 who delivered at SOG hospitals did not pay a service fee for their deliveries, whether vaginal or caesarean. In this respect, there has been a big change since the pre-SOG era, in which women paid 300 HGT (USD 7.50) for a regular birth, and were not permitted to leave the hospital until the fees were paid. However, SOG is not at all functioning when it comes to a woman's access to free drugs and medical supplies, which in the SOG scheme should be included in the cost of a delivery.

The vast majority of women are still paying significant sums to deliver in SOG hospitals; 98% of the women interviewed in group 1 who delivered at a SOG hospital (224/228) paid for either medication or other medical supplies when they delivered. The table below shows the

23(15/26 women who were turned away at SOG hospitals

24 We have not been able to access information regarding # of antenatal consultations per hospital.

25 WHO/PAHO SOG proposal.

26 WHO/PAHO SOG proposal.

breakdown of the cost of medication for vaginal and caesarean deliveries as reported by the women interviewed, with a comparison to the Haitian daily minimum wage.

Average cost of medication/materials per delivery	**HGT 2,050 USD 51.25**	**Minimum Daily Wage Apprx. USD 2.00[27]**
Average cost of medication for vaginal delivery	**HGT 1,740 USD 43.50**	**= 25 x daily wage**
Average cost of medication for caesarean	**HGT 5,359 USD 134**	**= 67 x daily wage**

To further put these costs into perspective, 25 kilos of maize costs about 700 HGT (USD 17.50) while a 1 kilo bag of beans costs 175 HGT (USD 4.30).[28] In some cases the drugs and materials (such as sutures or gloves) were purchased in the hospital pharmacy itself, in other cases (such as at the HUEH) the purchases are usually made in private pharmacies outside the hospital.

In order to pay for this medication, the women who gave birth at SOG hospitals (interviewed in group 1 and group 2) had to borrow the money, usually from friends or neighbours, but occasionally from professional money-lenders. The loans are sometimes made with a high rate of interest, taking months or years to pay back. In the course of our interviews we did not encounter any women who were turned away from a SOG hospital because they could not afford drugs, although most said the payment was very difficult for them.

An important point is that the majority of women see the elimination of the service fee as a great improvement, despite the fact that they still have to pay for medication. As we do not have detailed information regarding exactly how much women were paying for medication *before* SOG, it is difficult to establish whether there has been a true reduction in cost of delivery. However, it is clear that the *perception* has certainly changed, and women are now more likely to seek out hospital deliveries. A probable explanation is that the elimination of the user fee means that women no longer fear being kept at the hospital until they are able to pay.[29]

Of the 45 women interviewed in group 2, 12 delivered at home. All of the women who delivered at home used a matron; interestingly, the average cost of using a matron is not insignificant at HGT 685 (USD 17). There is, however, much more flexibility inherent in the use of a matron, as many will accept payment in kind, or allow instalments to be made

27 Estimate from 2008 rates as per MSF report Perilous Journey.

28 According to MSF-OCA weekly food-basket monitoring.

29 In MSF report ‘’’Perilous Journey,, women expressed a fear of being ‘trapped’ at the hospital until they could come up with the money to pay their delivery fee.

according to the family's ability to pay.. In cases of extreme poverty, some matrons reported they will waive their fee altogether. In focus groups with matrons, they stressed that theirs is a labour of love, rather than a profitable enterprise; all of the 25 matrons we interviewed had another job that provided them with their main source of income.

When asked about the ongoing practice of charging for medication, all the maternity directors agreed: The USD 28 reimbursement per patient under SOG is not sufficient to cover the costs of medication. With no functioning central pharmacy system in Haiti, it is difficult to assess the true cost of drugs for MoH hospitals. In fact, there has been no analysis of the real costs inherent in running obstetrical services (facility costs, maintenance, supplies, etc). According to Michel Brun, Technical Director of Reproductive Health at UNDP, UNICEF and UNFPA are considering taking on the project of doing this cost analysis, but that process has not yet begun.[30] Another explanation for the failure to provide free medication could be corruption. The notion of corruption was referenced frequently in interviews with health staff and in conversation with residents of PaP, not only with regards to health services, but in many aspects of Haitian life. It is possible that the sale of medication may be an income generating activity in a health system characterized by irregular salary payments.

5.4 Accessibility of Information

When the SOG program was launched in March 2008 there was a grand opening at MIJ hospital with great fanfare and press coverage. Since that time radio spots and leaflets have been used by the MoH to spread the world that women can access free maternal health services in SOG hospitals. However, despite this effort, only 40% of the women interviewed in group 1 and 2 had heard about SOG, and most of them from MSF outreach workers or from other patients in the hospital at the hospital at the time of their deliveries.

When asked to explain what they understood about the program, women replied simply ''free delivery''. None were aware that the SOG package should also include ante/post natal care, free drugs and transportation reimbursement. As noted earlier, in interviews with matrons, knowledge of SOG was very poor as well. During visits to SOG hospitals there were no obvious information materials regarding the program, and WHO/MoH do not currently have any plans to launch additional information campaigns.

However, according to the private organization that is conducting an independent SOG survey for WHO, there has been a 10% increase in the number of deliveries in SOG hospitals, both in PaP and across the country (small degrees of variation in different departments)[31]. Additionally, according to the same survey, 40% of women (country-wide) who delivered in SOG institutions reported that their previous delivery took place at home; this indicates a change in maternal health-seeking behaviour.

30 Meeting 30.04.09. Regarding cost analysis of obstetrical services: WHO admit the lack of knowledge is a major gap in the SOG planning, but such an analysis will be a very complicated and difficult undertaking.

31 WHO shared the results of the ongoing BRIDES survey (monthly summaries) with MSF OCA in PaP.

Another important source of information should be the matrons. According to the planning, matrons are meant to play a key role in informing pregnant women about the free services available to them, and by referring their clients to hospital for delivery. In focus groups with 25 matrons (group 4), only two matrons were aware of the SOG program. Choscal hospital has a very high number of patients arriving with matrons and receiving reimbursement for transportation. This is likely because Choscal had a previous relationship of cooperation with the matrons working in the surrounding neighbourhood.[32] However, in the other four SOG hospitals in PaP, the incentive system for the matrons is simply not functioning at all. WHO reportedly did radio spots at the beginning of the SOG program to inform matrons of the incentive system, but no further sensitization has been done, and none is planned.

5.5 Availability and Quality

The public hospitals in PaP have a legacy of staff strikes, unreliable hours of operation, stock ruptures and a host of logistical problems including electrical outages and plumbing disasters. As such, any analysis of quality of care must be viewed in this light. It should also be made clear that the fieldwork conducted to inform this report did not include an in-depth technical assessment of each hospital; instead this report focuses on the *perceived* quality of care and service from the patient's perspective.

Of the 228 women interviewed in group 1 who delivered at a SOG hospital, 89% claimed to have been satisfied with the services that they received at the SOG hospital where they delivered. Very few reported having to wait for longer than a few minutes before being examined, and fewer still complained about mistreatment by staff. According to the BRIDES independent survey, 77% of women globally (in all districts) are satisfied with the quality of care they received at SOG hospitals during their deliveries. This is not to say that women are entirely happy with their experiences at SOG hospitals; the concept of ''satisfaction'' is relative, and when asked to elaborate most women claimed to be satisfied if both they and their baby were healthy post-delivery, and had not suffered any extraordinary neglect or abuse.

5.6 Acceptability

Of the 12 women from group 2 who gave birth at home, 8 stated that they would have preferred to deliver at a hospital. The most common reasons given for staying home were that the baby came too quickly, that they lacked resources to pay for transportation or hospital fees, that there was no available transportation, and finally, that they were fearful of going to the hospital.[33] The notion of fear came up fairly regularly, usually expressed as a fear of ''scissors'' or ''stirrups''. When explored in further detail it became clear that many women worry that if they go to the hospital they will end up having a caesarean or an episiotomy. Others stated that they feel more comfortable at home where they can be with their family for support, rather than surrounded by strangers at the hospital.

32 Choscal operates in partnership with MDM-Canada. They have done some training of matrons in the neighbourhood regarding referral of complicated deliveries, etc.

33 These reasons were also echoed in focus groups with matrons.

All of the women we spoke to insisted that they would go to the hospital if they had any difficulties during delivery, regardless of their fear; however it is clear that there is still work to be done in terms of sensitizing women to hospital deliveries. A last concern that came up in interviews and focus groups is a fear that women from slum areas may not be well received by hospital staff. It is likely that this feeling comes from the pronounced economic and class divisions that are prevalent in Haitian society. This concept was developed and explored in the MSF report *Perilous Journey.*

6. Conclusions & Recommendations

Despite its limitations, the SOG program is an important project is designed to address some of the most significant obstacles to accessing health care for pregnant women. From our assessment, as well as from our daily work with vulnerable women in PaP, we know that poverty, lack of transportation and cultural norms all contribute to a situation in which women either cannot, or will not go to a health centre; SOG should make this journey easier.

Unfortunately, there are significant shortcomings in the implementation of the SOG program that must addressed; the high cost charged for medication and supplies, the failure to roll-out the transportation reimbursement and the incentive program for traditional birth attendant, as well as the persistent lack of knowledge among women about the program. It is the responsibility of donors and implementing partners to ensure that poor management, possible corruption and a lack of resources (human & physical) within the MSPP are addressed.

The most critical issue is the ongoing practice of charging women for medication. This is in clear violation of the spirit of the SOG program, and poses an obstacle in the access of care. The bottom line is that poor women are paying exorbitant sums for medication that should be free, under a program that is funded by the Canadian Government.

A final concern is that of funding. As it stands the SOG program is officially funded until the end of 2010. No new donors have been identified beyond that time. Pregnant women in Haiti are finally being offered some improved access to the vital maternal health services they require– to revoke that access after only two short years can only lead to further suffering and unnecessary loss of life.

During the course of this assessment and as part of our regular interactions with patients in PaP MSF has heard countless stories of women who have faced medical emergencies alone – unable to reach health services, or unable to afford them. MSF welcomes the SOG program, and sees it as an important initiative in the battle to reduce maternal mortality in Haiti. What is urgently needed now is the full implementation of the program and its continued funding.

Annex I: List of Meeting with Relevant Actors in Port au Prince

Name	Organization	Function	Date
Dr. Figaro	MoH (MIJ)	Director, Obstetrics Service	20.04.09
Dr. Viala	MoH (HUEH)	Director, Obstetrics Service	21.04.09 07.05.09
Dr. Dauphin	MoH (Carrefour)	Director, Obstetrics Service	11.05.09
Dr. Fleur	MoH (La Paix)	Director, Obstetrics Service	11.05.09
Michel Brun	UNDP	Technical Director of Reproductive Health	30.04.09
Myrna Narcisse Theodore	Ministry for the Feminine Condition and the Rights of Women	Director General	06.04.09
Martine Bernier	Centre for International Cooperation in Health and Development	Coordinator	13.04.09
Frantz Fortunat	BRIDES	Director	23.04.09
Jan Jakobiec	Government of Canada	Second Secretary	01.05.09 27.05.09
Dr. Carlos Gril	WHO	Haiti Representative	20.04.09 27.05.09
Dr. Evelyn Degraff	WHO	SOG liaison for WHO/PAHO	29.04.09 25.05.09
Guido Galli	MINUSTAH	Senior Political Affairs Officer	21.05.09
Brian Phillip Moller	MSF France	Head of Mission	17.04.09
Dr. Jenny Bien-Aime	MSF Belgium	Medical Doctor in charge of monitoring referrals	25.05.09
Key MSF OCA National Staff	MSF OCA	MS staff	Various

Annex II: Questionnaire used for phone interviews with women who were transferred by MSF for delivery

Questionnaire pour les Femmes référées de MSF pour accouchement

1. Date d'apel ___/___/_____ dd / mm / yyyy

2. Date de dernière consultation ___/___/____

3. Date d'accouchement ___/___/_____

4. Référée ☐1 Transférée ☐2

5. L'heure d'arrivée a l'hôpital référence ☐☐☐☐ Hrs (24hr horloge)

6. 7.

8. Nom _____ Prénom _____

9. Numéro de tel personnel _____

10. Numéro de tel du contact le plus proche _____

11. Adresse de la patient _____

12. Référence 1. _____ 2. _____

13. Lieu de transfert _____ Prise en charge Oui ☐1 Non ☐0

14. 13.1 Si non, pourqois _____

15. Lieu de l'accouchement

16. Si différent de lieu de transfert, pourquoi ? _____

17. Type d'accouchement Vaginal ☐1 Césarien ☐2

17.1 Nature du service Gratuit ☐1 Payé ☐2

17.2 Si Payé, quoi?

			Prix en HTG	Lieu d'achat
Gants	Oui ☐1	Non ☐0	17.2.1 _____	17.2.2 _____
17.3 Accouchement	Oui ☐1	Non ☐0	17.3.1 _____	17.3.2 _____
17.4 Medicament	Oui ☐1	Non ☐0	17.4.1 _____	17.4.2 _____
17.5 Analyses	Oui ☐1	Non ☐0	17.5.1 _____	17.5.2 _____
17.6 Lit	Oui ☐1	Non ☐0	17.6.1 _____	17.6.2 _____
17.7 Dossier	Oui ☐1	Non ☐0	17.7.1 _____	17.7.2 _____

17.8 Autres (specifié SVP) Oui ☐1 Non ☐0 17.8.1 _____ 17.8.2 _____

17.9 Autres (specifié SVP) Oui ☐1 Non ☐0 17.9.1 _____ 17.9.2 _____

18. Connaissez le programme de Soins Obstétrique Gratuits? Oui ☐1 Non ☐0

19. Comment est-ce que vous êtes venu connaître la programme SOG? _____

20. _____

Que savez-vous de ce programme? _____

_____

21. _____

Est-ce que vous étés satisfaites des services reçus à lieu d'accouchement? Oui ☐1 Non ☐0

21.1 Si non pourquoi? _____

_____

_____

22. _____

Est-ce que la mère est en vie? Oui ☐1 Non ☐0

22.1 Si non, est-ce la mort a été relier à l'accouchement? Oui ☐1 Non ☐0

22.2 Quel était la cause de la mort? _____ 22.3 Date mort ___/___/____

23. Est-ce que l'enfant est en vie? Oui ☐1 Non ☐0

23.1 Si non, est-ce la mort a été relier a l'accouchement? Oui ☐1 Non ☐0

23.2 Quel était la cause de la mort? _____ 23.3 Date mort ___/___/____

Annex III: Questionnaire used in interviews with women in MSF post-natal consultations

Questionnaire pour les femmes en consultation post-natale en MSF

1. Date ___/___/____ (dd / mm / yyyy) 2. Equipe MSF-H _____

3. Durée de l'entrevue _____ 4. Lieu de l'entrevu _____

5. Nom _____ 6. Prénom _____

7. Adresse de la patiente _____

8. Tel de la patiente _____ 9. Date de l'accouchement ___/___/____

10. Type d'accouchement Vaginal ☐1 Césarien ☐2 11. 1ière enfant? Oui ☐1 Non ☐0

A la maison

12. Est-ce que vous avez eu l'aide de quelqu'un? Oui ☐1 Non ☐0 12.1 Si oui, qui?
Matrone ☐1
Familier ☐2
Ami ☐3
Autre ☐4

13. Avez vous payé á cette personne? Oui ☐1 Non ☐0 13.1 Si oui, Combien? _____ HTG

14. Avez-vous eu des problèmes durant l'accouchement Oui ☐1 Non ☐0

14.1 Si oui, lesquels? _____

15. Est-ce que vous aurez préférez accoucher ailleurs? Oui ☐1 Non ☐0

15.1 Si oui, pourquoi? _____

16. Y'a t'il une centre de santé pour accouchement dans la zone ou vous habitez? Oui ☐1 Non ☐0

16.1 Nom du centre _____ 16.2 Lieu _____

17. Pourquoi n'avez vous pas été à ce centre de santé pour l'accouchement?
Manque de moyens ☐1
Distance ☐2
Insécurité ☐3
Tradition ☐4
Autres ☐5

17.1 Autres spécifié _____

18. A l'hôpital _____ 19. Lequel _____

19. Lieu de naissance de dernière enfant _____

20. Moyen de transport a l'hopital
Voiture privée ☐1
Taxi ☐2
Tap-Tap ☐3
A pied ☐4
Autres ☐5

20.1 Autres spécifié _____

21. Combien avez-vous payé? _____ 22. Durée du déplacement _____

22. Est-ce que vous avez été bien accueillie á la réception? Oui ☐1 Non ☐0

22.1 Si non, qu'est-ce qui s'est passé? _____

23. Combien de temps avez-vous attendu pour être prise en charge? _____

24. Si tardivement d'après vous á quoi est dû ce retard? (perception de la patiente) _____

25. Nature des services Gratuit ☐1 Payé ☐2

25.1 Si Payé, what?

			Prix en HTG	Lieu d'achat
Gants	Oui ☐1	Non ☐0	25.1.1 _____	25.1.2 _____
25.2 Accouchement	Oui ☐1	Non ☐0	25.2.1 _____	25.2.2 _____

25.3	Medicament	Oui ☐1	Non ☐0	25.3.1	25.3.2
25.4	Analyses	Oui ☐1	Non ☐0	25.4.1	25.4.2
25.5	Lit	Oui ☐1	Non ☐0	25.5.1	25.5.2
25.6	Dossier	Oui ☐1	Non ☐0	25.6.1	25.6.2
25.7	Autres (specifié SVP)	Oui ☐1	Non ☐0	25.7.1	25.7.2
25.8	Autres (specifié SVP)	Oui ☐1	Non ☐0	25.8.1	25.8.2

26. Est-ce que vous avez les moyens pour payer ces dépenses? Oui ☐1 Non ☐0

27. Comment avez-vous payer?

28. Est-ce que vous étés satisfaites des services reçus? Oui ☐1 Non ☐0

28.1 Si oui, a quel niveau? 1 ☐1 2 ☐2 3 ☐3 4 ☐4

Note: 1=un peu satisfait, 4=extrêmement satisfait

28.2 Si non, pourquoi?

(marqué toutes applicables)

Mal traitement par la personnelles ☐1
Hôpital trop chargé ☐2
Manque de personnelles qualifies ☐3
Services/médicaments trop chère ☐4
Rupture de medicaments ☐5
Autres ☐6

28.3 Autres specify _____

29. Avez vous reçu d'autres difficultés á l'hôpital? Oui☐ 1 Non☐ 0

29.1 Si oui, lesquelles? _____

30. Est-ce que vous connaissez le programme Soins Obstétriques Gratuits? _____

31. Comment est-ce que vous êtes venu connaître la programme SOG?

32. Que savez-vous de ce programme? _____

33. Pourquoi avez-vous décidé à venir á MSF pour les consultations pre ou post-natales

34. Questions ou inquiétudes

35. Autres commentaires