

Barriers affecting demand for reproductive, maternal, newborn and child health services in developing countries

Evie Browne
University of Sussex
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Question

What evidence is there about socio-cultural and other barriers affecting demand for reproductive, maternal, newborn and child health (RMNCH) services in developing countries? If possible please include information on the role of gender norms in accessing health services.

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1. Summary

Many studies conclude that a similar combination of barriers across various contexts work together to create low care-seeking behaviour and demand for reproductive, maternal, newborn and child health (RMNCH) services: cost; cultural, gender, and traditional norms; lack of knowledge and education; quality of service; and geographical inaccessibility. The same barriers are frequently identified across a broad range of literature and different countries, and the evidence is consistent and strong. There is a large amount of literature from South Asia, and a considerable amount from Sub-Saharan Africa. Most studies highlight that barriers are best addressed by considering them holistically and in the way that different factors intersect to combined effect. Prioritising one barrier over another may not achieve positive results. Community-level approaches including decision-makers and men are also recommended, to overcome intersecting barriers. Additionally, supply- and demand-side barriers often work in tandem, and where possible, multiple levels of the health system as a whole should be taken into account.

Coast et al. (2016) importantly note that 'Culture' is not always or only a barrier, but rather a population characteristic that must be taken into account in order to be responsive to communities' needs. Culture is not static, but is an ongoing interaction between communities, networks, and the wider environment, meaning it is dynamic and always changing.

Broadly conceptualised, gender inequality is widely considered a barrier to women's use of RMNCH services. Gender dynamics within the household may mean that women are prevented from making autonomous decisions about their care, with older women and husbands having more decision-making power, and women may not have enough access to household finances. Women's domestic care burden often means they are unwilling to take time away from home to attend health appointments or to deliver babies in a health facility.

Coupled with women's domestic and gendered responsibilities, comes an attitude that having children is "natural" and "women's business", meaning that men are often unwilling to give household resources to pregnancy and childbirth. Women across all regions of the world were likely to consider giving birth as a natural process which did not need any medical intervention or support unless there were obvious complications (Bohren et al., 2014). Medical care was often considered only as a last resort. Traditional practices and traditional birth attendants (TBAs) were also strongly preferred by some women, due to their willingness to attend women at home, and the possibility to develop a strong, personal bond (Bohren et al., 2014). TBAs were consistently seen across the literature as trustworthy and respectful of cultural preferences, making them a first choice for many women. Medicalised care was often seen as cold and dehumanising in comparison.

Quality of care and perceptions of disrespectful treatment emerged as important barriers to women's uptake of services. Consistent reports throughout the literature show that formal health facilities were perceived to provide poor care, insensitivity to cultural issues, abusive behaviour, discrimination, disrespect, and undignified and unfamiliar birthing practices (Bohren et al., 2014; Bohren et al., 2015; Jones, Lattof, & Coast, 2017). These poor services result in a lack of trust in healthcare providers, and sometimes fear and shame, which powerfully discourage women from seeking formal healthcare (Bohren et al., 2015). Trust in health services is undermined by disrespectful care, and likely to make women choose alternatives. Studies agree that the reputation of service providers is important in encouraging women to seek care; in particular, a

supportive attitude to cultural practices, use of appropriate languages, and allowing family members to be present.

Compounding all socio-cultural barriers is that of cost. Not only upfront costs for healthcare, but opportunity costs, like time away from income-generating activities, and hidden costs, like bribes, mean that women simply can't afford healthcare in many instances. The literature highlights that only reducing or removing upfront costs, like user fees, is not enough to increase care-seeking: the other intersecting barriers need to be addressed as well (Byrne, et al., 2013).

The literature consistently identifies distance, rural areas, and inaccessibility as barriers to accessing healthcare, and ones that are hard to overcome.

There is a large amount of literature on barriers to RMNCH in developing countries, including some strong evidence from systematic reviews, randomised control trials and impact evaluations. The quality of evidence is quite strong. Evidence often considers demand- and supply-side barriers together, or evaluates interventions, which address a number of barriers holistically. This report mainly focuses on results from systematic and comprehensive reviews which synthesise global evidence, rather than specific interventions or country contexts.

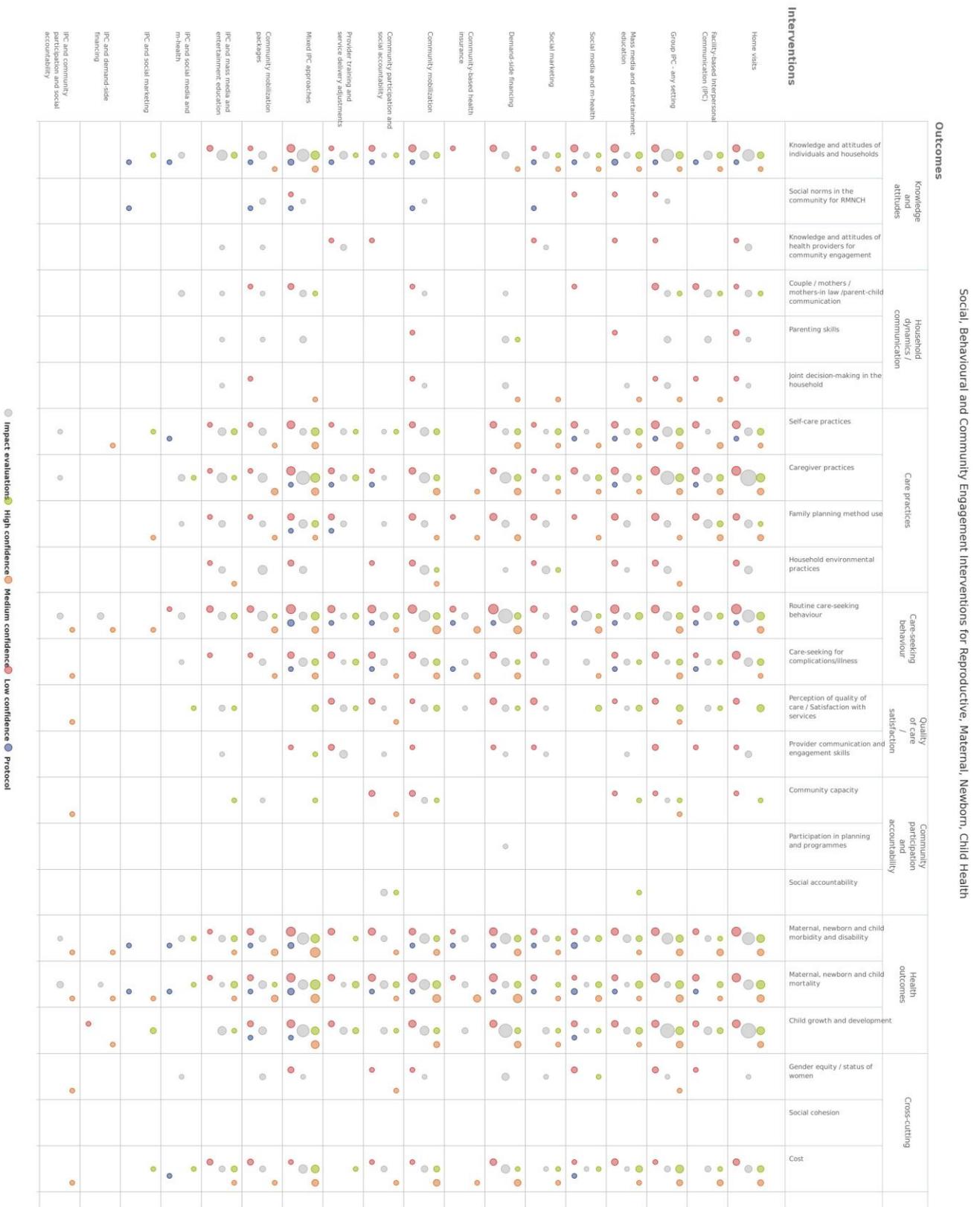
Much of the literature considers gender norms and gendered issues. RMNCH is still conceptualised in most research as mainly pertaining to women, but more recent work has started to include a nuanced approach to gender as a social construct and system, and to consider men's input and roles. This report considers gender inequality both as a stand-alone barrier, and reflects on gendered issues throughout.

2. State of the evidence

3ie's Evidence Gap Map

The impact evaluation group 3ie produced an evidence gap map in 2017 of interventions for RMNCH in low- and middle-income countries, supported by WHO (Figure 1). It is based on a systematic search for studies published between 2000 and July 2016. The map contains 142 completed systematic reviews, 457 completed impact evaluations, 13 ongoing systematic reviews and 38 ongoing impact evaluations. Bubbles of different colours indicate different types of evidence. Green (high confidence), orange (medium confidence) and red (low confidence) bubbles correspond to systematic reviews. High, medium and low confidence refers to confidence in conclusions about effects. It indicates the overall rating given to a systematic review based on a careful appraisal of the methods applied in a systematic review, using a standardised checklist. A purple bubble represents a protocol for a forthcoming systematic review. Grey bubbles represent impact evaluations. The larger the bubble, the greater the volume of evidence in that cell. Gaps indicate that there was no evidence available on a given intervention and outcome intersection.

Figure 1: Evidence gap map on Social, Behavioural and Community Engagement Interventions for Reproductive, Maternal, Newborn, Child Health



Source: 3ie (2017), Licensed under a [Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License](https://creativecommons.org/licenses/by-nc-sa/4.0/). <https://gapmaps.3ieimpact.org/evidence-maps/social-behavioural-and-community-engagement-interventions-reproductive-maternal-0>

3ie's conclusions that are relevant to this Helpdesk report include (Portela, et al., 2017): there are a large amount of evaluations on demand-side financing, mostly conditional cash transfers; care-seeking behaviour is a commonly-studied outcome; but few evaluations measure social norms or gender equity outcomes, although rural-urban divide is often considered to affect outcomes. 3ie concludes that gender equity is not well measured or considered as part of these kind of interventions. Disability was not considered in any study.

3. Gender

Gender inequality is widely acknowledged as a particular barrier to women's seeking and utilising healthcare services. The specific form that gender norms take varies from place to place, but some aspects appear to be widely practiced around the world.

A systematic review of interventions in South Asian countries – principally India and Bangladesh – showed that gender was a demand-side barrier to seeking antenatal, birth, and post-natal care (Gandhi, et al., 2020). In South Asia, women may not have control over decisions regarding their own healthcare, and boy children may receive preferential access to healthcare. In Nepal, a systematic review (Byrne, et al., 2013) showed that gender inequality has impacts on women's decision-making in the household, and a "complacent" attitude to women's health needs when giving birth. Women are unable to travel alone to health facilities, and stigma surrounding "polluted" bleeding women meant that men were unwilling to accompany them as needed if birth complications arose. Women were likely to avoid care-seeking because of their low status within the household, and the desire to avoid imposing further work on the rest of the family. In Cameroon, husband's control over finances and household decision-making meant that women were subject to their husband's decisions and unable to disobey or seek care alone (Nudelman, Teri, & Ouattara, 2018). Further, women may not be comfortable with male health workers. A comprehensive review identified that women may not be comfortable being treated by male doctors or by having someone examine their genitals, where this is considered culturally inappropriate (Hunter & Murray, 2017). In Somali region in Ethiopia, a Muslim majority region, male health workers for RMNCH are considered unacceptable by most female patients (Jalu, et al. 2019).

A series of papers in *The Lancet* (Heise et al., 2019) points out that gender norms create a one-sided responsibility for RMNCH falling entirely on women, while decision-making often remains in the hands of men. Men are often excluded or deemed not responsible for RMNCH, but at the same time, women need men's support to enable good outcomes, as they often act as gatekeepers to women's health. Occasionally, men's formal consent is required by healthcare providers (Heise et al. 2019). In India, men were reluctant to participate in maternal health interventions, seeing it as a "women's issue" (Miltenburg et al., 2017). In Cameroon, men were unwilling to be involved in "women's business", seeing it as emasculating, meaning that women were less able to seek healthcare, without their husband's support (Nudelman, Teri, & Ouattara, 2018). In Tanzania, men may delay seeking transport to health facilities for women in labour because they may not have been included in birth discussions and may not be aware, might be unavailable at the time, or be ashamed to be visibly supporting their wives (Miltenburg et al., 2017). In the case of childhood illnesses, a systematic review reports that male heads of households have to approve care-seeking; and where male heads were not available, other

elders would make those decisions (Colvin et al., 2013). Younger women were less able to make decisions, and decisions were never made by mothers alone.

Men's involvement in birth planning appears to increase the likelihood that they will support women giving birth by helping seek timely care (Miltenburg et al., 2017). In Ethiopia, many RMNCH decisions were made by women's husbands, including whether to seek care (as this is a financial decision) and family planning decisions (Jalu, et al. 2019). Women saw husbands' support for RMNCH visits as crucial for their health. Men's greater access to cash, and their decision-making power, mean that it is important to include them in pregnancy and birth to reduce women's barriers to accessing care. Their involvement and support for RMNCH is likely to considerably increase women's uptake of services (Nudelman, Teri, & Ouattara, 2018).

Jones, Lattof and Coast (2017) note in a review paper that a lack of alternative childcare can be a problem for some women; if they cannot leave their children safely, they are less likely to keep healthcare appointments. Domestic responsibilities may also make women more likely to choose to deliver at home (Bohren et al., 2014). Smith, Portela, and Marston (2017) identify that women's domestic care responsibilities might specifically prohibit them from being able to stay in a maternity waiting home due to the amount of time away from home that this entails. The pregnant person may not make this decision, but it may be a family-level decision made by a husband or mother-in-law (Penn-Kekana, et al., 2017).

Glassman et al. (2013) discuss the positive effects of conditional cash transfers (CCTs) on care-seeking behaviour for women, but caution that increased economic power may not be able to overcome entrenched gender norms. While cost may become less of a barrier, women are often unable to travel without being accompanied, and may continue to prefer traditional healers and methods. The authors state that CCTs would be most effective when their perceived benefits outweigh the costs of transgressing social norms.

4. Views of childbirth as natural

Some studies report an attitude among women and men that childbirth is a natural process that does not need medical attention, unless there are obvious complications. This attitude results in low care-seeking behaviour, perhaps until it is too late.

Miltenburg et al. (2017) found that several studies reported women's perceptions that birth was normal and natural, and required no preparation or planning. Bohren et al. (2014), in a systematic review, also found this – that both women and men describe childbirth as a natural process which does not require medical attention unless there are complications. If a woman had an uncomplicated first pregnancy, she is less likely to consider a facility birth for any other pregnancies. Health facilities were therefore regarded as only required to manage complications rather than a default delivery location. In particular, in Tanzania and Nepal, modern health services were regarded as a last resort, should complications arise, and were seen as not necessary for straightforward births (Miltenburg et al. 2017). In Cameroon, pregnancy was regarded as a women's issue that should proceed naturally, monitored only through norms and taboos around diet and behaviour (Nudelman, Teri, & Ouattara, 2018). In Bohren et al. (2014), women were also specifically afraid of caesarean section and episiotomy as these were seen to be unnatural and unnecessary. In Ethiopia, post-natal care uptake was low for the same reason, that if women felt they were healthy, they saw no reason to go for a checkup (Jalu, et al. 2019).

5. Religion and superstition

A study in Ethiopia found that decisions about how many children to have, and when, were considered to be acts of God rather than determined by husbands and wives (Jalu, et al. 2019). Birth spacing and contraception were considered to be inappropriate, while in rural areas, having many children gained respect in the community. In Nepal, a systematic review (Byrne, et al., 2013) showed some suggestion of a fatalistic attitude to women's birth outcomes, which were seen to be under god's control, not people. Many families preferred traditional treatments from shamans rather than health practitioners, supported by rumours and fear of modern medical practices. In Cameroon, some early childhood diseases were believed to be caused by angering the ancestors, and thus remedies should be traditional rather than medical, especially medicine associated with white Europeans (Nudelman, Teri, & Ouattara, 2018). Some studies also reported in Miltenburg et al. (2017) that complications during birth were seen as indicating issues such as adultery, causing women to remain silent and not seek care. It was commonly reported that preparing for birth by announcing the start of labour to the father or buying baby items in advance was seen to bring bad luck or jinx the birth, and should be avoided.

6. Education, knowledge, and tradition

Women's low levels of education and limited knowledge of maternal health needs are often cited as barriers to interventions (Jones, Lattof, & Coast, 2017). Higher formal education of women seems to be linked with greater behaviour change after interventions, although the chain of causality is not clear (Miltenburg et al., 2017).

Byrne et al. (2013) found that women's formal education was a major determinant of whether they had a facility-based delivery or not: those with higher secondary level were considerably more likely to use RMNCH health services than those with no education. Specific knowledge of reproductive health issues was also identified as a barrier, resulting in late presentation to a health facility, and in a more severe state. When patients present in this way, they are more likely to become critically ill, which feeds into a lack of trust in the abilities of health services. Women with disabilities are much less likely to have received sex education information or education on pregnancy and fertility, as there is often a lack of appropriate content (Oosterhoff, 2018).

A preference for traditional birth attendants (TBAs) and traditional forms of giving birth are often highlighted in the literature. Sometimes TBAs are seen as a barrier to women's use of modern medical services, but sometimes TBAs are included in programmes and interventions as a means to create more responsive, culturally appropriate, and therefore more utilised services. In a comprehensive review of maternity waiting homes (MWH), Penn-Kekana, et al., (2017) identified that including TBAs in the waiting homes was critical for increasing attendance. TBAs were often cited as being important to pregnant women because of being able to create a close bond with them, and because of their status in the community – rather than because of perceived quality of care (Bohren et al., 2014). Several studies report on the perception of closeness and long-term support, comfort, and familiarity, with TBAs, which other medical providers do not seem to achieve. Denying TBAs and other non-harmful traditional practices, such as burying the placenta, may be a barrier to women's seeking care (Bohren et al., 2015).

Pregnant women may not be fully in control of decisions around their pregnancy. Elder women often have considerable influence in decisions, especially about where to give birth (Bohren et al., 2014). Some women in Bohren et al. (2014) believed they should give birth in the same place

as their mothers and grandmothers to maintain intergenerational continuity, and elder women may encourage younger women to give birth at home. Elder women often have more power in this decision than husbands.

7. Low quality of care and lack of trust in service providers

A large number of comprehensive review papers highlight the consistent reports of disrespectful care within formal health services, resulting in women's fear of attending, and low perceived quality of care. Women may prefer to deliver babies at home rather than in a health facility, due to perceptions of dehumanising, over-medicalised treatment without respect for personal choices (Bohren et al., 2014). Although quality of care may seem to be a supply-side barrier, it has important effects on people's perceptions of RMNCH and the likelihood of their trusting in and seeking out health care. Improving the quality of care is likely to reduce barriers to uptake (Bohren et al., 2014).

Two systematic reviews (Bohren et al., 2014; Bohren et al., 2015) found many reports of health providers engaging in verbal and physical abuse, disrespectful and racist behaviour, neglect, overcrowding, long delays, and poor communication, resulting in women's perception of an overall poor quality of care in health facilities. Jones, Lattof and Coast (2017) identified that negative attitudes, discrimination, disrespect and/or outright racism exist within healthcare services. Negative interpersonal interactions caused women to feel shame and anxiety, decreasing their desire to attend healthcare services.

Specific groups of women were more likely to report discrimination than others. Ethnicity and race were often reported as factors which increased discrimination (Bohren et al., 2015). Poverty also exacerbated discrimination, with women of lower economic status reporting being humiliated by health services providers for their illiteracy, slum-dwelling, or for being "dirty". Fear of this kind of treatment was a powerful disincentive to deliver in a health facility in Ghana, Tanzania, and Sierra Leone (Bohren et al., 2015). Where women's sexuality is heavily controlled, pregnant women outside the norm, such as unmarried women, sex workers, or HIV-positive women, may be treated badly in health facilities, which may result in them avoiding seeking care because of the stigma and shame (Heise, et al. 2019). In Kenya and South Africa, women were afraid of being given a non-consensual HIV test, and that results would be disclosed in a crowded ward with no chance of privacy, resulting in stigma (Bohren et al., 2014; Bohren et al., 2015). Some of these women chose to deliver at home, on this basis. Unmarried adolescents and older women with many children reported being criticised by health staff, in a global systematic review (Bohren et al., 2015). Women and men with disabilities are very likely to experience discrimination from health services, due to a prevailing attitude that they do not have fertility desires or active sex lives (Oosterhoff, 2018). Further, in Uganda, people with disabilities found that health workers lacked skills to provide disability-specific care (Ahumuza, et al. 2014). Perceived insensitivity to cultural requirements by health service providers, such as a shared language or traditional birth positions, can be a barrier to uptake of care (Coast et al., 2016).

Perceptions of the low quality of care and possible poor treatment in health facilities is reported to contribute to many women choosing to give birth at home instead. In a systematic review, Bohren et al. (2014) identified that women were specifically afraid of being forced into unfamiliar and undesired birthing practices in health facilities, such as different birth position and unnecessary vaginal examinations. The experience was considered dehumanising and disempowering, as women felt they were not allowed to make their own decisions about birth. At

home, with a TBA, women felt more in control, with more dignity and privacy, and more supported by the attendance of a family member. Maternity waiting homes seem particularly likely to be regarded negatively in terms of their quality of care (Smith, Portela, & Marston, 2017). This review showed that poor quality of care, either real or perceived, was a strong barrier in women choosing whether or not to attend. In Ethiopia, some Somali region women preferred to go to a private hospital rather than public hospital or smaller health facility, because the private hospital had better privacy, services, ventilation, and hygiene, while the others were perceived to provide low quality and potentially dangerous care (Jalu, et al. 2019). Specifically, smaller health posts did not have a water supply, so women preferred to deliver at home if they could not afford the private hospital. In mountain regions in Nepal, a systematic review (Byrne, et al., 2013) found that women were dissatisfied with the health services provided, as they were considered cold, dirty, uncomfortable, with unpleasant staff and lack of supplies and equipment. Women reported a lack of respect and dignity for childbirth, such as being left partially dressed, not allowed to perform traditional practices, and not allowed to have family members present. These resulted in a preference to give birth at home, in familiar conditions and with family companionship.

Providing respectful and dignified care was essential in increasing women's uptake of maternity waiting home (MWH) services (Penn-Kekana, et al., 2017). In Peru (Gabrysch et al., reported in Jones, Lattof, & Coast, 2017), an intervention on culturally appropriate models for care at birth reported positive outcomes because service providers showed respect for preferences, local languages, and allowing relatives to be present. Cultural sensitivity was most commonly approached through employing health workers from similar cultural or linguistic backgrounds as patients, and improving respectful interactions (Jones, Lattof & Coast, 2017). Although CCTs are effective at encouraging care-seeking behaviour, Glassman et al. (2013) caution that the quality of care provided must also be sufficient, or health outcomes will not be improved. Where women perceived health facilities as competent, effective, and safe, they were more likely to overcome other barriers in order to deliver babies in a health facility (Bohren et al., 2014).

In the case of childhood illnesses, traditional healers and home remedies were preferred in a systematic review (Colvin, et al., 2013), because they were considered more likely than clinics and hospitals to listen, take time, consider patients' concerns seriously, and were thought of as more accessible and flexible.

Studies agree that the reputation of service providers is important in encouraging women to seek care; in particular, a supportive attitude to cultural practices, use of appropriate languages, and allowing family members to be present. Trust and respect shown to patients encourages women to attend health services, while bad experiences erode trust and make it less likely for women to choose health facilities in the future (Bohren et al., 2015). These qualities were often developed through interventions which instigated dialogue between communities and service providers, giving space to community participation in defining how they want care services to look and to address their needs effectively (Jones, Lattof, & Coast, 2017).

8. Cost

Affordability and low incomes are considerable barriers to accessing healthcare, noted in many studies. Beyond the upfront costs of healthcare, opportunity costs such as taking time off work are also important.

Facility-based care was viewed as prohibitively expensive by many women in a systematic review (Bohren et al., 2014). Both direct and indirect costs were seen as too high to manage. In Nepal, a systematic review (Byrne, et al., 2013) identified that cost remains a significant barrier to access even when user fees have been removed. The review showed that financial cost implications are greater for low caste status women as well as women with low wealth. Women with disabilities have even lower incomes than able-bodied women in Uganda, making care costs very difficult for them (Ahumuza, et al. 2014). Secondary costs are still important, for example, accompanying a pregnant person to a health facility carries an implication for both people of lost day's wages or other income.

Cost also carries a gendered implication. Women are less likely to have financial autonomy to make decisions about how to spend money (Heise et al. 2019). Women may need men's consent to make a decision with financial implications, which sometimes results in women seeking lower-cost, alternative or informal care (Heise et al. 2019). High costs for transport, facility-based care and out-of-pocket expenses mean that women very often opt for a cheaper alternative, which is often traditional care (Miltenburg et al., 2017). Due to cost, in Ethiopia women were likely to only visit a health centre after trying some low-cost home remedies (Jalu, et al. 2019).

A large number of interventions have used conditional cash transfers (CCTs) or vouchers as a way to overcome financial barriers to access. Glassman et al. (2013) conducted a systematic review on the impacts of CCTs on maternal and newborn health that is often referenced by others. They concluded that CCTs are effective at reducing barriers, with results seen in the areas of prenatal monitoring, skilled attendance at birth, and use of a health facility for birth. These results stand even though CCTs often have a broad scope and do not always focus specifically on RMNCH. However, the authors caution that economic poverty is rarely the only barrier to access, and that care-seeking is strongly affected by social, cultural, and health system factors as well. A more recent review of demand-side financing also identifies that covering treatment costs is usually insufficient to increase demand, and that other costs and intersectional issues must be considered (Hunter & Murray, 2017). For example, vouchers may not be utilised by women because some husbands did not want the stigma of being labelled as poor (Hunter & Murray, 2017). Another review (Jones, Lattof, & Coast, 2017) identified that cost remained an issue even where interventions were specifically targeted at making services culturally appropriate. Taken together, these studies show that economic and socio-cultural barriers are best considered alongside each other, as addressing one alone may not be enough.

9. Distance and accessibility

Several studies identify distance, rural areas, and geographical inaccessibility as barriers to accessing healthcare, and ones which are hard to overcome. Glassman et al. (2013) identify poor infrastructure as a barrier that cannot be overcome with CCTs or other economic incentives. Limited transportation, and high costs, compared to the accessibility of TBAs, mean that many women choose to give birth at home instead of at a health facility (Bohren et al., 2014). Many interventions have adopted accessibility strategies alongside improved cultural appropriateness, for example outreach services to rurally distant women or providing transport services (Jones, Lattof, & Coast, 2017). Inaccessibility was also an issue for women with physical disabilities in Uganda, who found the lack of ramps and disability-friendly facilities to be a serious barrier (Ahumuza, et al. 2014).

Maternity waiting homes (MWH) are commonly advocated for and implemented across the world to overcome accessibility issues, by providing lodging close to a health facility where women can stay for a few weeks close to the time of birth (Penn-Kekana, et al., 2017). However, simply building a MWH alone does not overcome transportation and access barriers, as women usually still need to pay for public transport to the MWH, which they may not be able to afford. Interventions which provided upfront or refund travel costs were more successful (Penn-Kekana, et al., 2017). Further, the provision of food was also a barrier to women's uptake of MWH, related to cost. MWH with good facilities, such as a hot shower in Ethiopia, meals provided, income-generating activities, and which allowed companions to stay or at least visit, resulted in much greater uptake and support for MWH.

10. Community-level barriers

Several studies identify that increasing women's utilisation of RMNCH services is not just about empowering women individually, but engaging at a family and community level as well. Smith, Portela, and Marston (2017) suggest that family and community decision makers are important in affecting whether women access health services. Interventions that have been successful have included mass media awareness campaigns, leaflets, and social mobilisation activities, including partnerships with religious leaders and men. These kinds of activities have generated community support for women's utilisation of RMNCH services and have helped overcome cultural and social barriers. Particularly, maternity waiting homes have found community participation and discussion very helpful in increasing attendance, responding to community feedback about what people want to see in MWH (Penn-Kekana, et al., 2017).

Howard-Grabman et al. (2017) identified that, in Tanzania, people perceived women's health as an individual, not collective responsibility. An intervention which focused on collective responsibility increased other people's awareness about the challenges women faced and how working together might help. This helped address community-level barriers, such as transportation, which helped enable women's better access to healthcare. Some community programmes have also been successful in increasing people's ability to address government, influence decision-making on health policy, and hold local providers to account, all improvements which reduce barriers for women to access healthcare.

11. Language

A few studies have noted that linguistic differences can be a barrier to care-seeking (Jones, Lattof, & Coast, 2017). In Guatemala, women expressed concerns that health workers did not share a language with them, and the potential this has for undermining respect for cultural beliefs (Penn-Kekana, et al., 2017). Sometimes, women were unable to bring interpreters or their non-family interpreters were denied access to wards (Bohren et al., 2015).

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Key websites

- 3ie: International Initiative for Impact Evaluation: <https://www.3ieimpact.org/>
- BMC Pregnancy and Childbirth 2017, Issue 17, Special Issue on Factors that affect implementation of health promotion interventions for maternal and newborn health in low-and middle-income countries: <https://www.biomedcentral.com/collections/MNHealth>
- HEART Maternal, Newborn and Child health section: <https://www.heart-resources.org/category/health/maternal-newborn-child-health/>
- Partnership for Maternal, Newborn & Child Health (PMNCH): <https://www.who.int/pmnch/about/en/>

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