DELIVERY CARE POLICY: SERVICE DELIVERY and QUALITY OF CARE

A series of articles in this issue of the journal are based on a study designed to evaluate the policy of the Government of Ghana to exempt women from paying for delivery care. Beyond answering the specific questions identified for the evaluation, the findings of this research will have wide implications for policy formulation and implementation, not just in our efforts to improve maternity care and save women's lives in Ghana but also other social interventions intended to reduce poverty and improve the wellbeing of Ghanaians.

I wish to comment briefly on the findings of the evaluation with specific reference to the thorny issues of service delivery and quality of care.

The first observation is that unfortunately, the period of implementation of the policy in the two regions, Central Region and Volta Region was too short to draw conclusions on the potential long term impact of the policy on service delivery and quality of care.

During the relatively short time the policy was being implemented, facilities and service providers tried hard to make it work because most of them were in favour of the policy. It is also reassuring to know that over short periods of time, the health care delivery system is capable of absorbing significant shocks as demonstrated by the evaluation. Had the implementation period been longer, say four or five years, a clearer and, perhaps, more definitive picture may have emerged about the cumulative impact of work overload and fatigue on service providers and the scarcity and shortage of medicines and supplies at different facility levels.

Even though it was implemented for a relatively short time, particularly in the Volta Region, and there was some confusion about its provisions, the evidence suggests that the policy led to significant and positive changes in care-seeking behaviour, resulting in more women seeking delivery in hospitals or clinics under the supervision of trained care providers. All professional groups interviewed reported working longer hours and seeing more patients. Not surprisingly, midwives, with a mean increase of eight deliveries per week and average increase in working hours of 17 per week, were most affected by these changes. In the medium to long term, these situations were bound to have adverse effects on service availability and quality of care. It is generally expected that when the National Health Insurance Scheme (NHIS) gets into full swing, demand for services, including delivery services, will increase significantly. These, likely, will pose serious challenges to services delivery and the quality of care unless supply side constraints are addressed. As the report puts it, "many basic obstetric care facilities (including health centres and the private clinics and maternity homes) in Ghana generally have resource constraints and therefore have limited capacity to cope with an increase demand of services".

The evaluation found no change in the quality of clinical care before or after the introduction of the policy in the two regions. This can only be explained by the fact that "the clinical care provided in hospitals was very poor both before and after the implementation of the policy". Considerable problems exist, nonetheless, in terms of quality of care provided at all levels of service provision.

The purpose of the policy was to increase the number of the women delivering in facilities and under the care of trained attendants. The goal was to reduce delivery related maternal and peri-natal mortality and morbidity. The evaluation found an increase in the absolute numbers of mothers dying from delivery-related complications in both regions although institutional MMRs declined. Sadly, one must conclude that the introduction of the policy, per se, has not changed the situation on the ground for pregnant women.

The findings related to clinical quality of care point to the urgent need for an objective reappraisal of our training, operational supervisory guidelines. If these are the conditions existing in our facilities now, what will happen when women accept the offer of fee-free deliveries and the benefits of the NHIS and flock to our hospitals and health centres for delivery?

Undoubtedly, pay and conditions of service, including incentives and other matters affecting staff morale such as opportunities for promotion and appreciation, do affect performance. It would, however, appear that lack of adequate supportive supervision may also be a major factor in the poor

quality of services currently available in our maternity hospitals and clinics. We also need to emphasize the role of continuing education and refresher courses for all staff, especially those who have been working for many years in relative isolation in rural health centres and hospitals if acceptable standards of clinical care are to be maintained.

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