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Nepal Safer Motherhood Project

a part of HMGN Safe Motherhood Programme

REPORT ON THE CONFERENCE "SAVING LIVES: SKILLED ATTENDANCE AT CHILDBIRTH", TUNISIA

By Susan Clapham and Dr Indira Basnett

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Options

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ABBREVIATIONS

BEOC	Basic Emergency Obstetric Care
CEOC	Comprehensive Emergency Obstetric Care
EOC	Essential Obstetric Care
FIGO	International Federation of Gynaecology and Obstetrics
IAG	Inter Agency Group
ICM	International Conference of Midwives
MCHW	Maternal and Child Health Worker
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Ratios
RH	Reproductive Health
TBA	Traditional Birth Attendant
WHO	World Health Organisation

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1. Introduction

The Saving Lives: Skilled Attendance at Childbirth conference was held in Tunisia from 13th to 15th November. It was organised by the Safe Motherhood Inter Agency Group (IAG)¹.

This report summarises the key themes and presentations from the conference. Annex 1 relates some of these issues to the Nepal context as the report writers were members of the Nepal team. The report also draws on a document presented at the conference entitled "Skilled Attendance At Delivery: A Review of the Evidence" (hereafter referred to as 'The Review').

Teams from seven case-study countries were invited to the conference. Countries had been selected on the basis of their potential to impact on their existing high levels of maternal mortality, and to serve as models for other countries in the future. The seven countries were Nepal, Bangladesh, Burkina Faso, Mozambique, Uganda, Nigeria, and Senegal.

One of the main objectives of the conference was that these seven countries should learn from the experiences of four other countries, where implementing skilled attendance at delivery has proved a key intervention in their progress in reducing maternal mortality ratios (MMRs). Teams from Tunisia, Malaysia, Botswana and Sri Lanka were therefore also invited to the conference.

Various introductory statements were made at the opening ceremony, which set the key themes for the conference. Referring to the ten lessons from ten years of safe motherhood (presented at the 10th Conference of the Initiative in 1997), Dr Fred Sai² stated that two key issues remain to be addressed: the inadequacy of essential obstetric care (EOC); and the need to address skilled attendance at delivery.

Other themes presented were; the critical role of a functioning health system, the political will to address maternal health by national leaders and their governments—using a rights based approach assists this process, the need for financial commitment and the impact of poverty reduction strategies.

¹ The IAG is a consortium of international organisations that support the safe motherhood initiative. It was founded in 1987.

² President, Ghana Academy of Arts and Sciences.

2. The concepts of skilled attendant and skilled attendance

Presented by Dr Khama Rogo, IPAS and Ms Deborah Armbruster, Consultant

The IAG defines the concept of the 'skilled attendant' (the caregiver), as distinct from that of 'skilled attendance' (the process by which a pregnant women is cared for). Skilled attendance results from the relationship between the skilled attendant or caregiver and the enabling environment. It is the enabling environment that determines whether or not a skilled attendant is able to save a life. The concept of skilled attendance brings to the fore the fundamental role of an effectively functioning health system in the delivery of safe motherhood services.

2.1 Defining Skills and Competency Levels

A joint WHO/UNFPA/UNICEF/World Bank statement (1999) on the definition of a skilled attendant reads, in part, as follows

"People with midwifery skills who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage or refer complications".

A minimum set of skills has been determined drawing on documentation from the International Conference of Midwives (ICM) and the World Health Organisation (WHO)³. These are the *essential* skills that an attendant (primarily those providing home delivery care) must be able to practice. A further set of skills is specified for those working at first referral sites. These skills are listed in The Review.

There was, however, little debate in the plenary on the different level of skills required. While the term 'minimum skills' is helpful, the description of the skills provided in The Review is limited. For example, The Review states that skilled attendants should "Perform life saving skills in cases of convulsion, obstructed airway, serious infection...". This does not take account of the fact that there is a range of management levels for these complications, ranging from simple first aid and prompt referral, to relatively sophisticated management strategies.

In order to assist countries in determining whether their different cadres of staff can be classified as 'skilled attendants', the IAG could usefully describe the competency level for each skill. This need is particularly acute in countries such as Nepal where peripheral health staff with relatively little technical training are the primary health care providers. The role of such health workers in the skilled attendance strategy is not clear in The Review⁴.

As well as defining the level of competence, it is important to sustain this level of competency. Countries need to ensure that protocols are available to health staff at all levels, which provide clear descriptions of the clinical responsibilities for different cadres of health workers. Countries also need to ensure that protocols are available to health staff at all levels, which provide clear descriptions of the clinical responsibilities for different cadres of health worker.

The need for *appropriate* and *timely* inputs by the skilled attendant was highlighted. The skilled attendant needs to be able to identify the correct course of action when faced

³ See bibliography.

⁴ See Annex 1, a report from the Nepal team, for further analysis of this issue in relation to Nepal.

with a given situation. It may be useful to remember that skills may be on a continuum, stretching from incompetent or inappropriate intervention, to negligent inactivity.

2.2 Management Issues in Skilled Attendance

Many service providers graduate with clinical skills and knowledge but with little understanding of the importance of management issues, and the ability to think critically. This can prove an obstacle to the process of 'skilled attendance'.

A range of management issues related to skilled attendance was highlighted, including the need to ensure a match between the skills of the provider and the environment in which he or she operates, and the need to ensure skill levels are maintained (particularly challenging in rural settings where few cases present).

2.3 The relationship between 'skilled attendance' and EOC

This is an important issue, which unfortunately was not debated in any depth during the conference. This may be partly due to the fact that there is little literature on the relative importance of skilled attendance as opposed to EOC (and the relationship between the two) in a country's safe motherhood strategy. By stating that midwifery care (and transportation in the event of an emergency) is the single most critical intervention, the literature infers⁵, but does not make explicit, that EOC is available. The Review maintains that skilled attendants can save lives in the absence of a referral system provided that the necessary equipment and supplies are available. However, while there is clearly a role for the 'skilled attendant' in situations where there is no referral backup, the extent to which skilled attendants impact on maternal mortality in the absence of adequate EOC health facility support is unknown. It is therefore difficult to primarily advocate for skilled attendance alone.

Although the use of the term 'skilled attendance' in a health strategy, implies the existence of available and indeed accessible EOC, the majority of cases attended by skilled attendants are normal deliveries. It is imperative, particularly for the purpose of health planning, to define the relative importance of inputs to ensure basic midwifery care and basic and comprehensive EOC. A strategy should be developed taking into account their relative weighting in a variety of local contexts. This has yet to be done. In resource-poor countries such as Nepal, resource allocation is always difficult and some guidance on this issue would be useful. For example, where EOC facilities do not exist, is it more important to upgrade health facilities *before* considering midwifery skills for home deliveries or are midwifery skills more important? Annex 1 looks at this issue in relation to Nepal.

3. The evidence for promoting skilled attendance as a key strategy for reducing maternal mortality

Presented by Dr Fariyal Fikree, The Population Council

3.1 Historical evidence

Analysis from northern European countries that succeeded in reducing their MMR prior to 1950 shows that this reduction occurred in two phases. The first phase (from 1870 to

⁵ For example, see Starrs, A. *The safer motherhood action plan: Priorities for the next decade*, report of the Safe Motherhood Technical Consultation, FCI, New York, 1997.

1900) is said to be due to strong political commitment to the provision of quality midwifery care. The second phase (from the 1930s) began with the advent of new technologies – now referred to as essential obstetric care or EOC.

There is evidence that wherever there was a high proportion of home deliveries by trained and supervised midwives, maternal mortality tended to be low. Crucial factors in the reduction of the MMR included social acceptance of midwives in the communities where they worked, their level of accountability, and a supportive policy environment. This evidence confirms that maternal mortality can be reduced, even in countries with poor socio-economic indicators.

3.2 Epidemiological evidence

While there is some evidence of a relationship between the proportion of deliveries by skilled attendant and the level of maternal mortality, this information is largely descriptive, and a formal causal link has yet to be established.

Difficulties in data collection were highlighted, as were problems arising from different definitions and interpretations of 'skilled attendance'. It is problematic to isolate the relationship between skilled attendance and maternal mortality since most skilled attendance occurs in health facilities and therefore other factors associated with an institutional birth are likely to play a role. It is not known to what extent placing skilled attendants in communities without available and adequate EOC health facility support will result in effective management of complications, and therefore lead to reduced mortality.

It can be said, therefore, that the *scientific* data on skilled attendance at delivery does not provide sufficient evidence to guide policy or programming, beyond recommending a more holistic approach to reducing maternal mortality. However, enough anecdotal evidence exists to suggest that a relationship between skilled attendance and maternal mortality *does* exist and to warrant further research in this area.

4. A Conceptual Framework

A new conceptual framework for skilled attendance has been developed⁶ and a modified version is presented in The Review (though this was not presented at the Conference). The framework identifies structural factors, inputs, outputs and outcomes. These **structural factors** are the relationships within and between the political/policy environment and the social/cultural environment, which elate to and affect safe motherhood. This includes the setting of international targets, laws and policies, standards of practice and industry regulation.

The **inputs** refer to interventions to improve the health system, such as service provision, health financing, and education and training. The environment in which such interventions are delivered, as well as the processes employed to deliver them, largely determine the potential impact of such inputs. The impact of such inputs are termed **outputs** and include a variety of factors related to quality of care, access and equity. The measurable **outcomes** include maternal and neonatal mortality and morbidity, provider satisfaction and cost effectiveness.

Key elements of this framework, some of which were discussed during the conference, are summarised below.

4.1 Political and social context

Political commitment to reducing maternal mortality is critical, as has been demonstrated by the experiences of Sri Lanka, Cuba and Honduras.

The setting and enforcing of international targets is an important structural factor that underpins the delivery of safe motherhood interventions. Two of the most relevant international targets are:

"By 2005, where MMR is very high, at least 40% of all births should be assisted by skilled attendants". (from the Special Session of the UN General Assembly, 1999)

ICM and the International Federation of Gynaecology and Obstetrics (FIGO) propose a target of one 'skilled attendant' per 5000 people, assuming a crude birth rate of 40 per 1,000. This translates to 1 skilled attendant per 200 births a year (WHO 1999) (Page 19 of IAG Review document)

Legislation and regulation play an important role in protecting clients and maintaining accountability on the part of the attendants, as well as enabling the skilled attendant to practice the full set of skills invested in him/her. Over recent years, the drive to identify national laws and agree international treaties that promote and protect women's right to safe motherhood has gathered pace, since it is increasingly recognised that existing laws can obstruct women's access to both care and information.

Professional associations can play an important role in advocacy and policy development, in defining standards of care, and in promoting the professional and personal development of their members.

⁶ Graham, W., and Bell, L. *Monitoring and evaluating skilled attendance at delivery: trials and tribulations*. Paper presented at the technical consultation Ensuring skilled attendance at delivery, WHO, Geneva, 2000.

With regard to the issues mentioned above, community perceptions and preferences regarding health and healthcare, as well as the identification of barriers to accessing and using services, are all critical factors that programme managers need to take into account in order to improve quality of care. This is a key means of maximising the potential of inputs to the health system. Full participation of the community in mechanisms to improve and monitor quality of care should be sought.

4.2 Organising the health system environment for the provision of skilled attendant care

There was some debate on the preferred place of birth. However, no particular setting is recommended and home delivery is felt to be appropriate provided that the person attending is suitably trained and equipped, and that referral to a higher level of care is available.

A recently developed framework⁷ sets out four basic models of delivery care, ranging from home care by non-professionals (Model 1), to comprehensive emergency obstetric care (CEOC) (Model 4). Model 2, which refers to home care by a professional linked to a referral system, and Model 3, which refers to births by professionals in a basic emergency obstetric care (BEOC) facility, are considered 'optimal' forms of care.

4.2.1 Infrastructure requirements

Presented by Ms Mary Ellen Stanton, USAID

Resources: The concept of an *enabling environment* was extensively debated and different frameworks were presented. There is now a considerable body of literature on essential obstetric equipment and supplies. The increasing emphasis on the availability and effective management of resources is welcome.

Referral Systems: Different elements of an effective referral system include community awareness of danger signs, knowledge of where to go and when (as well as the ability to get there), use of emergency funds and community-based insurance mechanisms, and community-based partnerships between all providers of care.

Minimum Infrastructure Needs: There was no discussion on the basic need for a facility to be considered safe and functional (which is the case in Nepal). The role of 'waiting homes' was not discussed in any detail except to say that there is limited evidence that they contribute to reducing maternal mortality. However, in settings where transport is poor there may be a role for timely and efficient referral to a home which is linked to EOC facilities. This is discussed in The Review.

4.2.2 Human resource development

Presented by Dr Raj Karim, IPPF

Training and Education: The Review provides some details on training and education needs for skilled attendants. These include the recommended elements of a sound pre-service education, recommendations for the training and preparation of educators, and preferred training materials (WHO Midwifery Modules 1996 and Life Saving Skills Modules of the American College of Nurse Midwives). Lessons learnt from selected

⁷ Koblinsky, M. et al *Issues in Programming for Safe Motherhood*, (draft documents), 2000, forthcoming

training methods are also highlighted. The current emphasis is on competency-based training.

Recruitment and Deployment of Staff Considerable time was devoted to discussion of recruitment and deployment of staff, which is often difficult in situations where nursing and midwifery careers do not attract young women. Retention of staff was also debated, since this is a recurrent problem for many countries. The need for supportive supervision was stressed, including professional audit, standard setting and development, accountability mechanisms, supporting female staff in remote areas and continuous educational and training inputs. The need for health care providers to be valued by the communities in which they work was also highlighted, as was the link between recruiting and maintaining staff and the enabling environment.

4.3 Monitoring and evaluation of the impact of skilled attendance

Presented by Dr Wendy Graham, Dugald Baird Centre, Aberdeen University

The Review presents some critical background information on inputs, processes, and outputs for safe motherhood programming and debates different levels of aggregation and the use of population-based versus service-based data. A range of indicators for monitoring and evaluation (M&E) is discussed and a variety of approaches to M&E presented.

The importance of determining programme goals and objectives and then proceeding to set the corresponding programme indicators was stressed. In other words, there is a need to articulate the conceptual framework (see above) at the outset, including programme inputs and expected outcomes. This is crucial for effective M&E.

Key indicators – "deliveries with skilled attendants" and "skilled attendance"

This issue attracted considerable debate. The UN General Assembly in July 1999 recommended that:

"in order to monitor progress towards the achievements of the conference goal for maternal mortality, countries should use the proportion of births assisted by skilled attendants as a benchmark indicator".

The underlying assumption is that an increase in skilled attendants will translate into a fall in maternal mortality. However, the interpretation of this indicator is difficult since a wide range of operational and contextual factors influence its value. It is not easy, therefore, to use this indicator for the purposes of national, regional and international comparison.

DHS data show that there is a degree of correlation between skilled attendance and the level of maternal mortality (The Presenter). However, data from the conference's seven case-study countries show that most of these countries have rates of maternal mortality far higher than would be expected given the proportion of births attended by a skilled attendant.

DHS data from 50 countries show that there is a higher degree of correlation between the MMR and the proportion of deliveries by doctors than there is between the MMR and the proportion of deliveries by midwives. This may be due to difficulties in defining "nurse midwives" and their more limited role in the range of life saving skills compared with doctors (The Presenter).

A ratio of 15% of deliveries by doctors and 85% by nurses was said to be the optimal ratio for reducing the MMR. However, this indicator may be misleading since it focuses

only on the proportion of skilled attendants and does not provide any measure of skilled attendance, i.e. the enabling environment. Work is currently underway to develop a way in which to assess attendance. One method of measuring the proportion of deliveries with skilled attendance was presented using DHS data from Malawi, although it was acknowledged that considerably more work in this field is required.

Measuring equity

It is crucial to reach poor women with safer motherhood services. DHS data reveal that poor-rich inequalities in access to health care are more marked in relation to access to skilled attendants for delivery care than is the case for access to other health services such as those for ARI and diarrhoeal diseases. This is further illustrated by the relationship between the level of maternal education and the proportion of deliveries with skilled attendants, given that maternal education levels are closely related to poverty.

Conclusions

The key messages from the plenary were as follows:

- New indicators are urgently needed to measure skilled attendance, since existing indicators which measure the proportion of deliveries by skilled attendant are limited;
- Progress in improving skilled attendance must be monitored using certain key differentials; and
- Greater use can be made of facility-based information.

4.4 Costing skilled attendance

Presented by Craig Lissner, WHO

4.4.1 The Cost of skilled attendance

It is well known that the majority of cost studies focus on individual maternal health interventions as opposed to the cost of delivering maternal health services as a whole, i.e. they exclude the cost of the enabling environment or of 'skilled attendance'. This issue was debated by the plenary and existing cost data were presented. Key statistics include the cost of a normal delivery, which can be as low as 2 US dollars per birth, and the cost per maternal and perinatal death averted due to improved maternal care (including deliveries by skilled attendants) which ranges from 1,000 to 3,000 US dollars.

Differences in costs between countries and facilities suggest that a variety of models for skilled attendance now exist, and some models will be more cost-effective than others. For example, the cost of non-complicated births is lower in health centres than in hospitals. It was stated that a range of cost saving mechanisms could be adopted, including the effective deployment of skilled staff and the effective use of clinical and management guidelines.

4.4.2 Sources of Financing

There is limited evidence of how the various sources of financing for health care (taxes, out-of-pocket expenditure, community contributions and donor contributions) are used for safe motherhood and on the amounts allocated from each source for skilled attendance.

A review of different financing mechanisms shows that services funded and provided primarily by national governments tend to be under-funded, of poor quality and provide limited access. There is mixed evidence on the use of user fees, although the potential exists to improve the management of existing user fee schemes. Such schemes must include mechanisms to ensure access for those that cannot pay (safety nets), and require

regular monitoring to ensure equity of access. It was mentioned that out-of-pocket expenditure for health services does not always constitute a barrier to access. Prepayment schemes, such as insurance schemes, were said to be promising and greater collaboration with the private sector was called for.

In many countries the restructuring of costs and financing mechanisms is now set in the wider context of health sector reform processes. An effectively functioning health system would enable the provision of skilled attendance. Costing for skilled attendance can usefully feed into the process.

It was recommended that countries undertake their own country-specific cost studies (Uganda has recently done so) in order to advocate for and inform the policy process. Such studies need to identify areas for cost savings. Tools were recommended, such as WHO's Mother Baby Package spreadsheet, and Cost Analysis in PHC by Creese/Parker of WHO.

5. Recommendations

The conference ended with a 'call to action' to all countries. The Review highlights recommendations as:-

- Global and national norms and targets for skilled attendants need to be defined and reliable methods of monitoring developed
- A national policy is needed to ensure skilled attendance during labour, birth and immediate post-natal period
- Competency-based curricula should be the common foundation for education
- The performance of skilled attendants must be continuously monitored and measured
- Financial investments to provide an environment in which skilled care can be provided are essential
- Financial barriers to accessing maternal health care need to be addressed

ANNEX 1: FOCUS ON THE COUNTRY TEAM WORKING GROUP, NEPAL

The team's composition

The Nepali team comprised eight professionals (four from the Government, three from development agencies, and one from an NGO). An equal number of technical experts were assigned to the group.

The process

The team had worked extensively to produce a report prior to the conference entitled "Meeting the Challenge of Skilled Attendance at Delivery: Nepal's Experiences"⁸. The team emphasised that this was a 'living document' and part of a consultation and planning process.

However, the expert team had not read the report and this considerably delayed much-needed analysis of the situation regarding safer motherhood in Nepal, since the Nepali team had to spend time describing the current situation to the expert technical team.

The team felt pressured into developing a plan. This did not seem an appropriate use of time for two main reasons: Nepal is about to engage in developing a 15-year strategic plan for safe motherhood, which will necessarily include this aspect of safe motherhood; and, there are many important programming issues to do with skilled attendance that need to be debated *before* planning can take place. However, the team did prepare a plan, although the term 'plan' must be loosely interpreted.⁹

Key Issues for Nepal

The two issues that were debated the most during the team work were:

- The definition of skilled attendance and its application to Nepal, and
- The relationship of skilled attendance to essential obstetric care in Nepal

1. The definition of skilled attendance and its application to Nepal

Defining a skilled attendant in the context of Nepal is not easy. The team looked to the conference for guidance on determining a minimum set of skills necessary for a service provider to be deemed 'skilled'. The Review states that "lower cadres may have some of these skills, particular for the management of normal labour and delivery, but further discussion and consensus is needed on the most appropriate role for them in the management of complications and in a skilled attendance strategy". Thus in countries such as Nepal where 'lower cadres' of staff are a key means of delivering safe motherhood services, particularly in rural areas, their role in the overall skilled attendance strategy remains unclear.

The experts assigned to the Nepal country team differed among themselves on this issue. One expert assured the team that it was for each country to determine its own definition of skilled attendant, while another stated that only those with professional training (excluding TBAs) could be deemed a skilled attendant.

⁸ The report "Meeting the Challenge of Skilled Attendance at Delivery: - Nepal's Experiences" can be obtained from the report authors on request.

⁹ The Nepal team plan can also be obtained from the report authors on request.

Nepal is currently piloting a scheme to assess whether Nepal's Maternal and Child Health Workers (MCHWs) can be deemed skilled attendants (using IAG definitions). A MCHW has the least formal training of all health workers in Nepal with only three and a half months basic training in maternal and child health. A six-week refresher course has been introduced this year. This is because national Reproductive Health (RH) protocols for MCHWs have been produced which define a level of competence higher than that currently held by MCHWs. It is acknowledged, however, that MCHWs under-perform, even against the currently specified skill level.

According to Nepal's RH protocols, MCHWs are eligible to be called 'skilled attendants' as their level of skill falls within the broad skill set defined by the IAG. However, it is still unclear as to whether MCHWs can indeed reach and sustain this level of competence and there is some difference of opinion as to whether the level of competency determined in the RH protocols is indeed appropriate for Nepal. The refresher course currently in operation still does not bring MCHWs up to that required level.

The Government's view is that MCHWs will gradually attain the required skill level by means of phased training. However, it will be at least a year before it is known whether the MCHWs are competent in the level of skill promoted by the refresher course. If so, further training inputs for the remaining skills will be required. Thus it will be several years before we can determine whether this cadre can be deemed a skilled attendant, as set out by the IAG.

Given that there is no realistic alternative to community midwifery in a country where over 90 per cent of deliveries take place in the home, the country team decided to consider MCHWs as skilled attendants while recognising that this term needs to be qualified. This issue was not resolved during the conference.

A number of the experts were clearly uncomfortable that an individual with such little formal training in maternal and child health could be deemed a skilled attendant.

2. The relationship of skilled attendance to EOC with regard to Nepal

In Nepal attention to skilled attendance over the last eighteen months was preceded (over the last three years) by a growing momentum to focus on the establishment of EOC, both basic and comprehensive.

As stated in section 2.3 above, there is very little literature regarding the relationship and necessary balance between skilled attendance and EOC, particularly with regard to resource-poor countries. By stating that midwifery care (and transportation in the event of an emergency) is the single most important factor in safe motherhood, the literature infers, but does not make explicit, that EOC is available. Nepal is a country where that assumption cannot be made.

The level and quality of emergency obstetric care in Nepal is woefully inadequate. A survey of over half of Nepal's districts revealed that the vast majority (95 percent) of women with complications are not receiving EOC. Only 0.7 per cent of deliveries were by caesarean section, compared with what is deemed to be an acceptable rate of 5%. This points to a high level of unmet need.

In Nepal, *both* EOC and skilled attendance are urgently required. While a skilled attendant, albeit an MCHW with limited capacity can manage an obstetric emergency to some extent, a functioning referral system linking the attendant to an EOC facility is essential in order to significantly reduce maternal mortality in Nepal. However, while

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endorses this position, the team acknowledges that there are serious resource constraints to implementing this approach.

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Nepal Safer Motherhood Project
c/o DFID Nepal, British Embassy
PO Box 106, Lainchaur
Kathmandu, Nepal

Telephone + 977 1 262110
Facsimile + 977 1 248989
Email smp@smp.wlink.com.np