Why do women deliver in facilities, or not?

A key strategy promoted by international organizations to reduce maternal mortality is skilled birth attendance. This should be a provider trained in the essential elements of delivery care, typically a midwife, who could deliver at home or in an institution. In recognition that this skilled provider on her own can often do little if complications arise, the next extension of the strategy is to promote institutional delivery, either in a health centre with beds, or in a hospital, district or tertiary. In this issue of the *WHO South-East Asia Journal of Public Health*, a literature review by Rajendra Karkee and colleagues explores why maternity services in Nepal are underutilized, despite good overall availability of facilities. Their review highlights that various interventions aimed at increasing use of maternity services have been only partially successful. The main factors common to the reasons for underuse of maternity facilities were: social, distance, cost, and perceived quality of care.

As Karkee and colleagues discuss, these findings from Nepal are similar to those in many other areas in the world. Nepal has particular geographical challenges with high mountains impeding access to health facilities which might be several valleys away. It is hardly surprising that women do not want to undertake such a journey in the late stages of labour, as there is no easy transport. Better roads and more health facilities nearby are the only solution, which is capital-intensive. Moreover, time and sustained effort are needed to change social factors such as cultural practices and a woman needing her mother-in-law’s permission to deliver in a facility.

One important reason for women’s non-use of facilities is their perception of the quality of care offered. Several surveys in diverse countries have shown that the quality of care provided in health facilities is often suboptimal. Quality might reflect general amenities such as cleanliness, provision of sheets, blanket and food, to the friendliness and technical capacity of staff. Pregnant mothers might not trust the first level facility, and would rather go to a private one or to a higher level facility right away.

One of the major concerns with the push for institutional delivery is patient safety and the prevention of nosocomial infections in particular. Newborns are especially at risk of acquiring multiresistant hospital bacteria as the first organism to colonize the hitherto sterile surfaces. To reduce the risk, it is therefore of utmost importance to improve hygiene practices, and control non-rational prescriptions of often second-line antibiotics in health facilities.

WHO has recently introduced an initiative to improve the quality of maternity care provided by midwives, first level health facilities and referral facilities. This should rectify issues from the provider side, if this is scaled-up in countries. However, complementary efforts will also be needed to influence the perceptions of consumers of the services. Otherwise, pregnant women will continue to stay at home and hope for the best.

Nepal is a forerunner of approaches using women’s groups to try to improve health outcomes for mothers and newborns; in a seminal cluster-randomized trial, a participatory intervention with women’s groups resulted in a 30% reduction in neonatal mortality and an even larger reduction in maternal mortality. The Nepal study has been replicated in several countries, and found to be successful in settings where access to care is an issue. WHO has recently summarized the evidence and recommends this intervention to improve neonatal and maternal outcomes.

Universal health coverage is the way forward recommended by WHO since 2013. This means that people receive the medical care they need without creating an undue financial burden. Providing free care for mothers and children will certainly have an impact on care-seeking. However, service provision has to be assured. Free access to a health facility without staff that is competent and without the necessary supplies does not constitute universal health coverage. Many countries need to increase their investment in health substantially to achieve this.

In conclusion, the decision where to deliver is a complex interplay of supply and demand factors and social practices. To address this, obstacles in access such as distance, financial burden and attitudes of providers need to be addressed. Quality of care has to be perceived in the community as adequate, so that a hospital is not seen as a place where you only go to die. The recent summary of the experience with women’s groups shows a way to address issues on the demand side too. How the factors interplay is different in different settings. Thus the
review from Nepal by Karkee and colleagues gives a useful country perspective, and similar analyses need to be undertaken in all countries to guide policy decisions.

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How to cite this article: Weber MW. Why do women deliver in facilities, or not? WHO South-East Asia J Public Health 2013; 2(3-4): 129–130.