

Steps towards achieving skilled attendance at birth

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Who should assist women in childbirth, what should these attendants do and not do under various circumstances, and where should births take place? Policies regarding these questions have been debated for hundreds of years. In 13th century Europe there was debate regarding who could perform a caesarean;¹ in mid-18th century France debate surrounded the royally mandated childbirth trainings for “an audience of rustics” (i.e. rural women);² in the United States of America currently there is debate regarding the right to a home-based birth;³ and in the developing world there is debate regarding promotion of health facility-based births.⁴ This debate seems likely to continue indefinitely.

WHO's position on where and with whom women should deliver has evolved from emphasis on training of traditional birth attendants (TBAs) in developing countries in the late 1950s and 1960s, to a recommendation that TBAs work with the health-care system, to a recommendation that they be integrated into the health system via training, supervision and technical support, to today's position of promoting professionally skilled attendance at all births.⁵ The facts that a) this position was adopted in 1997 and that it took an additional two years to specify the criteria required to be a “skilled attendant”,⁶ and b) that the policy sidesteps the issue of where births should take place, suggests that substantial internal debate swirled around this stance, as well. Although the WHO skilled attendance at birth policy remains today, it has now been incorporated into a continuum of maternal and child health care policy, resulting from the formation of the Partnership for Maternal, Newborn and Child Health in 2005.

Regardless of the evolving policy positions of various international agencies, advocates and researchers, women

are increasingly going to health facilities to give birth in many parts of the developing world. With the exception of sub-Saharan Africa, rates of births assisted by a medically trained attendant have shown impressive increases over the past 15–20 years and today data indicate that 59% of developing world births are assisted by a medically trained professional.⁷ The large majority of these births occur in a health facility. To what extent do these births receive skilled care? None of the commonly used indicators of use or availability of maternal health care is able to address the issue of skills. However, we know that despite increasing proportions of facility-based births and the existence of a long list of evidence-based interventions to address the main causes of maternal death, little change has been documented.⁸ A further conundrum is why, for any given level of professional attendance at birth, maternal mortality is higher in sub-Saharan Africa than in other world regions.

Although the proportions of professionally attended births vary greatly between and within countries, the facts that approximately half of developing world births occur in a health facility and that rates are increasing justify an increased policy and research focus on births in such settings. Recognition of the role of health facility-based care in the Partnership's continuum of care also justifies this increased attention. Why are evidence-based interventions not being implemented? Is the in-service training approach for essential obstetric care effective at achieving lasting change in provider practice? What else besides training might result in improved behaviours and health system management? What are indications for the increasing numbers of caesarean sections being performed, and what impact, if any, does the provision of non-medically indicated caesarean sections have on the

health system's ability to provide life-saving obstetric care to the poor? Why has research remained focused on large hospitals when care at lower level facilities is more accessible to many in the population and likely to be more cost-effective? Given the realities of manpower shortages faced by developing countries today, which medical procedures could be safely performed by non-physicians? Eight years after publication of the evidence-based WHO manual, *Managing complications of pregnancy and childbirth*⁹ the pre-service curricula in many developing countries still do not address its recommendations. Why is that so and what can be learned about the strengths and weaknesses of that dissemination process before publication of the updated manual?

These questions and a host of others need to be rigorously assessed by clinical trials where possible, or at least quasi-experimental designs, and no longer assessed via simple pre-post evaluations or completely overlooked. The provider behaviour change trial by Althabe and colleagues¹ represents an excellent model. Furthermore, facility-based births constitute a captive audience from a research perspective, making data collection relatively inexpensive. Research foci need to expand beyond the evaluation of medical procedures to include effective implementation of those procedures. The effects of such work may well offer benefits beyond the labour and delivery ward. As Julio Frenk, former Minister of Health in Mexico, remarked in opening statements at the 2007 Women Deliver conference in London, maternal and child health are the best entry points to improvement of the health-care system. ■

References

Available at: <http://www.who.int/bulletin/volumes/86/4/08-052928/en/index.html>

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References

1. Althabe F, Buekens P, Bergel E, Belizan JM, Kropp N, Wright L, et al. A cluster randomized controlled trial of a behavioral intervention to facilitate the development and implementation of clinical practice guidelines in Latin American maternity hospitals: the Guidelines Trial: Study protocol [SRCTN82417627]. *BMC Womens Health* 2005;5:4. PMID:15823211 doi:10.1186/1472-6874-5-4
2. Gelbart N. *The king's midwife: a history and mystery of Madame du Coudray*. Berkeley, Los Angeles and London: University of California Press; 1998.
3. Johnson KC, Daviss BA. Outcomes of planned home births with certified professional midwives: a large prospective study in North America. *BMJ* 2005;330:1416. PMID:15961814 doi:10.1136/bmj.330.7505.1416
4. Costello A, Azad K, Barnett S. An alternative strategy to reduce maternal mortality. *Lancet* 2006;368:1477-9. PMID:17071268 doi:10.1016/S0140-6736(06)69388-4
5. Sibley LM, Sipe TA. Transition to skilled birth attendance: is there a future role for trained traditional birth attendants? *J Health Popul Nutr* 2006;24:472-8. PMID:17591344
6. Graham WJ, Bell JS, Bullough CHW. Can skilled attendance at delivery reduce maternal mortality in developing countries? In: De Brouwere VVL, Van Lerberghe W; ed. *Safe motherhood strategies: a review of the evidence*. Antwerp: ITG Press; 2001. pp. 97-130.
7. Statistical Annex: Millennium Development Goals, Targets and Indicators, 2007. United Nations Statistics Division: 2008. Available from: <http://millenniumindicators.un.org/unsd/mdg/Default.aspx> [accessed on 1 March 2008].
8. Hill K, Thomas K, AbouZahr C, Walker N, Say L, Inoue M, et al. Estimates of maternal mortality worldwide between 1990 and 2005: an assessment of available data. *Lancet* 2007;370:1311-9. PMID:17933645 doi:10.1016/S0140-6736(07)61572-4
9. *Managing complications in pregnancy and childbirth: a guide for midwives and doctors*. Geneva: WHO, UNFPA, UNICEF, World Bank; 2000.