Delivering quality: safe childbirth requires more than facilities

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Using one of the most comprehensive datasets on maternal and perinatal mortality from low-income and middle-income settings to date, Sabine Gabrysch and co-authors[1] studied the relationship between facility delivery and a remarkable set of mortality outcomes, including antepartum and intrapartum stillbirths, early newborn mortality, and direct maternal mortality in Ghana. Although facility delivery on its own was not protective against mortality, the study[1] offers evidence that delivery in a higher-quality facility (particularly those well equipped to handle emergencies) was associated with substantial reductions in the probability of intrapartum stillbirth. Even though the study design and data do not allow any precise guidance on mechanisms, the most probable channel for this benefit is the increase in caesarean section availability in case of labour complications.

The overall weak association found between facility delivery and mortality is consistent with observational studies from low-income countries,[2] as are the protective effects for delivery in a high-quality facility on mortality.[3] Remarkably, Gabrysch and colleagues[1] find that the association between facility delivery and mortality did not improve, but might actually have deteriorated over time in this context. One possible explanation for these negative trends is the increasing pressure on Ghanaian health facilities—institutional delivery shares increased from 52% to 68% within 5 years. Combined with an annual population growth of 2–3%, this pressure implies a substantial increase in the typical workload of health facilities over a relatively short period of time that was probably not matched by commensurate increases in staffing and equipment. As the experience of the Janani Suraksha Yojana programme in India[4] and the free-delivery policy in Kenya[5] have shown, incentivising facility delivery without ensuring adequate quality of care is unlikely to result in major health improvements.

Although the findings of Gabrysch and colleagues[1] might be disappointing from a public health perspective, they are consistent with historical trends in high-income countries. In the USA the rapid transition from home to hospital-based deliveries in the early 1900s was not associated with any reduction in maternal mortality until hospital quality improved and, in particular, until the heightened risk of hospital-acquired puerperal sepsis was adequately addressed.[6]

In light of all the evidence, a clear shift in focus from quantity to quality seems urgently needed. A key challenge in the redirection from access to quality is the relatively scarce evidence regarding how to improve the quality of health care in low-income settings.[7] A growing body of literature shows that simply providing health workers with job aids and training cannot meaningfully and consistently improve outcomes.[8,9] One of the main challenges in this area is the complex nature of quality of perinatal care in clinical settings. Facility quality is neither easy to measure nor static as a concept; quality of care varies within facility across providers, across patients, even across day and time, with much higher maternal and newborn mortality within facilities at night and on weekends.[10] Quality metrics used in the literature—including the signal functions used in the study by Gabrysch and co-authors—have major shortcomings. Large innovations in quality measurement are needed to support the development of new strategies to improve quality.[7]

As challenging as improving the quality of care will be, these efforts alone might be insufficient to reduce delivery-related mortality. Maternal and newborn outcomes are established by more than the brief hours women spend with providers during labour, delivery, and the immediate postpartum period. Perinatal outcomes are strongly influenced by a range of other related factors, such as the quality and use of prenatal care and the strength of emergency referral systems. Transforming maternal care quality will also involve engaging the patient herself. Women express strong stated and revealed preferences for high-quality maternal care, but evidence is scant regarding how to inform and empower women to choose and reach high-quality providers.[11] More evidence is needed on how to make simple and transparent quality information readily available to pregnant women and on how to remove barriers to reaching high-quality care more generally. Together with system-level quality improvement efforts, reducing barriers between women and high-quality maternity providers can accelerate the transformation from facility delivery to safe delivery.

*Günther Fink, Jessica Cohen
Swiss Tropical and Public Health Institute and University of Basel, Basel, Switzerland (GF); and Harvard TH Chan School of Public Health, Harvard University, Boston, MA, USA (JC)
guenther.fink@swisstph.ch

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