DELIVERY CARE POLICY: SOCIAL DIMENSIONS

Proxy indicators for maternal and newborn health in Ghana indicate that reaching Millennium Development Goal (MDG) 5 by 2015, is by no means a given. The studies reported in this special issue of the journal are welcome for the insight they give on some of the possible reasons.

In considering the social dimensions of the lessons learned from the evaluation of the impact of the free exemption policy on maternal mortality, quality of care and health seeking behaviour, a number of issues are revealed.

Firstly, in regard to community perceptions concerning the advantages and disadvantages of institutional delivery care at the household level, results show that many non-users of health services held negative views on the attitude of health care providers. The findings do not stipulate which income or education strata of society actually hold this view; but future behaviour change communication strategies and programmes would benefit from that information. Although the fee exemption policy apparently benefited rich and poor, the results show that it was the rich that benefited most. Our future programmes need to find ways to re-dress that imbalance and ensure that the poor and the extreme poor (being in the majority and with highest fertility levels and health-risk factors) benefit the most if we are to see any decline in maternal mortality at the national level.

It is unfortunate that the study could not cover a period longer than 8 months in the Volta Region because other studies have shown that initial phases of an intervention often show results that are not sustained over the medium-longer term. Thus results may have been skewed to give a falsely optimistic picture of the impact of the fee exemption policy on the rate of institutionalized deliveries. Certainly it is encouraging to note that during the implementation of the exemption policy institutionalized deliveries did in fact increase in Central Region but decreased in Volta Region. However, given the reservations of non-users and the reservations health workers themselves expressed about the sustainability of the initiative, it is clear that this aspect needs further scrutiny.

Given the increase of institutionalized deliveries post-exemption, it appears that family decision making (constituting the first of the new well-known 3 delays described by Maine et al) is more influenced by financial considerations than cultural. Further evidence should be sought but the inference is that the fee exemption policy weakens considerably the force of certain cultural beliefs that increase delays at this level.

The implications of improving quality of care are clearly brought out by the finding that health centres in Central Region, where the intervention had a 2-year implementation period, actually recorded increases in institutionalized deliveries and a significant reduction in the number of referrals. The reimbursement scheme under the exemption policy apparently empowered the health centres to improve their drug, equipment and supplies situation to the extent that they were able to attract greater numbers of clients. This apparently was not the case in Volta Region where hospitals were the main beneficiaries. More important is the inference that health centres by being able to cope with the increased client load have demonstrated the underutilization of their staffing prior to the fee exemption policy. Health centres are physically closer to rural communities. Thus the Central Region experience, demonstrates that by ensuring adequate staffing and financing modalities that allow for adequate supplies, drugs and equipment combined with a fee exemption scheme may present a viable strategy for improving maternal and neonatal health care delivery in a sustainable manner.

Traditional Birth Attendants (TBAs) have long been the preferred provider in many communities because of their accessibility and compatibility with social norms and practices; however, over the twenty years since the launch of the Global Safe Motherhood initiative, in Nairobi in 1986, it has become clear that TBAs need to work closely with the formal health delivery system in order to ensure timely referral of obstetric emergencies. The findings of this study indicate that, in fact, there has been a shift from TBAs and indeed private midwives to public health facilities (hospitals and health centres). The health system needs to look at ways in which this transition can be facilitated.

Through the adoption of MDG 5, the way societies organize themselves to cater for women in labour

is now seen as a key indicator of the level of development. It would be interesting to document experiences of communities that extend fee exemption to women in labour. Could it be feasible and would it in fact result in lower maternal and neonatal mortality?

The reported findings indicate that though quality of care remained the same (in fact unacceptably poor) in spite of increased workload experienced under the fee exemption policy, delivery outcomes did improve and referral rates improved in Central Region but in Volta Region it decreased. Given the improved outcomes, it is assumed that community perception of the advantages of institutionalized delivery would under a fee exemption policy improve.

In summary, from a social dimension, it would appear that the fee exemption policy improved community perceptions regarding the advantages of maternal health care for women in labour although their perceptions of health workers attitudes did not. The policy also overcame cultural biases toward the use of TBAs and delivery practices. The policy facilitated decisions within the family in favour of institutionalized deliveries.

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