ANNUAL REPORT 2006

DEPARTMENT OF
MAKING PREGNANCY SAFER

World Health Organization

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Foreword

by Daisy Mafubelu
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Women need skilled birth attendants. For a mother and her newborn, a skilled birth attendant can make the difference between life and death.

Every woman has the right to care from a skilled attendant during pregnancy, childbirth, and immediately after birth. For this to happen, the World Health Organization estimates that the number of skilled attendants in developing countries needs to be increased by at least 333 000.

Life-threatening complications occur in 15% of all births. A skilled attendant is not only trained to attend to normal pregnancies, but to recognize and manage complications, and make referrals to a health centre or hospital if more advanced care is needed. Women in rural areas are most at risk of giving birth without a skilled attendant. In some of the poorest areas of the world, tens of thousands of people might share one doctor or midwife.

In the developed world, almost all women have a skilled attendant at birth.
In the developing world, more than 50% of women face birth alone, with a family member, or with a traditional birth attendant who may or may not be trained.

It is time to take action in countries. Even in countries torn apart by conflict, we have proven that we can save mothers' and newborns' lives if governments are committed, communities are engaged and support is there from the donors, non-governemental organizations and volunteers.
We have accomplished a great deal so far.

With this in mind, now is the time to focus on what has to be achieved. We have to keep up the work and the funding necessary to implement higher standards and measures in tackling maternal and newborn morbidity and mortality.

Together, we can work to save many more lives.

I Skilled care at every birth: standards and support

by Monir Islam
Director, Making Pregnancy Safer (MPS)

Approximately 15% of women experience a complication during pregnancy or birth – *little of which can be predicted but almost all of which can be managed.* This simple statement explains much of the drive behind our work to scale up skilled birth attendance in priority countries. It reminds us that most of the 530 000 maternal deaths that occur each year, as well as about half of the 7 million perinatal deaths, could be averted if all births were attended by a qualified professional backed up with a continuum of quality referral services.

Evidence for the decisive role of skilled birth attendants (SBA), and particularly midwives, in reducing maternal mortality is plentiful from both the industrialized and developing countries. In a study of how Malaysia and Sri Lanka successfully reduced their maternal mortality rates since the 1960s, it was noted that the outstanding feature of maternity-related health services in the two countries has been "the pivotal role of trained and government-employed midwives. They have been relatively inexpensive, yet they have been the cornerstones for the expansion of an extensive health system to rural communities. They have provided accessible maternity services in hospitals and communities, gained respect from the communities they serve, and are described with affection and admiration by the managers and policy makers in each country."[1] (See Figure 1 for a graphic illustration of results from Malaysia, Sri Lanka and Thailand.) The landmark World Health Report of 2005, *Make every mother and child count*, provides many more examples of how skilled birth attendants have contributed to reducing maternal mortality in different parts of the world.

An end to "poor-quality services for poor people"

In December 2006, at the First International Forum on Midwifery in the Community, my colleague Dr. Arletty Pinel of UNFPA's Reproductive Health Department said "There must be no more poor solutions for countries in the process of tackling poverty alleviation."

I could not agree more, and this is why we give such prominence to the issue of high-quality, evidence-based interventions. We cannot afford to throw money away on approaches that we know – i.e., can show with solid research – do not work or do not provide good value, even as a temporary measure. Take, for example, the question of whether to invest in training programmes for traditional birth attendants (TBAs). In the 1970s and 1980s, WHO and others promoted the training of TBAs in countries where there were insufficient numbers of health professionals or hospital beds to give all women skilled care during their confinement. It seemed to make sense as an inexpensive way of using what was already there in many communities, and it was often promoted as a temporary solution while countries were "in transition" to higher stages of development. Eventually, however, research in different parts of the world showed that most TBA training programmes had little impact on maternal mortality, were not cost-effective, and were unable to overcome deeply ingrained cultural factors that put women and newborns at risk. As the 2005 World Health Report put it, "the money spent would perhaps, in the end, have been better used to train professional midwives."

I do not mean to imply that TBAs should be ignored. In those countries and areas where they currently exist, TBAs are often a highly valued and respected resource in the community and it may certainly be better to consider them as important allies for health education and social support and a positive link between women, families and communities and the formal health care system. But they are not a replacement

for skilled birth attendants – they just do not have the necessary skills and understanding. Nor should it be assumed that a short training programme will give an otherwise unqualified person the critical thinking and decision-making skills necessary to practice, especially in isolated areas where supervision and referral possibilities are minimal.

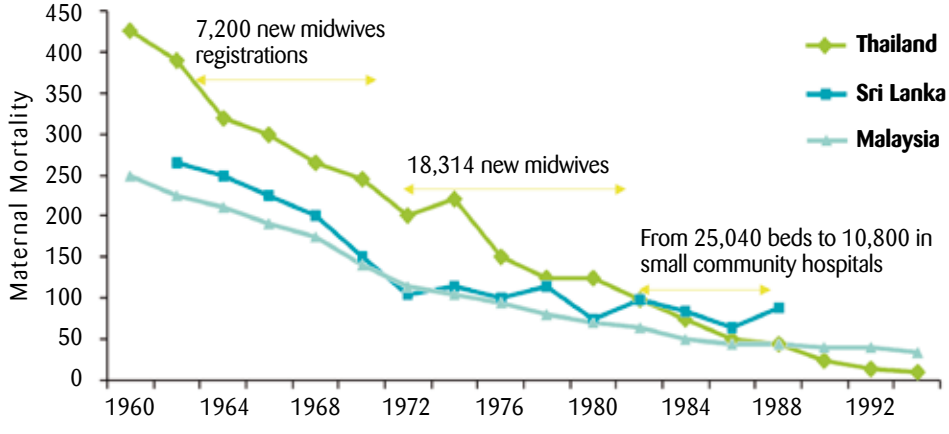
High standards now – not later

A viable workforce of skilled birth attendants cannot be achieved with half-measures, and low standards should not be accepted on the grounds that they are a temporary stopgap. When we speak of scaling up education and training for skilled birth attendants, we must be clear that we are talking about properly taught, competency-based curricula, delivered by programmes designed for the long term. Poor-quality training programmes, even in the lowest-income countries, should not be tolerated with the justification because they are all that can be afforded "for the moment." The moment will simply be wasted.

There is no ambiguity about the standards that need to be instilled if we are going to meet the targets set under the Millennium Development Goals 4 and 5 for newborn and maternal health respectively.

In 2004, a Joint Statement by WHO, the International Confederation of Midwives (ICM) and the International Federation of Gynaecology

Figure 1: Maternal mortality since the 1960s in Malaysia, Sri Lanka and Thailand



Source: Van Lerberghe W, De Brouwere V. Safe motherhood strategies: a review of the evidence. *Studies in health services organisation and policy*, vol. 17. Antwerp7 ITG Press, 2001. Cited in *World Health Report* 2005.

and Obstetrics (FIGO) set out clearly what is meant by a skilled birth attendant, including the core skills and abilities they must be fully capable of carrying out[2]. While the designation of skilled birth attendant may be applied to several professional categories – midwives, nurses with midwifery skills, and doctors with midwifery skills – the essential point is that they need to be able to carry out these core skills and abilities to a recognized standard.

The recruitment challenge

What about quantity? The best estimates we have suggest that about 333 000 additional midwives will be required to achieve 73% coverage by 2015 (along with an additional 27 000 doctors and technicians, and 35 000 birthing or maternity units). Recent analysis based on national DHS surveys found that in priority countries, less than half of the women had a skilled birth attendant present at their most recent pregnancy[3]. We do not have enough

Africa but also in Asia and Latin America, the propoartion decreased over time. There may be an element of over-estimation in these and other figures, since not all countries comply with international standards in their definition of a skilled birth attendant.

Clearly, immense efforts will be required in certain countries to reach the target coverage by 2015, without compromising quality standards. Part of the challenge will be to use available human resources in the most efficient ways; the 2006 *Lancet* series on maternal survival mentioned later on in this report provides some very useful thinking in this regard. But recruitment is a huge challenge in its own right. Even if we can ensure that funding and the basic infrastructure such as classrooms and teaching materials are in place (a big "if", to be sure) some formidable barriers need to be overcome. For example, too few young women in some countries are graduating from secondary

An important issue to address is the low status of midwifery in many parts of the world. In countries where the prevalence of HIV is high, special efforts may be needed to overcome the perception that attending births is an especially risky profession.

A supportive environment

This issue of perception brings me to my final point: the overall environment in which skilled birth attendants do their work. While a well-designed recruitment drive can contribute, a supportive environment and human resource policies are needed if good people are to be attracted to and retained in the profession. What does that mean, in practical terms? One important aspect is overcoming gender-related disadvantages faced by midwives and nurses. Being a predominately female profession, midwifery is far too often dismissed as "women's work," and therefore badly paid. Far too frequently, no arrangements are made