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Maternal and Neonatal Health Policies Facing Implementation Challenges in Public Health Facilities in Lomé, Togo

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ABSTRACT: The Togolese government has taken measures to improve maternal and neonatal health. Despite subsidies and free access, pregnant women and women in labor do not have easy access to the services and offers of maternal and child health programs. This study sought to determine the efficiency of maternal and neonatal health policies in the city of Lomé, Togo. The qualitative approach involved interviewing women, midwives, and resource persons to get their opinions on the new maternal and child health support programs in Lomé. Based on the theoretical framework of "complex adaptive systems" and "strategic analysis," the information gathered reveals that the implementation of measures to protect maternal and child health endeavors to ensure the holistic health of beneficiaries. Even though women are able to give birth safely and healthily, there are instances of inappropriate behavior, attitudes, and comments from some midwives that frustrate pregnant women or women in labor, causing them psychosocial distress. Therefore, continuously strengthening capacities and training of these health professionals to the code of conduct can increase the efficiency of health programs.

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KEYWORDS:
maternal and neonatal health policy, women's experiences, psychosocial impacts, health care, Lomé.

INTRODUCTION

The experience of pregnant women remains one of the factors contributing to high maternal and infant mortality rates, despite significant efforts made in the health sector in recent decades. Access to maternal health services and care is one of the causes of death of women and children (WHO, 2011). It is estimated that 80 mothers and 2,400 children die from preventable causes every day (WHO, 2014). Approximately 70% of all maternal deaths occur in sub-Saharan Africa and providing appropriate access to care is a challenge (UN/WHO 2023). The need to protect maternal and neonatal health has led the Togolese government to put in place various measures aiming at strengthening the health system.

Many maternal and neonatal health policies have been implemented in Togo. In fact, the

Prevention of Mother-to-Child Transmission of HIV (PMTCT) program was launched in 2011. It is one of the priority components of the fight against AIDS and it offers primary prevention services for women of childbearing age, family planning for HIV-positive women, care for HIV-positive pregnant women, and mother-child follow-up. National maternal and child health policies, beyond the context of the AIDS pandemic, take into account the entire target population of mothers and children, especially those from vulnerable segments of the Togolese population.

From May 2011, cesarean sections, which were previously costly and unaffordable, ranging from 85,000 to 110,000 CFA francs, or three times the minimum wage for low-income households, began to be subsidized. The government's policy that "aucune femme ne doit mourir en donnant vie" (no woman should die while giving birth [my own translation]) has led to a significant reduction in the cost of cesarean sections to 10,000 CFA francs in Togo's public health centers.

The cesarean section subsidy program has undoubtedly been successful, but with 40 deaths per 1,000 women recorded in 2014, the national policy, which aims to reduce maternal deaths to less than 100 per year, has emphasized a new preventive approach (Togo Officiel, Minutes of the Council of Ministers, August 25, 2021). The national program to support pregnant women and newborns, called "WEZOU" ("The Breath of Life" in Kabyè, a local language), was launched with the aim of reducing maternal and neonatal mortality rates. It aimed to provide progressive care for all medical services related to pregnant women from the confirmation of pregnancy until the 42nd day after delivery: prenatal consultations, tests, and prescriptions. With a view to integrated health care, the "WEZOU" project increased access to health care for women by eliminating the cost of care for many services. The protection of pregnant women and newborns must continue with other support measures such as the distribution of mosquito nets.

These are some of the measures taken by the Togolese government and its partners in the area of maternal and child health policies. Despite subsidies and free services, pregnant women and women in labor do not have easy access to maternal and child health programs and services. In Lomé, where most of the country's health resources are concentrated, bypassing public sector health centers is a reality (T. M. Djoré, 2021). Neonatal mortality is high there, at 29 deaths per 1,000 births, compared to 28 per 1,000 in the Maritime Region. The question arises as to what makes maternal and neonatal health policies less effective, to the extent that they have less impact in Lomé than in other local arenas in the Maritime Region. How do decision-makers and health professionals, who are involved in the implementation of the program, contribute to the efficiency of maternal and neonatal health programs in Lomé? What is the childbirth experience like for women in health centers? What are the difficulties faced by stakeholders and what proposals are there to address these challenges?

In order to answer these questions, a qualitative approach was useful. This involved interviewing 37 women in Lomé with regard to the programs that support them, the facilities they have access to and the difficulties they experience during pregnancy and childbirth, as well as their suggestions for overcoming these challenges. Subsequently, interviews were conducted with 15 midwives and 7 resource persons about their experiences and perceptions of the new maternal and neonatal health programs.

Analysis of field data using complex adaptive systems theory and strategic analysis reveals that in public sector health centers, the effective implementation of maternal and neonatal health policies is undermined by the attitudes, behaviors, and comments of some care providers. Midwives who were not involved in the planning of new maternal and child health programs cause psychosocial distress to women in labor. Thus, the adoption of policies to protect maternal and neonatal health need to be accompanied by training those involved in their implementation. Prior to the adoption of maternal and child health policies, workshops are needed to provide midwives with ethics and professional conduct relating to new products. Researchers from a range of disciplines should also be involved in the design, implementation, and evaluation of any new maternal and neonatal health policies.

1. MATERIALS AND METHODS

This study surveyed women in Lomé who had benefited from maternal and neonatal health programs implemented by the Togolese government. Given the difficulty of formally identifying beneficiary women, they were randomly selected according to a specific inclusion criterion: having undergone at least one pregnancy or childbirth follow-up in public health center. In addition, resource persons in charge of implementation were also interviewed in order to understand how the new maternal and child health interventions are managed and deployed. Finally, midwives were asked to analyze the role they have played and to assess their level of involvement in the operational implementation of these programs, particularly in terms of supporting beneficiaries and adapting interventions to the realities each specific area. To minimize biases associated with this common method, I used procedural corrective measures (guaranteed anonymity, varied anchor points, and proximal separation) and post-hoc verifications.

2. THEORETICAL APPROACH

The theoretical approach known as “Complex Adaptive Systems” (P. E. Plsek & T. Greenhalgh, 2001) was used to understand that the country's fragile health system is dynamic and non-linear. It also allowed me to consider maternal and neonatal health policies as implemented in a context composed of adaptive agents, namely midwives, who used to interact to produce often unpredictable emerging results. This approach emphasizes the value of service providers, namely midwives, as co-constructors of maternal and neonatal health policies.

Strategic analysis (M. Crozier and E. Friedberg, 1977) provides a better framework for studying the implementation of maternal and child health policies, focusing on the interplay between actors, power relations, and the concrete rationales that structure public action in the field. It facilitates understanding of the gaps between designed maternal and child health policies and the policies implemented by midwives. Strategic analysis also provides a better understanding of areas of uncertainty in health services. In the case of this study, this theory was useful in understanding that midwives, by controlling these areas, develop coping strategies that negatively influence the implementation of maternal and neonatal health policies.

3. ETHICAL CONSIDERATIONS

The field survey was approved by the authorities. Participants were informed of the ethical provisions and made aware of their right to participate freely or to refuse without constraint. Only individuals who gave their informed verbal consent were included in the study. Data confidentiality and respondent anonymity were guaranteed throughout the research process and during the writing of the manuscript, in accordance with ethical principles.

4. RESULTS

4.1. Difficulties experienced by women during pregnancy and childbirth

Childbirth marks the end of a woman's pregnancy and the birth of one or more newborns. This period of separation between the mother's body and that of her fetus involves a process ranging from pain management to psychological distress women experience. Previously, there were many causes of high maternal and infant mortality but advances in research have contributed to reducing

these disparities. Still, despite reforms to improve childbirth process in Lomé, some practices in health centers are criticized. The relationships between pregnant women and women in labor and healthcare providers are questionable, and conflicting interests pit stakeholders against each other. Indeed, interviews with women whose childbirth journeys led them to public health centers in Lomé reveal some difficulties. Relationship problems overwhelm these beneficiaries, with healthcare providers, mainly midwives, including birth attendants. A woman reports:

> I gave birth to my first son on April 23, 2023, at the Sylvanus Olympio University Hospital in Lomé. I was admitted the night before, around 7:00 p.m. The welcome by the on-call staff was tense, and I quickly realized that I would have to endure mistreatment from those who were going to assist me. I waited about 20 minutes before the person who was supposed to take care of me came to me. After examining me, this midwife assigned me a bed. The contractions were so painful, but the midwife was very harsh and indifferent to my pains, even though I asked her for help several times. At the slightest request, she would scold me and end up whispering and swearing. Around midnight, when I called her to help me relieve the increasingly intense pain, she scolded me again and went to bed. She had just finished her day, because I didn't see her come back to my room until I left. The rest of the night was very long for me. The next day, we were checked by doctors and midwives, and the one who was on duty came to prescribe a product to induce labor and assisted me until the placenta was delivered. The poor treatment discouraged me to such an extent that the second time around, I went to a private clinic (Report from a woman receiving maternal and child health services in March and April 2024) [My own translation].

As can be seen, a certain number of problems have been noted during childbirth in public health centers responsible for implementing maternal and neonatal health programs. Analysis of the report indicates that the problems experienced by pregnant women and women in labor, the main beneficiaries of these services, include poor reception, language barriers, and poor time management. Indeed, interviews reveal that the welcome of women at public health centers for childbirth is poor. On the one hand, the long waiting times are unbearable for women in labor. On the other hand, they report verbal abuse, which, far from alleviating their pain, actually exacerbates it.

Women have at times been victims of mistreatment by the professionals who are supposed to assist them. The reported misconduct of some healthcare providers includes shouting, intimidations, reprimands, whispering, swearing, indifference, mockery, refusal to act, or delayed intervention. All women have had a bad experience and abhor it.

Women's childbirth experiences have been marked by unavoidable physical pain and psychological resulting from mistreatment by healthcare professionals. These practices parallel with maternal and child health policies, which aim to promote holistic health of pregnant women.

4.2. Informal payments during childbirth

One of the issues women face during childbirth is related to finances. Knowing that subsidies and gratuities pertaining to the programs do not exclude the obligation to make some payments, service providers take advantage of this to extort money from women in labor and their families. A woman, having received maternal and child health services, in March and April 2024, states:

> She prescribed a delivery kit costing 5,000 CFA francs. Well before my mother arrived to buy the kit, the midwife came to offer me an injection against internal bleeding, which she sold me for 4,000 CFA francs. She then used a kit she had in her cupboard to help me before my mother returned [My own translation].

In the words of women interviewees, formal payments are characterized by visits to the pharmacy. However, in addition to purchases at the pharmacy, informal payments continue to be made in the form of private agreements between the healthcare provider and either pregnant woman or the one in labor. According to the interviewees, informal payments involve the direct purchase of products from midwives. There is also evidence of overcharging through requests for more products (for maintenance) than are necessary.

> After the birth, my companion brought them cleaning products for the delivery bed, consisting of a liter of bleach, a bar of soap, and a disinfectant commonly known as ‘détole’. The midwife refused to take them, saying that the standard recommendation was two liters of bleach, two bars of soap, two bottles of Detole, two liters of cologne, and two 250F bars of Omo soap. At that point, the midwife, who was an acquaintance of mine, felt ashamed and intervened, telling the delivery nurse to take what we had brought and not to try to take any more (Comments from a woman receiving maternal and child health services, March and April 2024) [My own translation].

These reports show that childbirth in public health centers involves formal and informal payments, in kind and in cash, to the health professionals on duty.

A pregnant woman at the end of her pregnancy, when she goes to a health center to give birth, hopes to find good care there. Reading the reports written by the women shows that even though they receive the necessary care to give birth in public health centers, some of their expectations are often not met. Indeed, the outcomes of their experiences show that they were all satisfied, given that they all left with healthy mothers and babies. Despite the achievement of these common goals, these women's memories of their childbirth experiences were marred by discouragement, feelings of regret, unpleasant surprises, and remorse.

In order to preserve the achievements of maternal and neonatal health policies in health centers, malfunctions must be remedied. Even though assisted childbirth by health professionals has led to a significant reduction in maternal and infant deaths, it is important,

according to the concluding statements of the women surveyed, that improvements continue to be made to increase the performance of maternity services.

Indeed, women agree that the care provided to women admitted for childbirth must be improved by strengthening the capacities of service providers.

4.3. Challenges to ethical values in the midwifery profession

Certain behaviors and practices of those in charge of implementing maternal and child health policies are out of step with the standards prescribed for better care of beneficiaries. Discussions with women after they have given birth have shown that, thanks to care programs, midwives help women deliver their babies safely and soundly. No infant or maternal deaths have been reported, which partly demonstrates the effectiveness of these programs. Overall, analysis of the comments reveals that healthcare professionals are trained, skilled, resilient, and capable of assisting women in giving birth without excessive risk of loss of life. The problem in health centers, especially public ones, is one of interpersonal skills rather than technical skills. The information gathered shows a lack of ethics and professional conduct among some midwives and their assistants. In their services provision, they undermine respect for the dignity of women in labor, lack kindness towards them, and fail in their mission to fulfill their duties responsibly. The behavioral differences of midwives toward women in labor pose a problem in terms of training. A report from a midwife during March and April 2024 reports session unveils: “I was trained in the ethics and professional conduct of my profession at the National Midwifery School seven years ago. After that, I had no further opportunities to strengthen my skills in this area” [My own translation]. It should be noted that midwives' initial training covers the concepts of professional ethics and conduct. Given that new medical technologies require service providers to undergo additional training, the technical requirements brought about by the introduction of new services in maternal and child health care require that those involved in implementation receive training on the ethics and professional conduct associated with these products. However, the midwives concerning with the implementation of the services in public health centers did not receive training before the launching of the new maternal and child health products.

The inadequacy or even lack of continuous education in ethics and professional conduct for midwives, who play a major role in implementing maternal and child health programs, is a major obstacle to the efficiency of such policies. The failure to train midwives in the ethics and professional conduct associated with new maternal and child health protection programs does not promote a culture of respectful and responsible practices centered on pregnant women and women in labor, based on respect and dignity. Training and capacity building sessions need to emphasize the ethics and professional conduct in order to improve the performance of health care providers.

4.4. Health policies and systems and the need for research support

There is a growing for research to support health system and policies. The achievability of SDGs lies with the support of resources derived from research. The health sector needs research support in order to perform effectively and efficiently. In Togo, the national policy on the quality of health services highlights the lack of research and the failure to integrate modules on the quality of these services into initial training health centers. It emphasizes the need to integrate research data to guide policies at the local level (PNQSST, 2019). Indeed, research and research coordination are considered essential functions of the WHO, which provides the necessary guidance for research activities by defining the role of each partner in joint health research efforts.

Research contributions are eagerly awaited to facilitate the adoption and implementation of maternal and child health policies capable of driving the achievement of sustainable development goals (SDGs). However, the knowledge base for strengthening health systems and reorienting policies in Togo, a low- and middle-income country, is insufficient (World Health Organization, 2009). For the country, the facts show that the level of research data production is too low to drive progress. Indeed, according to scientific research indicators for countries around the world between 1996 and 2021, Togo has an annual average of only 106 scientific publications, compared to 342.48 for its northern neighbor Burkina Faso, 295.36 for its eastern neighbor Benin, and as many as 1,254.4 for its western neighbor Ghana (The SCImago Journal & Country Rank). In terms of research, Ghana achieves, in one year, a score that Togo needs approximately 12 years to achieve. Undoubtedly, these output differences will lead to differences in the success of policies such as those relating to maternal and neonatal health.

Research output are expected to impact health policies in these countries and increase life expectancy: 63.2 years for men and 65.5 years for women in Ghana, compared to 60.4 years for men and 62.2 years for women in Togo (https://www.donneesmondiales.com/afrique/index.php). The low level of scientific output, which does not facilitate the efficiency of policies such as maternal and child health in Togo, is a concern in more than one area of research. The health sciences concerned in the sector have to produce data capable of meeting these challenges. Health scientists will come together to discuss the best approaches for improving the performance of maternal and neonatal health policies.

5. DISCUSSIONS

The support provided by healthcare professionals during childbirth does not take into account women's mental health issues. This study has discovered, during interviews that women's words, gestures, and facial expressions display feelings of pain that they have to deal with constantly. Sometimes it is unmanaged psychological conditions during childbirth that lead women to choose specific

delivery centers rather than the healthcare facilities available to them. Pregnant women choose to give birth in private clinics rather than public health centers to avoid mistreatment.

Although this study does not highlight it, it is possible that certain policies pose risks to the survival of beneficiaries. Indeed, it is recognized that increasing cesarean section rates in the population remains a priority for most African countries where the rate remains insufficient (less than 5%), but this policy of subsidizing cesarean sections must be systematically accompanied by a program to improve the quality of obstetric care (Zongo A, Kouanda S, Fournier P, Traore M, Sondo B, et al., 2014).

In their implementation, operation, and evolution, maternal and neonatal health policies are faced with incapacities to achieve expected results. This means that new medical technologies, improved clinical trials, increased health investments, and increases and changes in health resources are not likely to increase the level of health efficiency. This raises questions about the new approach to addressing maternal and child health challenges. Thus, "ways of thinking are in fact the real capacities available to humans to understand the problems they face and implement the appropriate tools and procedures to address them" (P. Duran, 2018). It is therefore possible that the various contributors to health, brought together within a common framework or a collective action mechanism, each with their own mode of reasoning, could collaborate to find a common solution for sustainable maternal and child health.

Multidisciplinary approaches, alongside clinical sciences are necessary to address health issues. Many fields such as epidemiology, demography and statistics, social and behavioral sciences, health economics, policy-making, and management sciences, as well as certain aspects of clinical sciences produce knowledge. Each of these disciplines can provide information to support maternal and newborn health policies. Thus, research on health behavior, health economics, health policy, clinical epidemiology, etc., are all oriented toward the same goals (WHO, 1990). Avid researchers are eager to address issues related to the implementation of maternal and child health policies altogether in an interdisciplinary federal framework to develop common strategies in order to upgrade health standards.

CONCLUSION

The purpose of this study has been to discuss the challenges pertaining to the implementation of maternal and neonatal health policies in public health facilities in Lomé. This study has shown that implementing maternal and neonatal health policies in Lomé is jeopardized and the expected results are not met due to a lack of resources to efficiently support such policies. The results of the study coupled with the statements of interviewees indicate that midwives and birth attendants are taking advantage of this shortcoming to hinder the implementation of programs.

On the one hand, the study has proved that the behaviors and practices of midwives and birth attendants, who are key stakeholders in the implementation chain, are not aligned with the targeted objectives by the policies. These practices, which are not included in the planning process, cause psychological distress among pregnant women and women in labor. Thus, midwives unconsciously contribute to the emergence of invisible mental health problems in the implementation of maternal and neonatal health policies. To improve the effectiveness of maternal and neonatal health policies, it is necessary to:

ensure ongoing training and capacity building for providers with ethical concerns and professional conduct of midwifery and childbirth assistance; and

help support programs with material and technical resources, in particular the integration and use of the results of studies based on a multidisciplinary approach.

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