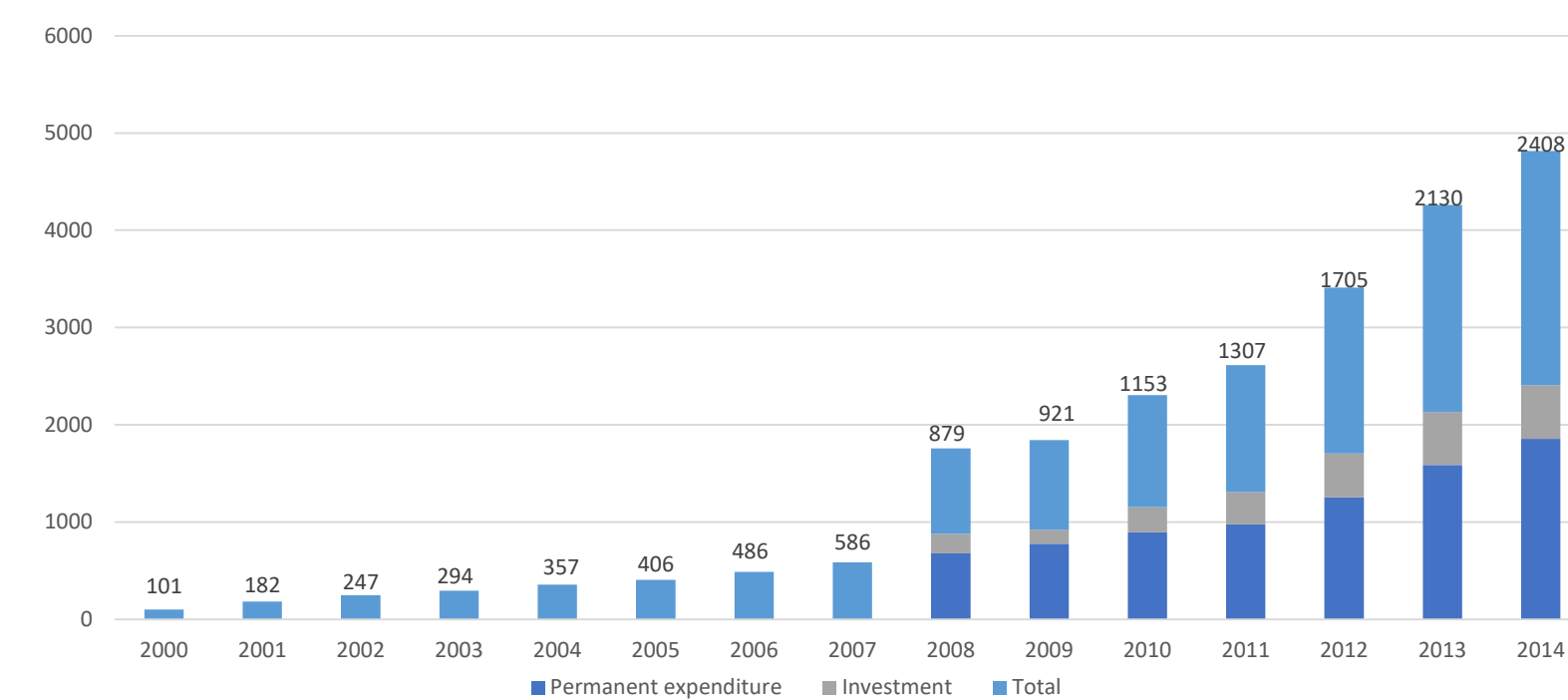


Background

- Health reform (2007-2014)
- Change of the Constitution (2008)

General executed budget of the state allocated to health 2000-2014 (US dollars in millions)



- BUT: no better outcomes in maternal health and worst situation in the rural Andean region

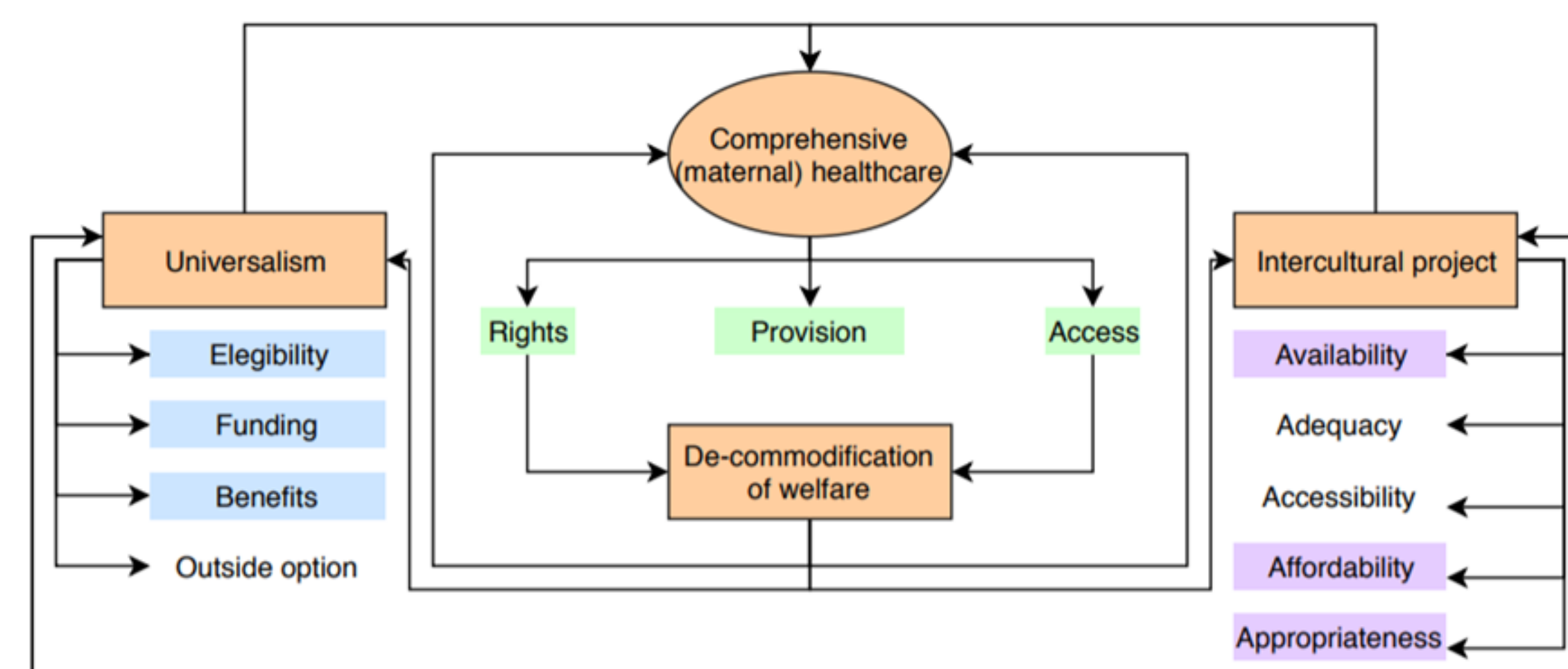
What was my research objective?

- Identify and seek an explanation for the gaps between the State provisioning of maternal healthcare and the needs of the female population from various ethnic groups in order to contribute to ensure the right to comprehensive maternal healthcare

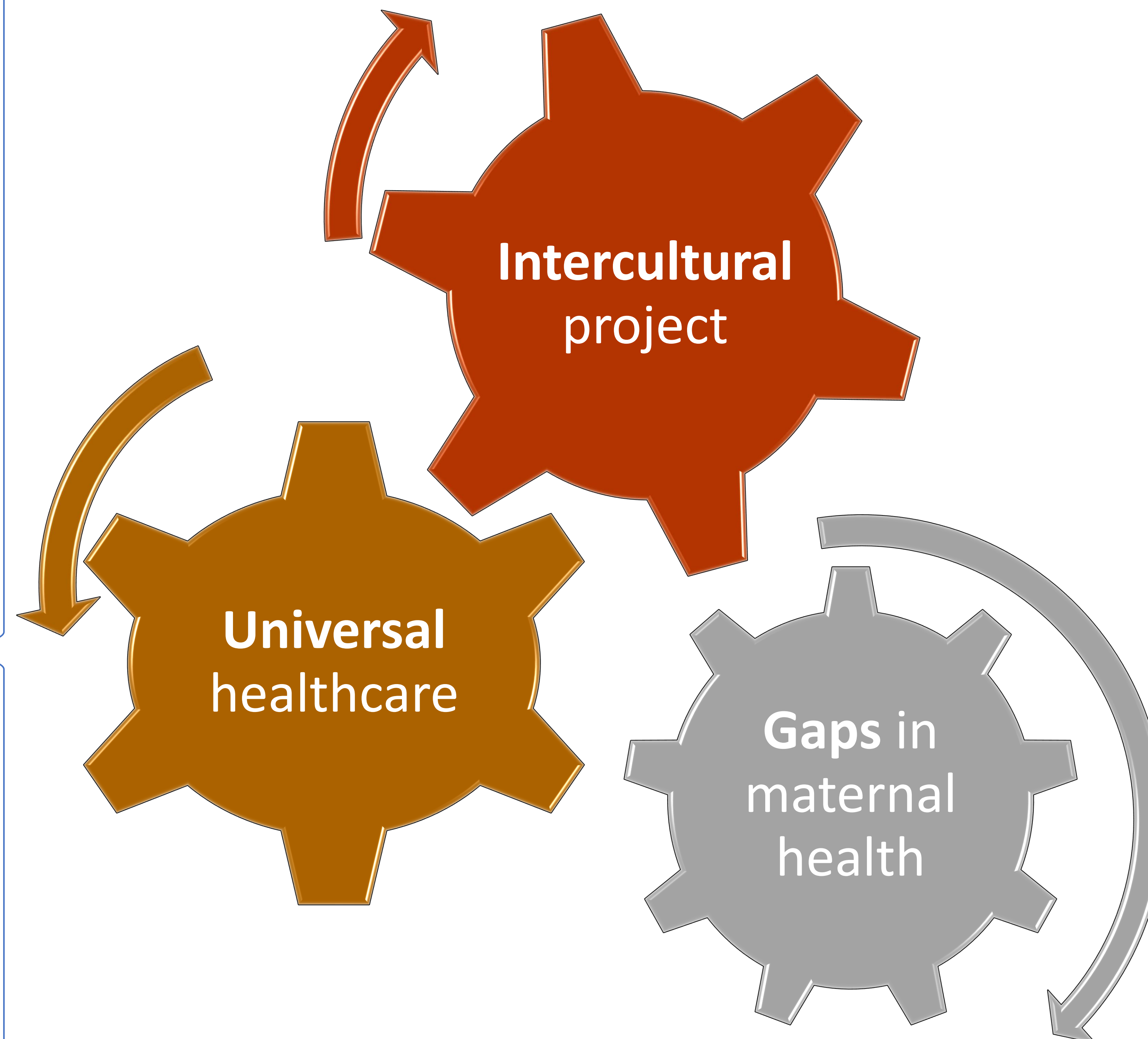
What was my research strategy?

- Mix methods approach

What was my framework?



-Elegibility: Formally an entitlements based approach, but a fragmented public system



- Funding:** permanent expenses have to be financed with permanent income
- Maternal and reproductive health had a residual budget. Programmes related to attention in accidents and heart attacks have more allocation. Both main causes of death among men



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Results

-Benefits: Abortion only possible in cases of rape to a mentally disabled woman.

-Culturally Adequate Birth strategy

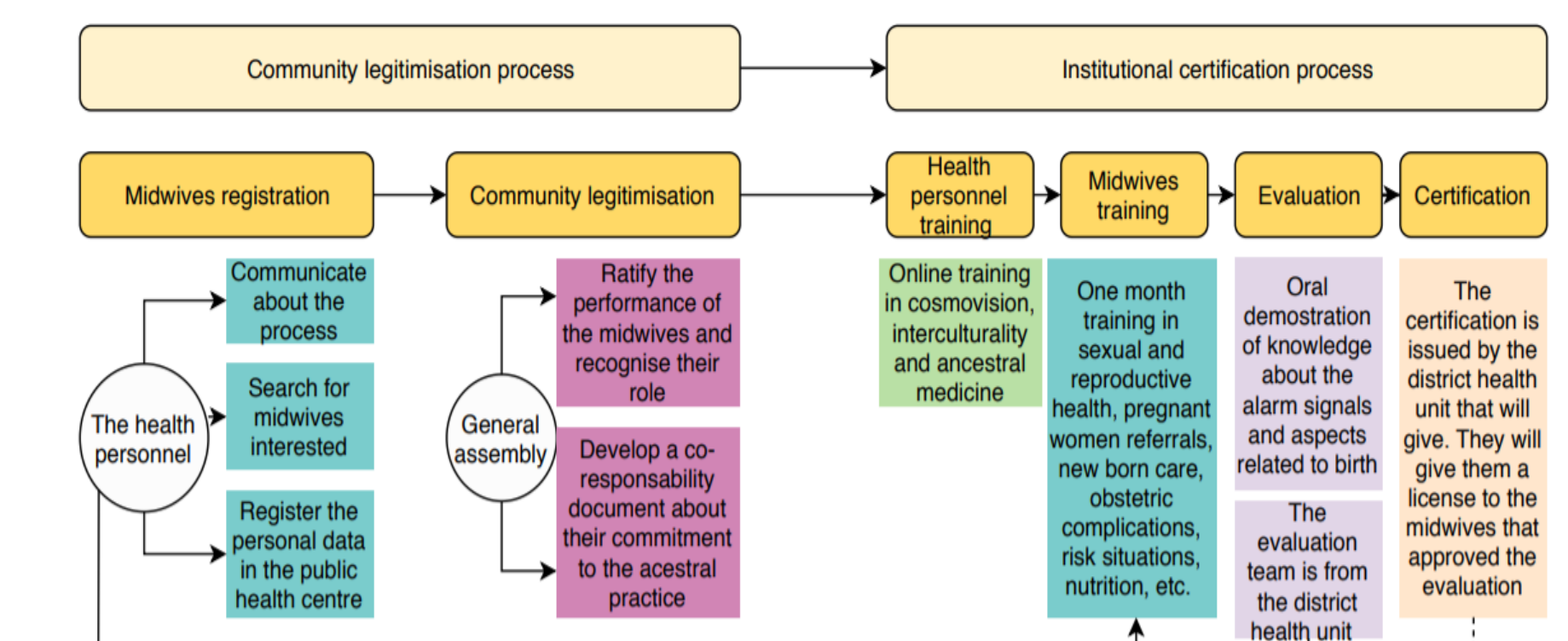
-GAPS: no births at home possible, coverage of hidden costs, and measures addressing opportunity costs

-Appropriateness: Effort of a more comprehensive maternal health package

-In 2018, 46% of births were c- sections (private sector: 80% with health centres even sponsored with public budget)

-Availability:

Process of community legitimisation and institutional certification of midwives



-Affordability: Free of charge services have contributed to indigenous women access to public facilities

-Lack of midwives in the public provision: free services versus traditional practices.

-When there is no mean of transportation or even worst when the price is unaffordable, this makes whatever is provided actually not available

-Public policy rethinking: “I did not attend the health centre, I wanted to be *macha* (...) you know indigenous women are strong”