into good hands

progress reports from the field

UNFPA

SAFE

contents

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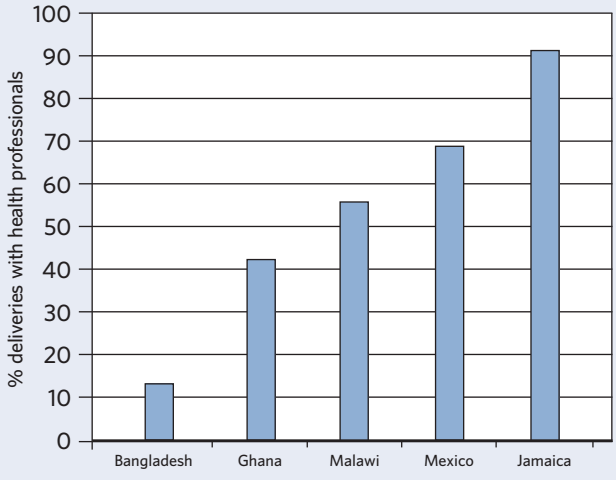
introduction

This booklet, a companion to the Maternal Mortality Update 2004, documents research and interventions to improve skilled care at birth throughout the developing world. It includes an overview of efforts by UNFPA and its partners in policy and advocacy, training, health system improvements and community mobilization as well as summaries of SAFE strategies developed in five countries.

Highlights of UNFPA's efforts also reveal the range of approaches and entry points required to address the various constraints to providing skilled delivery care that arise in different contexts. UNFPA interventions in this area include technical and financial support for training programmes, procurement of equipment and supplies for obstetric care, and collaboration with governments in the development of policy and protocols regarding skilled care. These interventions have been integrated into national programmes to ensure optimal levels of support and coordination. SAFE's research in Bangladesh, Ghana, Jamaica, Malawi and Mexico clearly illustrates the range of problems that may be encountered in different contexts. These studies also emphasize the need to identify strategies to overcome specific barriers and constraints.

PROPORTION OF DELIVERIES WITH HEALTH PROFESSIONALS IN SAFE COLLABORATING COUNTRIES



SOURCE: SAFE, University of Aberdeen

Taken together, the examples in this report show that making skilled attendance universally available is a complex process involving health-care systems as a whole. To meet the challenge of saving mothers' lives, the lessons learned and evidence captured from these ongoing projects should be used to refine future efforts. Moreover, successful projects should be scaled up to become national programmes.

skilled attendance at birth: UNFPA country support in 2002-2004

Ensuring skilled care for all births is a prerequisite for making sure that those women who develop complications can get timely emergency obstetric care.

Skilled care can be provided in a variety of settings: at home and in health centres and public or private hospitals. While the setting for skilled care may vary from place to place, the support of a reliable health system is essential for safe deliveries. Shifting births to facilities has generally been a reliable strategy for reducing maternal deaths, but for some countries, especially those with large rural populations and few health professionals, this may not be feasible in the short term. Regardless of the approach, the key to saving lives is the presence of a skilled provider backed by a health system that facilitates successful treatment of obstetric complications.

UNFPA is committed to collaborating with its partners – NGOs, donors, country governments and civil society – in developing and implementing a joint vision and strategy regarding skilled attendance at birth for all regions of the world where safe motherhood is not yet a reality. In all regions, UNFPA supports strategies and activities to increase skilled care at birth. The following section describes policies, strategies and activities to improve delivery care that have been adopted by countries and supported by UNFPA Country Programmes in 2002 and 2003. The range and combination of approaches reflect the diversity of economic, social and political contexts among regions and within countries. A few countries have adopted an interim approach that includes the training and deployment of community health workers who can provide a limited number of life-saving skills during home deliveries at the village level. Additionally, some countries are establishing close partnerships with traditional birth attendants and drawing upon their important social roles in the community to encourage women to deliver with health professionals in health facilities. The local context – which takes into consideration such things as the availability of resources, political commitment and cultural norms and practices – plays a crucial role in shaping strategies to improve delivery care. While there is no single correct approach, we need to maintain our focus on increasing access to skilled attendance at birth.

This report draws upon UNFPA Country Office annual reports from 2002 and 2003 as well as information obtained directly from Country Offices. Although many countries have made significant achievements, we were able to include just a fraction of them in this report. UNFPA's geographic divisions assisted in selecting these examples of our work.

africa division

In sub-Saharan Africa, a region that accounts for nearly half of the 529,000 maternal deaths each year, the need for skilled attendance is acute. Between 1990 and 2000, the percentage of deliveries with skilled attendants in the region only increased from 40 per cent to 43 per cent, according to population-based surveys. Many factors complicate women's access to skilled care in this region. Often women give birth at home because of the prohibitive cost of medical care or cultural beliefs that promote home-based delivery. Some simply lack confidence in the health system. Difficult geographic terrain and limited transportation may present obstacles to reaching a skilled attendant. The dearth of skilled providers is another constraint. The situation is exacerbated by resource-strapped health systems that offer few incentives for skilled providers to practice in rural or isolated areas. The devastating impact of HIV/AIDS on the health workforce further limits the pool of skilled providers. In certain contexts, traditional birth attendants are more trusted than medical professionals since they are familiar and respected members of the community.

In February 2004, many global partners – including EngenderHealth, Family Care International, Family Health International, the Global Partnership for Safe Motherhood and Newborn Health, JHPIEGO, UNFPA, UNICEF, USAID and WHO – convened in Harare, Zimbabwe to develop a road map for meeting the Millennium Development Goals in the region. Improving skilled attendance at birth was identified as a primary goal. Strategies to attain this goal include strengthening the referral system, advocacy to secure political commitment and resources (including human resources) for maternal health, and increasing partnerships among government agencies, NGOs, educational establishments and professional associations. Many countries have already adopted numerous strategies to address skilled care at birth. Health sector reform, in the context of sector-wide approaches, is emerging as an opportunity to fund and deploy human resources more equitably among urban and rural regions. Training is another crucial strategy employed by many countries. Recognizing the important role played by traditional birth attendants within the community, many countries make efforts to include them in safe motherhood interventions as points of referral to health-care facilities and sources of information. Ideally, continuing dialogue among stakeholders will foster a regional consensus on strategies and activities to improve delivery care and reduce maternal death and disability.

Policy and Advocacy

Botswana, **Burundi**, **Senegal**, **Uganda** and **Zimbabwe** have developed policies defining a skilled attendant and strategies to increase the proportion of deliveries they attend. In **Burundi** in 1995, only 9.5 per cent of deliveries occurred in health facilities. Since then, Burundi's reproductive health programme has designated strategies to increase the proportion of attended births, such as enhancing the technical capacity of personnel and facilities and promoting the use of partographs during labour. With support from UNFPA, standards for reproductive health services, including those related to skilled attendance, were developed by Burundi's Ministry of Health. In **Senegal**, the National Action Plan for Maternal Mortality specifies that only physicians, midwives or nurses are qualified skilled attendants. Regional training schools were opened for midwives with financial support from

the Japan International Cooperation Agency. **Uganda's** National Health Policy, developed in 1999, limits its definition of a skilled attendant to formally trained health providers such as doctors and nurse midwives. For the last 20 years, however, fewer than 40 per cent of births have had skilled attendants. In response, the Government of Uganda, in collaboration with UNFPA, is focusing on training personnel, upgrading infrastructure, providing emergency obstetric care and strengthening the referral system for obstetric emergencies. In **Zimbabwe**, the National Safe Motherhood Policy defines skilled birth attendance as essential obstetric care (including emergency obstetric care and ante- and post-natal care) provided by a nurse-midwife, clinical officer or medical doctor at a health facility. This definition specifies that basic and comprehensive emergency obstetric care, the availability of blood and blood products, and a reliable referral system for obstetric emergencies should be in place. In 2003, Zimbabwe's Ministry of Health integrated reproductive health care with maternal and child health programmes into its strategy for increasing skilled care at birth. In **Botswana**, the Safe Motherhood Protocols refer to skilled care as supervised deliveries attended by a doctor or trained midwife. Strategies to improve delivery care include the development of infrastructure, investment in health personnel and community outreach. This focused response contributed to an increase in supervised deliveries from 66 per cent in 1984 to 87 per cent in 1996.

Training for Skilled Attendants

Training of health personnel continues to be one of the most important regional strategies to increase the proportion of women receiving skilled care during delivery. UNFPA has actively supported this through the development of training protocols and curricula as well as financing personnel to attend national training sessions. In 2003, the Ministry of Health in Burundi initiated training of a cadre of midwives in the provision of sexual and reproductive health services including obstetric care. UNFPA also supported the training of physicians at primary and provincial-level hospitals. In **Senegal**, UNFPA has supported training of health providers at various levels. In UNFPA's two pilot provinces of Tambacounda and Kolda, 89 providers from the health-post level received training in basic obstetric care. At the health-centre level, 25 providers received training in post-abortion care, blood management, neonatal resuscitation and obstetric echography. Senegal's Ministry of Health has leveraged resources from external donors for training and emergency obstetric care to Zinguichor, a neighbouring province. **Uganda's** policy on training reflects the Ministry of Health's priority on skilled attendance. While nurses and midwives were previously trained separately, all nurses are now required to have midwifery training. The Ministry of Health also mandates regular in-service training as a part of continuing education for promotion. The number of medical schools in the country has increased from one to three, and doctors are increasingly specializing in obstetrics and gynaecology. In **Zimbabwe**, UNFPA supported training of trainers in post-abortion care. Nurses and midwives are the main providers of maternity care in **Botswana**. UNFPA supported training of nurses in midwifery skills as well as in-service life-saving skills training for midwives and doctors. UNFPA also contributed to refresher training for doctors on Caesarean sections.

Building an Enabling Environment

In **Burundi**, UNFPA provided maternity kits and equipment and supplies for obstetric care to health centres and primary-level hospitals, some of which serve internally displaced persons. UNFPA also supported the enhancement of data collection tools and the supervision of 25 facilities that perform deliveries. In **Senegal**, providing equipment for basic emergency obstetric care has become an important strategy for enhancing the working environment. In **Uganda**, a total of 961 health centres have been staffed with doctors and nurses and upgraded to perform emergency obstetric care. UNFPA also supported creation of a referral system for obstetric emergencies called RESCUER. This includes a radio communication system, ambulance services and improved quality of care at health units. Piloted in one district in 1997, RESCUER now covers ten districts, and four more are preparing to implement the programme. UNFPA procured and distributed equipment for basic emergency obstetric care in rural health centres in **Zimbabwe**. Although nearly 86 per cent of **Botswana's** people live within 15 kilometres of a health facility, access to services is still problematic in some remote areas. As part of an ongoing, multi-sectoral approach, Botswana is developing new health units and upgrading existing ones. UNFPA has supported this process through the procurement of equipment. Most

Community Mobilization

Involving the community is another strategy many countries are adopting to improve skilled care at birth. In **Burundi**, community activists have sensitized people about the need for skilled care and getting women to health centres for delivery. In **Senegal**, imams are promoting the importance of safe motherhood. Communities in **Uganda** participate in a system that refers and transports women to centres offering emergency obstetric care. Recognizing the important role played by traditional birth attendants in communities, UNFPA supported a community-based programme in **Zimbabwe** aimed at building their capacity to recognize the symptoms of obstetric complications and refer women to the nearest health clinics when necessary. Family welfare educators in **Botswana** have played an important role in educating the community regarding safe motherhood and encouraging women to deliver in health facilities. UNFPA also supported information, education and communication campaigns to raise awareness and promote use of services within the community.