How behavioral science can nudge pregnant women to attend prenatal care in Haiti.

eMBeD
Mind, Behavior, and Development Unit

Haiti has the highest maternal and neo-natal mortality rates in the Latin America and Caribbean region, at 529 deaths per 100,000 live births, and 24 deaths per 1,000, respectively (IHE and ICF 2018, World Bank 2017). Based on current trends, Haiti is unlikely to meet the United Nations' Sustainable Development Goals to reduce the maternal mortality ratio to less than 70 maternal deaths per 100,000 live births by 2030 (World Bank 2017). Low rates of prenatal and postnatal care, and institutional births, are all contributing factors. While 91 percent of women go at least once to a health institution for prenatal care, only 67 percent made the four recommended visits, and only 33 percent go to a postnatal visit within 48 hours of delivery (IHE and ICF 2018).

In Haiti, most women – especially the poorest – deliver at home with the help of a *matron* (traditional birth attendant). *Matrons* have little formal training, and often receive knowledge from their elders. But they are essential members of the community, and the individuals to whom most expecting mothers turn for advice and guidance.

The Project

In an effort to provide actionable ideas to reduce mortality rates, the World Bank , with support from the Umbrella Facility for Gender Equality, embarked on a diagnostic to identify structural and behavioral barriers preventing women from attending prenatal care visits, and from delivering at a health institution. The objective is to uncover the drivers to increase safe birth deliveries in Haiti.

The diagnostic relies on evidence from an extensive review of the literature (public documents, research articles, and studies) and key-informant interviews, which informed the design and implementation of qualitative fieldwork. Thanks to focus group discussions (FGDs) and semi-structured interviews (SSIs) with a range of actors including pregnant women, *matrons*, health workers, family members, community health workers, and community leaders, the diagnostic describes how pregnant women make decisions by exploring: prenatal care behaviors, attitudes and opinions around institutional delivery, perceptions, social structures, and relationships, among other contributing factors.

Key Findings

The team finds several (sometimes intertwined) structural and behavioral barriers to seeking, reaching, and receiving antenatal care and institutional deliveries.

Behavioral biases – including availability and optimism bias – deter women from taking actions.

Pregnant women often underestimate the likelihood of pregnancy complications, or of needing complex care beyond the capabilities of the *matrons*. Likewise, if they cannot immediately recall a family member or friend who might have required more care, they are less likely to pursue care themselves. And *matrons* similarly fall victim to these heuristics, underestimating the need for care or probability of pregnancy complications, referring women to hospital care too late in a delivery scenario to save lives.

Structural barriers are real, and women's concerns about their impact are often rational and warranted.

Often, women are unaware as to when they should seek additional care. Given the bumpy state of the roads, traveling in a motorcycle to reach a hospital while pregnant and during labor can be frightening and dangerous. Women rightly fear that they will suffer injury on the way to the hospital or deliver before arriving. And uncertainty around hospital costs – including the total cost of their stay, medication, and more – makes it less likely for women in situations of poverty to seek out clinical care.

The way hospitals and medical staff make women feel, and the perceptions around quality of care, matter as much as the care itself.

Even if women are able to go to the hospital for care, many women are averse to the treatment they receive – or that they imagine they will receive. Though some women receive good care, others report being made to feel inferior, receiving condescending or rough treatment, or being forced to deliver in uncomfortable situations. In our interviews, women reported their fears of hospital settings; as one woman stated, "I was afraid to give birth in the hospital because of rumors that we have to give birth alone in a room, while at home we are surrounded by the family." Others reported seeing women being left alone post-operations, of infants receiving negligent care, or simply that the hassle of needing family members to bring food to the hospital was enough to dissuade them from seeking out hospital care.

Policy Implications

In a context like Haiti where large structural barriers are prevalent, a simple awareness campaign emphasizing the importance of prenatal check-ups and of institution deliveries are probably insufficient to create meaningful behavior change. Interventions that target key potential decision points, beliefs, and behaviors may provide opportunities for overall improved outcomes for women and children.

One potentially high-impact area may be focusing on changing beliefs among women and *matrons*. Providing more (and more persuasive) messaging about what necessitates an institutional delivery, about what women might expect to find in hospital settings, and appropriate timing (in the form of calendars) can help lessen the lack of knowledge about when it is essential to go to a health institution.

A simple awareness campaign emphasizing the importance of prenatal check-ups and of institution deliveries is probably insufficient to create meaningful behavior change.

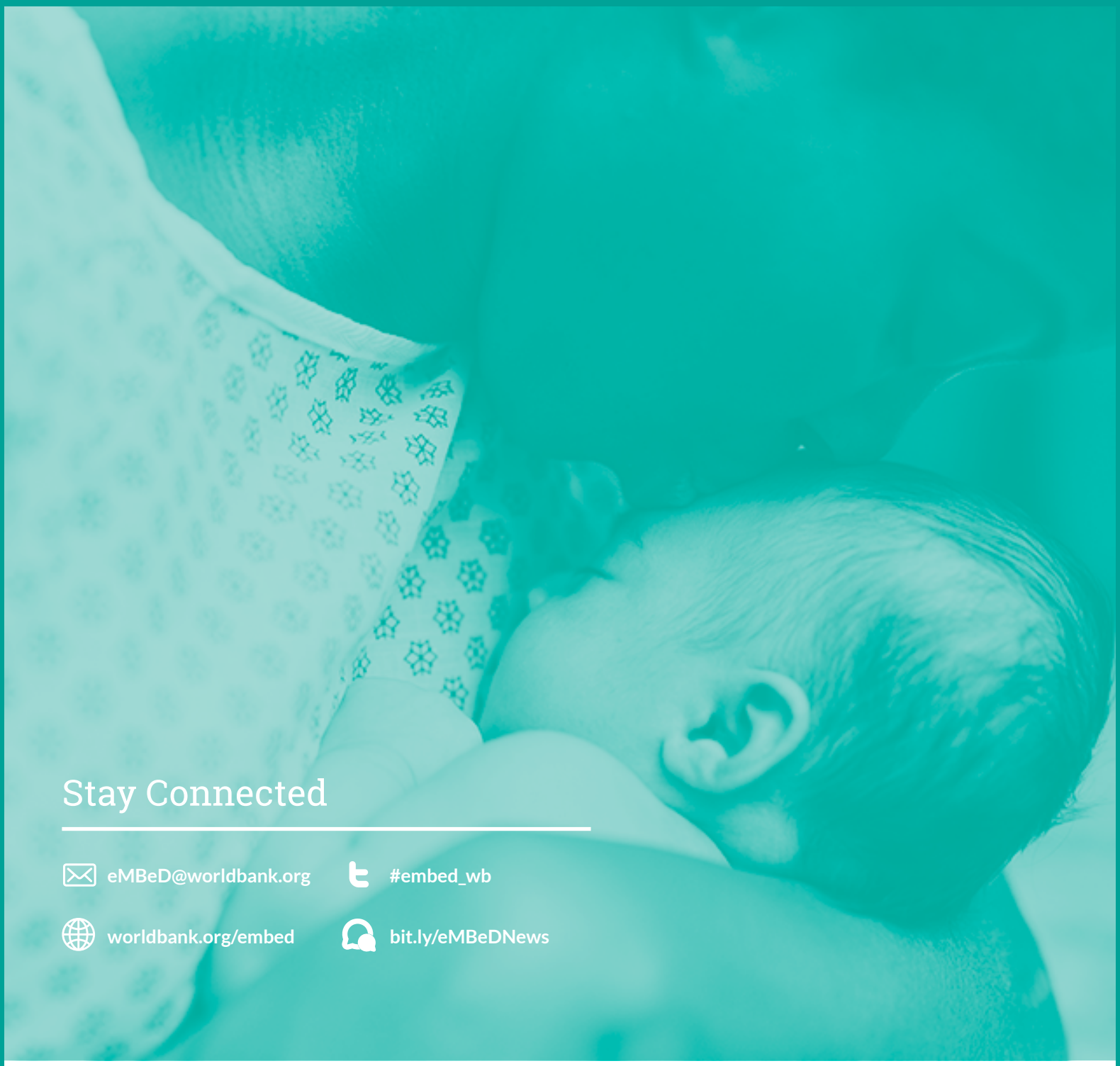
In addition, better, more salient information may alleviate some of the hesitation or uncertainty that inhibits care-seeking behaviors. Interventions that eliminate some of the ambiguities around the cost of hospital care may enable women to feel less uncertainty bias around being able to afford this care. Providing more – and better – information about what to expect during a health visit and their rights during visits may also eliminate some of the hearsay and ambiguity women rely on and experience.

Interventions that target medical staff may also go a long way to improving the perception of care, and therefore the likelihood that women seek it out. Training medical and administrative staff as to how to make pregnant women feel more at ease, personalizing models of care, and helping women and *matrons* become more familiar with their closest health institution may all decrease fear of seeking institutionalized care. A social recognition intervention aimed at rewarding *matrons* who encourage safe deliveries and institutional referrals may also go a long way in incorporating the community-recognized role of the *matrons* into the institutional care system.

Helping pregnant women deliver safely in Haiti is complex, but understanding the behavioral barriers to action can make a big impact in improving the effectiveness of any new policy or program.

About eMBeD

The Mind, Behavior, and Development Unit (eMBeD), the World Bank's behavioral science team in the Poverty and Equity Global Practice, works closely with project teams, governments, and other partners to diagnose, design, and evaluate behaviorally informed interventions. By collaborating with a worldwide network of scientists and practitioners, the eMBeD team provides answers to important economic and social questions, and contributes to the global effort to eliminate poverty and enhance equity.



Stay Connected

eMBeD@worldbank.org

#embed_wb

worldbank.org/embed

bit.ly/eMBeDNews

WORLD BANK GROUP
Poverty & Equity

eMBeD
Mind, Behavior, and Development Unit

UMBRELLA FACILITY FOR GENDER EQUALITY

References:

IHE and ICF. 2018. Enquête Mortalité, Morbidité et Utilisation des Services (EMMUS-VI 2016-2017). Pétion-Ville, Haïti, et Rockville, Maryland, USA: Institut Haïtien de l'Enfance (IHE) et ICF.

World Bank. 2017. Better spending, better care: A look at Haiti's health Financing. Washington D.C.: World Bank.

Last Update: June 18th, 2019