Skilled Care at Every Birth

Report and Documentation of the Technical Discussions held in conjunction with the 42nd Meeting of CCPDM Dhaka, 5-7 July 2005

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The report and recommendations of the Technical Discussions on Skilled Care at Every Birth, held in conjunction with the 42nd meeting of the Consultative Committee for Programme Development and Management (CCPDM), held in Dhaka, 5-7 July 2005 were presented to the fifty-eighth session of the Regional Committee for South-East Asia. The Regional Committee noted the report and endorsed the recommendations. The Committee also adopted a resolution on the subject (SEA/RC58/R2).

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Part I – Proceedings*

* Originally issued as "Consideration of the Recommendations Arising out of the Technical Discussions on Skilled Care at Every Birth" (document SEA/RC58/5 dated 13 July 2005)

1. INTRODUCTION

Technical Discussions on Skilled Care at Every Birth (Agenda item 6 of the 42nd Meeting of the Consultative Committee for Programme Development and Management) were held in Dhaka on 6 July 2005. H.E. Prof Dr Mya Oo, Deputy Minister for Health, Myanmar, and Dr Gunawan Setiadi, Chief, Bureau of Planning, Ministry of Health, Indonesia, were elected as Chairman and Rapporteur respectively. All the CCPDM participants, local/special invitees and WHO staff concerned participated in the discussions.

1.1 Opening Remarks by the Chairman

The Chairman, in his opening remarks, said that it was opportune that this year the subject for the Technical Discussions was Skilled Care at Every Birth as he considered it critical for achieving two of the eight Millennium Development Goals (MDGs). He reminded the audience that MDG 5 calls for a reduction of the maternal mortality ratio by three quarters between 1990 and 2015 and MDG 4 for a reduction in the under-five mortality by two thirds during the same period. He emphasized that skilled care at birth is recognized as an important input for improving maternal health and reducing child mortality.

Evidence from all over the world, including from within the South-East Asia Region, indicates that it is indeed possible to institutionalize skilled attendance at birth with positive outcomes for maternal health. He quoted the positive experiences of Thailand, Sri Lanka and Kerala state in India in this regard.

The Chairman was of the view that the subject would merit a multi-dimensional deliberation. This included policy issues related to human resource development, health sector financing, attention to equity, legal issues and attention to prevailing societal norms and customs for community involvement, and several others.

The Chairman hoped that active deliberations during the session would result in practical recommendations that could be implemented in different

country scenarios. He then invited Dr P.T. Jayawickramarajah, Acting Director, Family and Community Health, WHO/SEARO, to deliver his remarks.

Dr Jayawickramarajah explained that the topic of the Technical Discussions is very relevant as the theme of the World Health Day 2005 is Maternal and child health: Make every mother and child count. The working paper has been produced through teamwork involving external experts. He hoped that the group could discuss key policy issues and challenges as well as the way forward to countries and WHO.

Next, the Chairman gave the floor to Dr Ardi Kaptiningsih, Regional Adviser, Reproductive Health and Research, WHO/SEARO, to introduce the working paper.

1.2 Introductory Remarks

In her presentation, Dr Kaptiningsih stated that timely access to skilled care at birth is the most crucial factor for the survival of pregnant women and their newborns. Skilled care at birth is defined as the essential care for childbirth and the immediate postpartum period that every woman and her newborn need. It includes: (a) routine care for all women and their newborn, (b) special care for those who need integrated interventions, and (c) management of complications of pregnancy and childbirth and problems in newborns. Such care should be provided as a continuum at primary health care level by health care providers with midwifery skills (skilled attendants) and, when complications occur, at secondary health care level that requires additional health care providers with obstetric, anaesthetic and paediatric skills supported by appropriate services.

A brief overview of skilled care at birth in the South-East Asia Region was provided. The South-East Asia Region (SEAR) accounted for 174 000 maternal and 1.4 million neonatal deaths in 2000, representing 33% and 35% of the global figures respectively.

Several useful lessons learnt from within the Region have contributed to achieving high levels of skilled care at birth. One of the key factors that contributes to success in this regard is the availability of skilled attendants at community level with a referral back-up, providing emergency obstetric care and special care for newborns with problems, in a functioning health system.

All countries with a low maternal mortality ratio and neonatal mortality rate have high access to skilled care at birth.

Countries in the SEA Region are at different stages of development of skilled care at birth. For countries with a very low level of skilled care at birth, the major problem is the lack of skilled attendants at community level. Even when existing health care providers are given the responsibility to provide maternal and newborn care, they often do not have the required skills, essential equipment and support and back-up referral services. A few countries that have succeeded in deploying adequate number of skilled attendants at community level face other challenges. These countries need to ensure that the technical quality of care provided is adequate; supervision and referral back-up services are effective, and basic supplies and equipment and outreach services for the poor and disadvantaged groups are in place. Countries with high coverage of skilled care at birth may still have areas with low access. Such countries often face problems related to overuse of ultrasound screening and high rate of caesarean sections.

Ensuring universal access to skilled care at birth requires a composite set of interventions. Member States face a number of challenging policy issues related to human resources; inadequate health sector financing; reaching the poor and the disadvantaged; low status of midwifery as a profession, and the need for sustainable referral networks and services, as well as effective leadership and management.

It is the responsibility of governments to ensure skilled care at every birth as it is the right of all pregnant women and their newborns. Countries will need to make a number of strategic decisions with a long-term vision. Critical among these will be: human resource development and management; capacity to manage long-term, phased-in interventions; mobilizing funds for universal access to maternal and newborn health services; improving the referral system, comprehensiveness, integration and quality of services; working effectively with individuals, families and communities, and ensuring multisectoral and intercountry collaboration.

2. DISCUSSIONS

The following sections provide the highlights and conclusions of the discussions on various issues relevant to skilled care at every birth. All

countries expressed their commitment to achieve the MDGs related to maternal and newborn health and shared their policies and interventions carried out in this regard. It was considered that the time was opportune to discuss the topic in the CCPDM since the theme of the World Health Day 2005 relates to maternal, newborn and child health.

Many interventions, such as efforts to train basic health workers in midwifery, strengthening accreditation system for training institutions, improvement of referral services, policy decisions on safe abortion services, financing scheme for poor women for childbirth and emergency obstetric and newborn care, NGOs' involvement, have been implemented in different countries of the Region. It was also recognized that some countries had a long way to go to scale up these interventions across the country so that skilled care at birth can be accessed by all.

Some constraints were identified in scaling up these interventions, i.e. investment in the health sector in many countries is still less than 5%, and only a small proportion of it is allocated to maternal and newborn health; limited equipment, drugs and supplies; difficulties in deployment of skilled attendants at community level and relevant specialists at first referral level. The issue of brain drain was also raised by DPR Korea and Nepal. Low educational status was also identified as one of the factors that influenced demand for professional care during pregnancy, childbirth and postpartum period. The issue of pre-service training of skilled attendants at primary health care level is clearly a major issue in many countries of the Region, especially those with a low proportion of childbirth attended by skilled attendants.

A number of important issues were raised by participants from countries. Among others:

- Although the focus should be on skilled care at birth and during the immediate postpartum period since most deaths occur during this period, there is a need to promote a continuum of care throughout pregnancy and life-cycle. Issues such as the need for family planning, improvement of nutrition status, prevention of unwanted pregnancies and teenage pregnancies, prevention and management of unsafe abortion, as well as prevention and management of common diseases in pregnant women, such as malaria and anaemia should be addressed adequately.

- Community involvement in taking care of pregnant women and newborns, and in timely referral of pregnant women and their newborns when complications and problems arise.
- There should be a global fund for maternal and newborn health to allow countries to achieve the MDGs in respect of maternal and child health, including newborn health.

The country participants then divided themselves into three working groups: (1) countries with a proportion of births by skilled attendants less than 50%, i.e. Bangladesh, Bhutan, India, Nepal and Timor-Leste; (2) those with a proportion between 50 and 80%, i.e. Indonesia, Maldives and Myanmar; and (3) those with a proportion more than 80%, i.e. DPR Korea, Sri Lanka and Thailand. The groups discussed issues related to human resources and health systems in order to achieve universal skilled care at birth, as well as way forward for Member States and the role of WHO. The outcomes of the group work can be summarized as follows.

(1) Human resources development

- All countries with a proportion of births by skilled attendants less than 50% agreed that there is a need to have a long-term plan for human resource development for maternal and newborn health that includes plans for production, placement, retention and career development.
- The category of health professionals with midwifery skills at community level (skilled attendants) may differ in each country as country situations and needs are different; however, there should be no compromise in quality relating to skilled care. The needs and competencies should be identified by each country and training on midwifery tailored according to their needs.
- Strengthening of training institutions in midwifery is a major issue, and mechanisms should be in place to ensure quality of training.
- The Chair of the SEA Regional Multi-disciplinary Advisory Group on Nursing and Midwifery, who was specially invited to this meeting, stated that the Task Force would identify these competencies in consultation with countries at its next meeting.

(2) Health systems

- Strengthening district programme management is a major concern. This would include management of human resources, including optimization of their performance; organizing health services, as well as programme monitoring and fostering community involvement.
- Adequate financing for expanding access to and improving quality of skilled care at birth should be available. A mechanism for global pooling of funds for maternal and child health should be established. Special attention should be given to the poor and the disadvantaged, as well as underserved areas in countries.
- The private sector should be on board, together with the government initiative, to achieve universal skilled care at birth.

Place of delivery should not be a problem as long as skilled care is provided. There are examples in some countries that can manage safe delivery at home by skilled attendants.

3. CONCLUSIONS AND RECOMMENDATIONS

After reviewing the country situations in the SEA Region and key issues and challenges in achieving universal skilled care at birth, the group made the following recommendations:

To Member Countries

(1) National and sub-national planning and programming needs should be strengthened to give due attention to the need for long-term plans and strategies to ensure equitable access and quality of skilled care at birth.

(2) Gaps in human resources for skilled care at birth should be reviewed and appropriate human resource policies for skilled care at birth developed or modified to include planning, production, placement, retention and career development.

(3) Barriers to access and utilization of skilled care at birth should be identified and evidence-based actions to overcome these developed and implemented.

(4) Appropriate health system improvement should be instituted to strengthen programme management, health care delivery and financing.

(5) Demand for skilled care at birth should be improved.

To WHO

(1) Technical support should be provided to Member States to review and revise their human resource policy, strategy and plans as well as in their implementation so to ensure skilled care at every birth.

(2) WHO should assist Member States in strengthening their health systems and provide evidence-based norms and standards in ensuring skilled care at every birth.

(3) WHO should advocate for increased financial resources from national and international agencies to support national efforts in ensuring skilled care at every birth as well as facilitate a mechanism for global pooling of funds for maternal and child health.

The Technical Discussions Group proposed that the fifty-eighth session of the Regional Committee adopt a resolution on the subject. A draft resolution was accordingly prepared for consideration by the Regional Committee.

Part II – Resolution, Agenda and Working Paper

Resolution*

The Regional Committee,

Recalling World Health Assembly resolution WHA58.31 and its own resolutions SEA/RC53/R9 and SEA/RC56/R9 relating to health of mothers and newborns,

Noting with concern the unacceptably high maternal and neonatal mortality in the Region,

Recognizing that most maternal and neonatal deaths arise from complications during childbirth or immediately after birth and that almost all of these deaths are preventable considering the availability of skilled care at birth,

Acknowledging that a large proportion of women and newborns in the Region do not receive skilled care at birth, and

Having considered the report and recommendations of the Technical Discussions on Skilled Care at Every Birth (document SEA/RC58/5) during the Forty-second Meeting of the Consultative Committee for Programme Development and Management at Dhaka in July 2005,

1. URGES Member States:

   (a) to strengthen national and sub-national planning and programming so as to give due attention to the need for long-term plans and strategies to ensure skilled care at every birth;

   (b) to identify barriers to equitable access and utilization of skilled care at birth, and to develop evidence-based actions to overcome these;

   (c) to review the gaps in human resource for skilled care at birth and, as appropriate, to develop or modify human resource policies for skilled

* SEA/RC58/R2

care at birth which includes planning, production, placement, retention and career development;

(d) to institute appropriate improvements in their health systems to strengthen programme management, health care delivery and quality of care including an effective referral system, and to increase financing, and

(e) to improve the demand for continuum of skilled care with special attention to ante- and post-natal care of mothers and their newborns, and

3. REQUESTS the Regional Director:

(a) to enhance technical support to Member States in reviewing and revising their human resource policies, strategies and plans and assist in their implementation to achieve skilled care at every birth;

(b) to assist Member States in strengthening their health systems and provide evidence-based norms and standards to ensure skilled care at every birth, and

(c) to advocate for increased funding from national and international sources to support national efforts to ensure skilled care at every birth, and assist in the development of a mechanism for global pooling of funds for maternal and child health.

Agenda*

1. Introduction
2. Overview of skilled care in the South-East Asia Region
3. Key issues and challenges for successful implementation and expansion
4. The way forward for WHO and Member States
5. Points for consideration

* Originally issued as document SEA/PDM/Meet.42/TD/1.1 dated 24 June 2005

Annotated Agenda*

1. INTRODUCTION

- Preamble, what is skilled care and who is a skilled attendant
- Why skilled care at every birth is an issue in the South-East Asia Region:
  - Poor maternal health in the SEA Region accounts for 33% of global mortalities
  - Newborn deaths account for 35% of global moralities

2. OVERVIEW OF SKILLED CARE IN THE SOUTH-EAST ASIA REGION

- Situational analysis – cross-country comparisons of access and utilization:
  - Differences in key maternal and newborn health indicators across countries, as well as wide differentials within countries
  - Positive experiences in Member States with high access to skilled care, such as Thailand and Sri Lanka, and lessons learnt in countries currently implementing strategies to increase access and utilization
  - Universal access to skilled care requires a composite set of interventions that addresses all aspects of the health system: even in countries where health systems are at different stages of development
  - Different phases of development of skilled care at birth.
- The main policy issues for the SEA countries:
  - Need for long-term human resource development plan
  - Inadequate financing and need for a pro-poor approach
  - Need for strengthening midwifery care

* Originally issued as document SEA/PDM/Meet.42/TD/1.2 dated 24 June 2005

  - Leadership and management capacities
  - Referrals networks and services
- Commitment of Member States to improve maternal and newborn health.

3. KEY ISSUES AND CHALLENGES FOR SUCCESSFUL IMPLEMENTATION AND EXPANSION

- Human resources
  - Meeting the standards for minimum skills set, especially of skilled attendants at primary care level, including professionalization of midwifery
- Management of phased implementation of interventions requires strong management systems, including monitoring and evaluation
- Improving comprehensiveness, integration and quality of services, both technical and user perspective
- Financing for universal access to maternal and newborn health services
- Working more effectively with individuals, families and communities to improve access to and utilization of skilled care
- Multisectoral collaboration

4. THE WAY FORWARD FOR WHO AND MEMBER STATES

- Creating an enabling policy environment to accelerate action to ensure universal access to skilled care at every birth:
  - Action at country level to address key issues and challenges
  - Advocacy, better financing, logistics, social support systems, including families and communities
- Strengthening health systems, especially management systems and monitoring mechanisms
- Coordination, collaboration and consensus building across multiple actors and different sectors
  - Operational and strategic partnerships for achieving common goal
- Role of WHO.

5. POINTS FOR CONSIDERATION

- Increasing investments at all levels of the health system for skilled care at every birth – need for long-term vision and planning
- Strengthening human resources for skilled care, including urgent need for professionalization of midwifery
- Strategies for reaching underserved populations and communities for reducing maternal and neonatal mortality
- Need to invest in management capacities including addressing quality of care, including in countries where maternal mortality rates are low.

Working Paper*

EXECUTIVE SUMMARY

Timely access to skilled care at birth is often the most crucial factor for the survival of women and their newborns as most deaths and serious complications occur at the time of birth and the immediate post-partum period. Skilled care at birth is the essential care during this critical period that every woman and her newborn need. At the primary health care level, skilled care should be provided by health care providers with midwifery skills (skilled attendants), while complications arising at the secondary level should require health care providers with obstetric, anaesthetic and paediatric skills. Addressing the issue of skilled care at every birth is necessary to achieve a reduction in maternal and under-five mortality rates, as stated in the Millennium Development Goals (MDGs) 5 and 4 respectively.

The South-East Asia (SEA) Region accounts for 174 000 maternal and 1.4 million neonatal deaths every year, which are 33% and 35% of the global figures respectively. In addition, one million stillbirths occur in the Region. Several useful lessons learnt from within the Region have contributed to achieving high levels of skilled care at birth. One of the key factors that contributes to success in this regard is the availability of skilled attendants at community level with a referral back-up, providing emergency obstetric care and special care for newborns with problems, in a functioning health system. All countries with a low maternal mortality ratio and neonatal mortality rate have high access to skilled care at birth.

Countries in the SEA Region are at different stages of development of skilled care at birth. For countries with a very low level of skilled care at birth, the major problem is the lack of skilled attendants at community level. Even when existing health care providers are given the responsibility to provide maternal and newborn care, they often do not have the required skills, essential equipment and support and back-up referral services. A few

* Originally issued as document SEA/PDM/Meet.42/TD/1.3 dated 24 June 2005

countries that have succeeded in deploying adequate number of skilled attendants at community level face other challenges. These countries need to ensure that: the technical quality of care provided is adequate; supervision and referral back-up services are effective, and basic supplies and equipment, and outreach services for the poor and disadvantaged groups are in place. Additional challenges are instituting adequate and appropriate career development schemes to ensure their retention in communities they serve. Countries with high coverage of skilled care at birth may still have areas with low access. Such countries often face problems related to overuse of ultrasound screening and high rate of caesarean sections.

Ensuring universal access to skilled care at birth requires a composite set of interventions. Member States face a number of challenging policy issues related to human resources; inadequate health sector finances; reaching the poor and the disadvantaged; low status of midwifery profession, and the need for sustainable referral networks and services, as well as effective leadership and management.

It is the responsibility of governments to ensure skilled care at every birth as it is the right of all pregnant women and their newborns. It is also a part of their commitment to achieve MDGs. Countries will need to make a number of strategic decisions with a long-term vision. Critical among these will be: human resource development and management; capacity to manage long-term, phased-in interventions; increasing the financing for universal access to maternal and newborn health services; improving the referral system, and comprehensiveness, integration and quality of services; working effectively with individuals, families and communities, and ensuring multisectoral and intercountry collaboration.

The way forward for Member States in their efforts to ensure skilled care at every birth would include addressing issues related to human resources for maternal and newborn care; advocacy for improving the financing for maternal and newborn health; strengthening the health system to overcome obstacles to the provision of and access to skilled care at birth and ensuring coordination, collaboration and consensus across multiple sectors to address these issues in implementing a long-term plan. WHO will provide technical support to Member States towards identifying solutions to key public health challenges; establishing evidence-based norms and standards for ensuring quality of care; facilitating capacity building; advocating for resource mobilization, and monitoring of progress.

1. INTRODUCTION

"Childbirth is a central event in the lives of families and the construction of communities: it should remain so, but should be made safe as well" – World Health Report 2005.

For the purpose of this document, skilled care at birth is defined as the essential care for childbirth and the immediate postpartum period that every woman and her newborn need. It includes: (a) routine care for all women and their newborns in normal childbirth, (b) special care for those who need integrated interventions according to specific disease patterns, and (c) management of complications of pregnancy and childbirth and problems in newborns.

Such care should be provided as a continuum at the primary health care level by health care providers with midwifery skills (skilled attendants) and, when complications occur, at secondary health care level that requires additional health care providers with obstetric, anaesthetic and paediatric skills supported by appropriate services. It includes effective links among those services in the form of efficient and timely transportation to the referral facility, as well as communication. It also links to and supports care for women and newborns at the household level and by the community.

It is the right of all pregnant women and their newborn infants to get the best possible health care, especially during childbirth and immediately after birth. This is the time when most complications and deaths occur. It is the responsibility of governments to ensure skilled care at every birth for the safety of pregnant women and their newborns. Yet, in many countries of the South-East Asia Region, such care is not available to all pregnant women and their newborns for many reasons.

Reducing the high burden of ill-health, including unnecessary deaths due to pregnancy and childbirth, is a complex issue. It calls for a combination of social, economic and health interventions, as well as changes in individual

and family behaviour. However, timely access to skilled care at birth, particularly before and when complications arise, is often the most crucial factor for the survival of women and their newborns. No country has reduced its maternal mortality ratio (MMR) to below 100 per 100 000 live births without ensuring skilled care for a high proportion of births. Consequently, the international consensus is that skilled care at every birth is the key to making childbirth safer for women and their newborns.

As many countries in the Region have very low access to and utilization of skilled care at birth, it is necessary to draw attention of all stakeholders for concerted efforts to assist countries in achieving their commitment. Unless this issue is addressed adequately, achieving a reduction in global maternal and under-five mortality, as stated in the UN Millennium Development Goals 5 and 4, will not be possible.

2. OVERVIEW OF SKILLED CARE IN THE SOUTH-EAST ASIA REGION

2.1 Situational Analysis on Maternal and Newborn Health

(a) Review of key maternal and newborn health indicators

The estimated number of maternal deaths (174 000) in the SEA Region accounted for almost 33% of the global maternal mortality, while more than 1.4 million newborn deaths accounted for 35% of global neonatal deaths and 45% of under-five child mortality. Another one million stillbirths also occur each year in the Region.

One of the major differences between countries with a high level of maternal mortality ratio (MMR) and neonatal mortality rate (NMR) and those with low levels is that most low MMR and NMR countries have high access to skilled care at birth (see Table).

Table: *Maternal and neonatal mortality and proportion of births attended by skilled health personnel in the SEA Region, 2000*[a]

Country	No. of maternal deaths	Maternal mortality ratio (per 100 000 live births)	No. of neonatal deaths	Neonatal mortality rate (per 1000 live births)	Proportion (%) of births attended by skilled health personnel in 2002[b]
Bangladesh	16 000	380	163 800	39	21.8
Bhutan	310	420	2 380	34	23.7
DPR Korea	260	67	7 020	18	98.6
India	136 000	540	1 058 400	42	42.3
Indonesia	10 000	230	94 500	21	68.4
Maldives	10	110	290	29	70.3
Myanmar	4 300	360	44 400	37	77.5
Nepal	6 000	740	35 640	44	13.0
Sri Lanka	300	92	3 960	12	97.0
Thailand	520	44	19 200	16	94.5
Timor-Leste	140	660	n.a	n.a	19.5
Total	173 840		1 429 590		

[a]. The estimated data may not be similar to the data reported by countries due to the wide range of indicators and the different methods and sources of estimates, particularly for MMR.

[b]. Source: Basic Indicators: Health Situation in South-East Asia, 2004.

Source: Department of Reproductive Health and Research, World Health Organization (http://www.who.int/reproductive-health/ MNBH/ maternal_mortality_2000/ index.html)

Bangladesh, India, Indonesia, Myanmar and Nepal have the highest number of maternal deaths, constituting 90% of all maternal deaths in the Region. Bangladesh, Bhutan, Nepal as well as Timor-Leste, have a low proportion of births attended by skilled attendants – an average of around 20%. More than 60% of births in many countries of the Region occur at home. There are, however, wide differentials within countries, both in terms of rural-urban, as well as by income groups or education standards – even in countries with a high coverage of skilled care.

(b) Experiences of countries with universal coverage of skilled care

Despite the complexity and difficulties involved in providing skilled care at birth, there are examples within the Region of countries that have achieved universal skilled care at birth. In Sri Lanka, Thailand and DPR Korea, more than 95% of births are covered by skilled care. This has been achieved even with limited resources and high poverty levels. The key to their success was maximizing available resources and making strategic priority investments based on long-term plans, supported by high-level political commitment. They have also been building appropriate health systems including human resources and the infrastructure needed for strengthening and expanding skilled care at birth over a number of years.

These countries started with community-based midwifery care to cover almost all pregnant women and newborns. This included home-based deliveries, with midwives referring complicated cases to a nearby health facility. As the socioeconomic status of the community improved, more births began to take place in health facilities. Similar experiences can be seen in some Indian states where MMR is low, e.g. Kerala and Tamil Nadu.

Factors that contribute to this success include: (i) high commitment to provision of maternal and child care; (ii) a functioning health system; (iii) regulation of skilled attendants to ensure quality of services; (iv) advancement of professional skills and knowledge; (v) referral back-up: hospitals well equipped and managed to provide emergency obstetric care and special care for newborns with problems; (vi) strong management team for health, both in quantity and quality; (vii) progressively phased-in interventions; and (viii) having good monitoring systems in place.

(c) Lessons learnt from countries towards achieving skilled care at every birth

There have been useful lessons on ways of increasing access to and utilization of skilled care. One of the main strategies employed has been the rapid expansion of accredited midwifery-trained health personnel based in the community, making them available to all families, and ensuring that these skilled health workers are supported and are reasonably rewarded financially. For example, Indonesia has deployed thousands of community-based midwives who are also allowed to open a private clinic while they are part of

and supervised by the public health system and by their professional body. Some countries have addressed access to skilled care at birth through making maternal and newborn health services free of charge. Others are looking at quality improvements, developing standards and protocols and implementing maternal and perinatal audits.

Evidence indicates that training of traditional birth attendants (TBAs) has had little impact on maternal mortality. However, in some countries, efforts are being made to train TBAs with no parallel action to strengthen the infrastructure or investment in developing skilled health workers. In other countries, such as Indonesia, while the government has established a community midwifery programme, it has simultaneously fostered partnership between these skilled attendants and TBAs – with clear roles of TBAs for non-clinical aspects of care. World Health Report 2005 proposes that where TBAs are well integrated into the community and are well respected, efforts can be made to redefine their role to become support workers or health promoters.

Bangladesh has been training female health staff at field level in selected skills to provide antenatal care, conduct normal births, provide postpartum and newborn care and recognize and refer complications. Even though "community skilled birth attendants" do not yet comply with the definition of a skilled attendant, this approach is an interim step forward and reflects the commitment of the government in reducing maternal and neonatal mortality. It is envisaged that these female health workers will function under the support and technical supervision of a skilled attendant as they are linked to an upazilla health centre equipped to provide skilled care. However, there is a need to develop a long-term plan for evaluation and further improvement.

Other strategies for increasing skilled care at birth can be seen in some parts of India and Nepal. The state of Kerala in India has achieved universal coverage of institutional deliveries for over a decade. Local authorities encourage families to seek facility-based care for births through investing in social development and ensuring women's participation in decision-making. Nepal has piloted high quality but low technology birthing centres as part of hospital services but separate from the main maternity area. The birthing centre has been very successful in training midwives from other areas as it allows sufficient hands-on experience under close supervision by well-qualified clinical midwife trainers.

(d) Different phases of development of skilled care at birth

Countries in the Region are at different stages of development of skilled care at birth. For countries with a very low level of skilled care at birth, the major problem is the lack of skilled attendants at community level. In these countries, although existing health providers may be given the responsibility to provide maternal and newborn care, they do not have the required skills. They often lack essential equipment and support, and, in most cases, have no back-up for referral services. Moreover, they are often busy with other primary health care duties which prevent them from devoting sufficient time for providing appropriate maternal and newborn care, especially during childbirth. The challenge then for these countries, among other things, is mainly to ensure the availability of skilled attendants in adequate numbers with appropriate distribution, supervision and support.

A few countries that have succeeded in deploying adequate numbers of skilled attendants at community level nevertheless face other challenges. These countries need to ensure that all the components of skilled care at birth are in place, that the technical quality of the care provided is adequate, that supervision and referral back-up services are effective, and that basic equipment and supplies – especially emergency drugs, equipment for surgery, safe blood transfusion and laboratory services – and outreach to the poor/disadvantaged groups are well in place. Other challenges include acceptability of skilled attendants in and by the community, assisting them to stay in the community they serve, deployment in remote areas with a very small population and development of an adequate and appropriate reward system, including career development schemes.

For countries with high coverage of skilled care at birth in the Region, there are still some areas with low access – usually disadvantaged/remote areas and areas of conflict. At the same time, there is a growing tendency in the urban areas of these countries for over-medicalization of normal pregnancy and childbirth, such as overuse of ultrasound screening and high rate of caesarean section, which also cause unnecessary morbidity and mortality to the mothers as well as their fetuses/newborns.

(e) Universal access to skilled care requires a composite set of interventions

One of the reasons for the slow progress in improving maternal and newborn health is the adoption of a single action response, rather than a comprehensive approach. For example, some countries have invested in emergency obstetric care facilities without attention to the other components of skilled care at birth. Similarly, focusing only on behavioural changes of the community, or recruiting volunteer health workers, or deploying poorly-trained health workers to provide care for mothers and newborns simply does not work without improving the overall health systems to ensure skilled care at birth.

The issue for the Region, therefore, is how to rapidly achieve universal access to and utilization of skilled care at every birth, effectively and efficiently. This should take into consideration that there will be a large number of home-based births in many countries in the foreseeable future. Making skilled care at every birth a reality will require high-level political commitment and action to push through important policy initiatives.

2.2 Policy Issues

Analysing the situation, it is clear that almost all Member States face a number of challenging policy issues, including:

(a) Human resources for maternal and newborn health

Many countries with high MMR and low coverage of skilled care at birth lack human resources for maternal and newborn health, especially at primary care level and primary referral facilities. This is further hampered by the lack of a long-term human resources development plan. Specifically, there is a need to pay attention to the following issues.

- ***Availability of skilled attendants at primary health care level and its referral back-up.*** There is a need, first, to ensure sufficient numbers of skilled attendants recruited and deployed at community level with necessary support. These skilled attendants should function as part of a primary health centre providing services at community level. At the same time, there is a need to equip sufficient numbers of health care providers with obstetric,

anaesthetic and paediatric skills and support services at the nearest hospital – as a primary referral facility – for managing complications and health problems in women and their newborns. Retaining those employed and keeping them motivated is crucial in hardship areas which may need special incentives and recruitment of local people. In addition, issues of ethnicity, culture and language require special attention.

- ***Quality of pre-service training.*** During the past decades, a serious decline in quality has been seen in midwifery training. The reasons for this decline have been: (i) rapid and ill-planned scale-up of production of midwifery-trained health workers; (ii) increased pressure to include the expanding range of tasks to be performed at field level, thus overloading the curriculum; and (iii) increased size of class, with the number of students exceeding the available case-load, resulting in a lack of hands-on experience. Too often, the training curriculum does not focus on transfer of skills and development of core competencies, as defined by WHO, the International Confederation of Midwives (ICM) and the International Federation of Gynaecology and Obstetrics (FIGO) – or critical thinking/problem-solving skills. The ideal duration for developing all the essential core competencies for skilled attendants at the primary care level has been identified as 18 months. This includes midwifery theory and hands-on practice with close supervision, although it will vary depending on the knowledge and skills at the point of entry. As highlighted by World Health Report 2005, it can be done as a stand-alone programme or included within or after taking a nursing course. It can, also be developed in parts (e.g. one year of intensive theory and practice and six months' supervised internship) as country situations and resources permit.

- ***Variation in definition of a skilled attendant at community level.*** There is a lack of consistency across the countries in terms of education and accreditation of skilled attendants at community level. There are different cadres of midwifery workers with varying time-spans of basic training ranging from 6 to 18 months after different levels of basic education (primary, junior or high school). There is an urgent need for countries to define the core competencies that different types of human resources should posses.

- ***Delegation of authority in health care practice.*** Skilled attendants at community level are often most restricted in their tasks. Some countries are recognizing the need to address this problem. Indonesia, for example, has given community midwives the responsibility of providing first aid management of obstetric complications and newborn problems. In India, recently, there has been a notable change in policy to allow auxiliary nurse-midwives (ANMs) to practise some selected life-saving skills. Issues related to upgrading of staff skills, supervision and support in carrying out the new tasks, how staff will be assisted to maintain their competency levels, and how to change the current pre-service curriculum are being discussed in order to arrive at a consensus.

> There should be a comprehensive, long-term plan for human resources development, especially in countries with a high MMR and low level of skilled care at birth.

(b) Inadequate health sector financing

Almost all countries in the Region face a serious lack of investment in health services generally and in maternal and newborn health in particular. Health investment from public sources in most countries is still low, usually below 5% of GDP. There is an urgent need for governments to make higher investments in health, especially for activities at primary health care level, and for ensuring quality of its referral back-up. Inadequate health financing has caused people primarily to pay out of pocket for accessing care, making ill-health one of the major drivers of poverty.

Health benefit schemes or insurance must include care during pregnancy, childbirth and post-natal period and for early newborn care. They should also include coverage for the management of maternal complications and newborn problems. In addition, these packages should provide screening and treatment of diseases, such as malaria, TB, HIV/AIDS and underlying conditions, i.e. diabetes and anaemia in pregnant women.

Decentralization in health care settings is increasingly seen throughout the Region. While it has improved the situation in some areas, it may become a potential threat to prioritization and adequate resource mobilization for

skilled care at birth. Indonesia, for example, has seen some of its provinces failing to invest in funding for community midwives.

(c) Need for a pro-poor approach and equitable deployment of human resources

Coverage with skilled care at birth is unevenly distributed in the countries of the Region. A sufficient number of skilled attendants need to be deployed close to the community they serve; this is particularly important for the poor and disadvantaged populations. Data from the Demographic and Health Survey (DHS) in India, for example, showed that less than 10% of women in the poorest quintile utilize skilled care at birth, while more than 80% of those in the highest quintile utilize skilled care. Other countries also showed similar disparities. Governments, therefore, need to allocate the necessary finances for skilled care at birth to ensure that the poor can access such care.

Life-saving and emergency referral back up care of good quality should always be available free at the point of use, especially for the poor. Sometimes cost recovery and insurance schemes exclude the poor and do not cover costs of obstetric emergencies and other health problems in pregnancy. However, the Region does have a number of examples of pro-poor innovative finance schemes. The Self-Employed Women's Association (SEWA) in the state of Gujarat, India, has an insurance scheme which works on very low premium and insures its women employees and which includes maternity care and management of complications. Thailand has included maternal and newborn care in the 30 Baht health care scheme that has been implemented all over the country. In Indonesia, there is a government-funded safety net programme for poor pregnant women and promotion of a community saving scheme "tabulin" for childbirth. Bangladesh is adopting the pro-poor approach, as reflected in its Poverty Reduction Strategy Paper (PRSP).

(d) Need for strengthening midwifery as a profession

Midwifery in most countries of the Region is not seen as a profession. Neither is it recognized that midwives or those who practise midwifery require "specialist" type of pre-service training. Midwifery is often integrated into the basic nursing curricula where the time spent on developing midwifery competencies is frequently too short. In some instances, this has led to nursing

subjects and specialization taking precedence over development of midwifery competencies.

Having generic, low level or multipurpose health care workers to provide skilled care at birth, especially in the community, may sound theoretically useful. However, it can pose problems when trying to maintain standards and competency levels where having the necessary specific competency for dealing with pregnancy and birth-related complications is critical.

Additionally, very few countries have an established mechanism for licensing midwifery practice. Few have a proper functioning accreditation system to ensure that institutions prepare practitioners for safe midwifery practice. Without such licensing and accreditation systems, it is unlikely that midwifery will acquire the status of a profession, and thus will never be as attractive as other occupations. This has serious implications for recruitment of entrants with the necessary educational background.

Sri Lanka has made midwifery an attractive and well-respected profession since the early period of its efforts to reduce MMR. Both Sri Lanka and Thailand had introduced a strong licensing and accreditation system in order to ensure that midwives, who were licensed, were truly competent. The current scenario in some countries becomes a vicious cycle of low status of midwifery personnel; poor recruitment; low morale which leads to poor quality of care, lack of empowerment; and, finally, low utilization of services.

(e) Need for effective, sustainable referral networks and services

Skilled care at birth includes the capacity to be able to refer women and newborns quickly in the event of emergencies. Although only a limited number of women and newborns will develop a life-threatening complication, very few of these can be predicted. Thus, all pregnant women should routinely develop birth and emergency preparedness plans during antenatal care supported by their families and communities. These plans should include identification of the nearest referral facility, within 2-4 hours' journey time, funds for referral, means of transport to the facility, who will accompany the pregnant woman; as well as identification of members of the family who can act as blood donors, if needed.

The linkage between primary health care services and the first referral unit, while crucial in the process of saving the mother and the newborn, is a major problem in many countries. There is a need for continuous collaboration between programme managers responsible for maternal and newborn health at primary care level and those responsible for referral facilities. This would help develop a strong professional relationship between skilled attendants at community level with health professionals at first referral facility.

> World Health Report 2005 recommends investing in high quality midwifery care units staffed by small teams of midwives and linked to an emergency referral facility, to ensure quality primary-level care with adequate referral and emergency back-up. Such units can be established as midwifery-led care units, or birthing centres, that are either independent or part of a hospital facility. Such units, however, must function on a 24-hour basis. It can be a cost-effective model that provides quality and culturally appropriate *skilled care at birth*. In addition, they help to avoid over-use of medical technologies, as well as overcrowding at the referral facility.

Equally problematic is the poor quality of many obstetric referral facilities. Some of them lack basic equipment and infrastructure and cannot undertake essential life-saving surgery or offer blood transfusions. Others are overcrowded and inhospitable, while some others have the capacity to manage emergency cases, but for various reasons refuse to do so. In many countries, placement of medical specialists in the first referral hospital is a major problem as they usually prefer to work in urban settings.

The referral network is crucial to successful provision of skilled care and should include all public as well as private maternal and newborn health service points. Standard referral and clinical protocols for management of complications will help facilitate effective management and quality referral network. Transportation and fair financing mechanisms to ensure that all women and newborns can be referred during an emergency are imperative.

(f) Need for effective leadership and management

At operational level, strong leadership and management of maternal and newborn health programmes is necessary for achieving skilled care at every birth. The use of local data for planning, programming and decision-making is

crucial for programme managers to initiate effective interventions. However, many countries in the Region lack even the most fundamental information systems, i.e. vital registration, thus making it difficult to ascertain the number of births and deaths as well as information on underserved areas.

Involvement of the community in decision-making is essential. Although there are signs of increased community participation in many aspects of governance across the Region, there is still an overall lack of women's participation. Without a voice, women's needs and concerns regarding skilled health care during pregnancy and childbirth are not taken into account.

2.3 Member States' Commitment Towards Protecting Childbirth

The significance of childbirth to women's health and well-being has been a matter of global public debate for years. The International Conference on Population and Development (ICPD), held in Cairo in 1994, its five-year follow-up meeting (ICPD+5), and the 1995 Women's Conference in Beijing, among others, reinforced the link between women's health, including their reproductive health, and development. In 2000, the significance of reproduction and the health of both women and children were acknowledged when 189 Member States of the United Nations signed the Millennium Declaration, thereby endorsing the Millennium Development Goals (MDGs).

One of the goals, MDG 5, calls for improvement in maternal health, while MDG 4 calls for a reduction by two-thirds of the under-five mortality rate, which will require reduction of neonatal deaths by 50%. One of the indicators for MDG 5 is the proportion of births attended by skilled health personnel, with the targets to achieve 50% and 60% in 2010 and 2015 for high MMR countries; and 85% and 90% globally. Thus the commitment from Member States to ensuring safe childbirth is clear.

MDG Indicators for Goal 5

The two indicators proposed by the MDGs framework for monitoring progress towards MDG 5 are: (i) a reduction of MMR by three-quarters between 1990 and 2015; and (ii) an increase in the proportion of births attended by skilled attendant/skilled health personnel. The international targets for the proportion of births attended by a skilled attendant calls for 80% of all births by 2005, 85% by 2010 and 90% by 2015. In countries where MMR is very high, at least 40% of all births should be assisted by skilled attendants by 2005, 50% by 2010 and 60% by 2015.

The issue remains how to achieve it as fast as possible in an effective and efficient manner, keeping in view the country situation.

3. KEY ISSUES AND CHALLENGES FOR SUCCESSFUL IMPLEMENTATION AND EXPANSION

It is the right of all pregnant women and their newborns to get the best possible health care, especially during childbirth and immediately after birth, which is a critical period in their lives. Therefore, it is the responsibility of governments to ensure skilled care at every birth as part of their commitment to achieve the MDGs. There are critical components that make up skilled care and countries will have to make a number of strategic decisions with a long-term vision, which include the following issues:

(a) Human resources development and management

The key issues and challenges include:

- Training and/or deployment of sufficient number of skilled attendants at community level, especially for countries with high MMR and low level of skilled care at birth. There should be a long-term plan for human resources development for maternal and newborn health for achieving at least 60% skilled care at birth in 2015. A consensus on the minimum skills set for skilled birth attendants at community level is needed.
- Strengthening pre-service midwifery training institutions to ensure that their graduates will have the necessary skills as proposed by WHO, ICM and FIGO. This should be in line with efforts to professionalize midwifery.
- Strengthening supervision, ongoing performance review and development systems to ensure that skilled attendants are able to provide quality care, with necessary delegation of authority for those working at community level, and maintain their motivation and morale.
- Ensuring availability and equity in distribution of health providers with obstetric, anaesthestic and paediatric skills at first referral facilities in order to manage pregnant women and their newborns with complications or health problems.

(b) Capacities to manage long-term/phased implementation of interventions

The key issues and challenges include:

- Strengthening capacities to take control and implement long-term plans. This will require strong public health leadership and management at all levels. Countries should realize from the outset that there are no quickfixes. Investments are needed to develop skills of programme managers to make and implement long-term plans, which includes advocacy to policy-makers and politicians. Managing resources at primary care and referral levels, as well as establishing strong linkages between the two levels in providing quality care for all pregnant women and their newborns, is a great challenge.
- Strengthening monitoring and evaluation for better programme planning and management. Future interventions should be based on relevant information and sound evidence. Doing this will require robust health information systems, so that decisions can be based on real data.

(c) Increasing financing for universal access to maternal and newborn health services

The key issues and challenges include:

- Promoting and advocating, especially to parliamentarians and other high-level policy makers for appropriate increase in funds for maternal and newborn health programmes
- Identifying ways to garner political commitment and accountability to ensure mobilization of the needed resources
- Securing financing for long-term plan of human resources development for maternal and newborn health, especially for countries with high MMR and low level of skilled care at birth
- Ensuring that basic equipment, drugs and supplies for services at primary health care level and first referral facilities are adequately financed

- Giving special attention to the poor and disadvantaged, as well as pockets of underserved areas in each country. This will require identification of such target groups and areas, as well as providing adequate funds. Mechanisms to reduce out-of-pocket expenses for care, especially for the poor, should be established.

(d) Improving the referral system, comprehensiveness, integration and quality of services

The key issues and challenges include:

- Reduction of MMR and newborn mortality cannot be addressed only at the primary care level. Provision of quality maternity care requires a team approach and continuum of care from community to primary health care and referral facility. For the team to work in harmony, there must be good collaboration between primary and referral facilities.
- Increasing availability and access to emergency obstetric and neonatal care to save lives.
- Integration of prevention and management of common diseases in pregnant women and their newborns, such as immunization, tuberculosis, malaria, sexually transmitted infections, including HIV/AIDS, into maternal and newborn health services.
- Improving the quality of services at primary health care and referral levels, both from technical basis – judged by conforming to national evidence-based standards – and for the user's perspectives of care.

(e) Working more effectively with individuals, families and communities

The key issues and challenges include:

- Partnership for managing emergency cases and in using community resources. Greater attention needs to be given to educating and working with communities to develop birth and emergency preparedness plans, including transport and communication systems. Community involvement in referring mothers and their newborns with complications or health problems should be encouraged, i.e. in managing transportation, costs and communication.

- Changing behaviours for better care of mothers and newborns, taking cultural traditions into consideration. It is important to educate mothers, families and community leaders on how to take good care of a pregnant mother/newborn at household and community levels during pregnancy, childbirth and the postpartum period. Childbirth has a strong social dimension; however, ensuring safety should be a priority. This should be linked to efforts for women's empowerment so that their voice and demands can be taken into consideration.

(f) Need for multisectoral and intercountry collaboration

The key issues and challenges include:

- At national and sub-national levels, linking with and using formal and informal governmental, private and professional organizations, as well as nongovernmental organizations (NGOs) and community-based organizations (CBOs).
- Intersectoral collaboration and involvement of other ministries at national and sub-national levels, e.g. ministries of education, finance, social welfare, women's affairs, transport, migration, etc. to address relevant issues. To be successful, the health sector must advocate and proactively seek to inform other sectors about the need for and benefits of skilled care at every birth and what is required to support this.
- Good governance at all levels, to ensure that decentralization and devolution of powers provide a supportive environment and sufficient financing and commitment to achieve skilled care at every birth, and to ensure equitable access and utilization of quality care.

4. THE WAY FORWARD FOR MEMBER STATES AND THE ROLE OF WHO

4.1 Member States

Each country must plan and create an enabling policy environment to accelerate action to ensure universal access to skilled care at birth as a right for all women and their newborns. This will require:

(a) Addressing issues of human resources for maternal and newborn health, especially for countries with high MMR and low level of skilled care at birth.

- Assessment of the country situation on human resources for maternal and newborn health and identify gaps in meeting the needs for skilled care at birth.
- Follow-up actions based on the above assessment: for countries with a low coverage of births with skilled attendants, there is a need to develop a long-term plan in meeting the requirement of human resources. For countries with medium coverage, plans for improving coverage and quality of services and strengthened linkage between primary care and first referral levels need to be developed. Countries with high coverage need to further improve the quality of care and focus on underserved areas.
- Review of policies related to skilled attendants: pre-service and in-service training, regulatory policies on midwifery, deployment, technical supervision, etc.

(b) Advocate with relevant decision-makers at national and sub-national levels to improve financing of health systems, especially for maternal and newborn health. Financing schemes for the poor, community financing initiatives, insurance schemes and other innovative financing mechanisms should be promoted, implemented and carefully monitored from the start to ensure their effectiveness.

(c) Strengthening the health system to overcome the many and different obstacles to the provision of, access to and utilization of skilled care at birth. This will include:

- Adequate financing for maternal and newborn health programmes at local/district level to ensure that necessary activities, basic equipment and supplies for skilled care at birth both at primary health care and its referral back-up are well covered.
- Good management of resources at all levels to ensure that they are utilized in an effective and efficient manner in order to achieve universal skilled care at birth and to ensure quality of care. An

effective system for monitoring and evaluation of coverage and quality of services should be in place.

- Improving access to skilled care at birth by addressing the issues of: (i) availability of skilled attendants at community level and equity in distribution of health providers with obstetric, anaesthetic and paediatric skills at first referral facilities; (ii) adequate functioning of skilled attendants and referral facilities; (iii) costs, transportation and communication issues, especially for cases with complications or health problems; (iv) special attention given to poor and the disadvantaged groups, as well as pockets of underserved areas.
- Improving quality of services at primary health care and first referral levels, as well as strengthening linkages in managing referred cases and in technical supervision.
- Strengthening involvement of women, families and communities in: (i) caring for women and newborn in normal condition; (ii) birth preparedness and referring those with complications and problems; and (iii) building confidence in and trust of skilled health workers and the services they provide.

(d) Coordination, collaboration and consensus building across multiple actors and sectors to address the above issues and in implementing long-term plans. This includes:

- Strengthening operational and strategic partnerships for achieving common goals with all actors and agencies including public and private sectors and NGOs.
- Mobilizing resources for assisting the government to carry out the long-term plan.

4.2 Role of WHO

In assisting countries to achieve skilled care at every birth, WHO has the following roles:

(a) Technical leadership in collaboration with partners to assist Member States in identifying key public health issues and challenges needed to overcome the many and different obstacles to the provision of, access to

and utilization of skilled care at birth, and in establishing consensus among all stakeholders.

(b) Establishing evidence-based norms and standards on which to base key decisions on quality of care, as well as for policy-making. Guidelines and tools are available and require adaptation and implementation at country level.

(c) Facilitating capacity building of decision-makers and managers at different levels, as well as institutions for education and training, especially for midwifery, and for public health leadership. There is an increased need for this, among others, due to the widespread decentralization that is taking place across the Region.

(d) Advocacy for global resource mobilization through existing networks and partnerships, as well as their expansion. Priority will be given to countries in greatest need.

(e) Monitoring and reporting progress towards achievement of targets of MDGs 5 and 4. The reports can be used as a basis for further action.

5. POINTS FOR CONSIDERATION

With regard to the above-mentioned issues, the following points need consideration:

(1) Need for a long-term plan for human resources in order to achieve universal skilled care at birth.

(2) A long-term strategy to increase investments at all levels of the health system for achieving universal skilled care at birth.

(3) Strengthening management capacities, i.e. management of resources at all levels to ensure that they are utilized in an effective and efficient manner in order to achieve universal skilled care at birth and to ensure quality of care. A good system for monitoring and evaluation of coverage and quality of services should be in place.

(4) Strengthening pre-service midwifery training institutions, which include the development of a proper accreditation system in order to ensure that they prepare practitioners for safe midwifery practice. This would improve the status of midwifery as a profession.

(5) Expanding access to and utilization of skilled care at birth with special attention to the poor, the disadvantaged and underserved communities. Access to emergency obstetric care is a major issue in many countries, including those with medium level of skilled care at birth.

(6) Improving quality of care in all countries, including those with low MMR. There is a need for continuous improvement of quality, equity, attention to newborn health and prevention of unnecessary medicalization of childbirth.

Suggested Further Reading

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GLOSSARY AND OPERATIONAL DESCRIPTIONS OF TERMINOLOGY

Skilled care at birth Essential care for childbirth and in the immediate postpartum period that every woman and her newborn baby need. It includes routine care for all women with integrated interventions according to specific disease patterns, and management of complications of pregnancy and childbirth and problems in newborn infants.

Continuum of care Essential care that is provided as a continuum at the primary health care level by health care providers (skilled attendants) with midwifery skills and, when complications occur, at secondary health care level (first referral level/facility) where there is a need for additional health care providers with obstetric, anaesthesia and paediatric skills and support services. It includes effective links among those services in the form of efficient and timely transportation to the referral facility, as well as communication. It also recognizes the importance of support and linkages with the household and community for self-care, prevention of illness and demand for healthcare.

Integrated interventions Interventions in maternal and newborn health service that includes prevention, screening and treatment of common diseases in pregnant women and their newborns. These interventions include immunization, control of tuberculosis, malaria, sexually transmitted infections, HIV/AIDS including PMTCT, etc.

Human resources for skilled care *includes*

- Skilled attendants: accredited health workers with midwifery skills, who have been educated and trained to proficiency in skills needed to manage normal (uncomplicated) pregnancies, childbirth, and immediate

postnatal period, and in the identification, management and referral of complications in women and newborns.

- Doctors with obstetric and anaesthetic skills.
- Doctors with neonatal/paediatric skills.

Place of care *includes*

- Primary health care level, including health centres and outreach services.
- Secondary health care level (first referral level): hospital with surgical and blood transfusion services.
- Referral between the two.