WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA

ORGANISATION MONDIALE DE LA SANTE
BUREAU REGIONAL DE L'AFRIQUE

ORGANIZAÇÃO MUNDIAL DE SAÚDE
ESCRITÓRIO REGIONAL AFRICANO

REGIONAL COMMITTEE FOR AFRICA

AFR/RC53/RT/2
3 July 2003

Fifty-third session
Johannesburg, South Africa, 1–5 September 2003

ORIGINAL: ENGLISH

Provisional agenda item 11.2

SAFE MOTHERHOOD: IMPROVING ACCESS TO EMERGENCY OBSTETRIC CARE

Round Table 2

CONTENTS

Paragraphs

BACKGROUND 1–8

FRAMEWORK 9–18

CHALLENGES 19–22

DISCUSSION POINTS 23–28

EXPECTED OUTCOMES 29

BACKGROUND

1. The magnitude of the problem of maternal and newborn morbidity and mortality is not fully appreciated.

2. Maternal mortality is one of the leading public health problems in developing countries. Death associated with pregnancy, delivery and the first six weeks after delivery still affects approximately 600 000 women in the developing world.[1] Nearly half of these deaths occur in the African Region, a region that constitutes only 12% of the world's population and only 17% of the world's annual births.

3. Africa is the only region where there has been no improvement in maternal deaths for more than a decade. Indeed, the average maternal mortality ratio has increased from 870/100 000[2] live births in 1990, to 1000/100 000 live births in 2001.[3]

4. For every maternal death, at least twenty women are left incapacitated by the sequelae, *inter alia*, obstetric fistulae, chronic pelvic pain syndrome and infertility. The majority of these occur in poor women living in rural areas or disadvantaged and underserved communities in urban centres.

5. The main direct causes of maternal mortality in the African Region are haemorrhage during pregnancy, delivery and after delivery (25%); sepsis (15%); unsafe abortion (13%); pregnancy-induced hypertension (12%); and obstructed labour (8%). The indirect causes include malaria, anaemia, tuberculosis and HIV/AIDS.

6. Through timely access to appropriate emergency obstetric care (EOC), 75% of these maternal deaths could be averted. EOC refers to health system preparedness and response to complications as and when they arise.

7. Due to delays, women fail to access appropriate care when complications arise. These delays on the pathway to appropriate care are:

(a) the delay to seek care in health facilities: this is related to the woman's inability to decide if and when to seek appropriate care and the lack of birth preparedness within the family and community;

(b) the delay in reaching the appropriate health facility due to poor road and communication networks, lack of means of transportation and inadequate financial resources;

(c) the third delay refers to the time between the woman's arrival at the health centre and the facility's response in providing appropriate care; this delay may be the most critical for the survival of the pregnant woman and the newborn.

---

[1] Reduction of maternal mortality: A joint WHO/UNFPA/UNICEF/ World Bank statement, 1999.
[2] Maternal mortality estimates: Revised 1990 estimates of maternal mortality, WHO and UNICEF, April 1996.
[3] Maternal mortality in 1995, estimates developed by WHO, UNICEF, UNFPA, 2001.

8. In most countries of the Region, the health system remains weak and cannot adequately respond to the health needs of the mother and newborn. The health system is characterized by an inadequate number of skilled attendants; lack of necessary equipment, medications and supplies, and a poor referral system. In the African Region, available statistics show that skilled attendants are present for only 42% of deliveries. Studies show that the higher the proportion of deliveries with skilled attendants in a country, the lower the country's maternal mortality ratio[4] and neonatal mortality rate.[5]

FRAMEWORK

9. Following the review of implementation of the Safe Motherhood initiative and based on the lessons learned, the key interventions for accelerated maternal mortality reduction were identified as:

(a) prevention of unwanted pregnancy, and prevention and management of unsafe abortion;

(b) promotion of skilled attendance in pregnancy and childbirth;

(c) improvement of access to referral care when complications arise.

10. In 1999, WHO launched the Making Pregnancy Safer (MPS) initiative to reiterate its commitment to maternal mortality reduction. The aim of the MPS initiative is to ensure that women and their newborns have access to the care they need and deserve through strengthened health systems and appropriate community level action. To date, MPS is being implemented in 39 countries in the Region.

11. In spite of the global and regional initiatives, access to emergency obstetric care remains geographically, financially and culturally elusive to the majority of women in African countries, specifically the poorest of the poor.

12. Improving access to emergency obstetric care primarily involves addressing the barriers to quality EOC at all levels through:

(a) equitable distribution of services;

(b) adequate and skilled personnel coupled with delegation of authority and supportive supervision;

(c) creation of an enabling environment that promotes staff commitment and morale as well as client utilization.

13. At the community level, the health providers, extension health workers and traditional birth attendants present an entry point into the community and can play a very important role in improving

---

[4] Safe motherhood strategies: A review of the evidence, Brouwere V and Lerberghe K, 2001.
[5] Policy perspectives on newborn health, Population Reference Bureau and Save the Children, 2002.

access to EOC. The first and second delays can be addressed by training health workers to educate and encourage women, their partners and families to:

(a) recognize signs of life-threatening complications;

(b) know when and where to seek appropriate care when complications arise;

(c) develop birth preparedness plans, including emergency transport.

14. At the primary health care level, facilities should be equipped to offer basic emergency obstetric care services for normal delivery; manual removal of the placenta and retained products; and administration of intravenous sedatives, antibiotics and oxytocin.

15. The first referral level is a comprehensive EOC facility which offers all the basic emergency obstetric care services as well as surgical procedures, including caesarean section under anaesthesia and safe blood transfusion.

16. It is imperative to increase EOC coverage and access. For every 500 000 people, there should be at least four basic emergency obstetric care facilities and one comprehensive emergency obstetric care facility.

17. Due to inadequate communication systems, impassable roads and long distances between referral points, many women die enroute to a facility. The referral system should effectively link the different levels of health care, including the community level, to ensure a continuum of maternal health care.

18. In spite of numerous interventions, some maternal complications may still occur, but deaths from pregnancy and childbirth-related complications can be averted.

CHALLENGES

19. Most of the challenges to the provision of emergency obstetric care are linked to the ability and capacity of the health facility to provide critical EOC interventions. In general, health systems in most countries of the Region are very weak and this has major implications for the quality of EOC.

20. The barriers to emergency obstetric care include:

(a) frequent shortages or lack of medications, essential supplies and equipment;

(b) inadequate blood transfusion services;

(c) inefficient laboratory support services;

(d) inadequate staffing, shortage of appropriately trained personnel and lack of staff supervision;

(e) shortage of operating theatres for obstetric emergencies, resulting in delays in surgical interventions;

(f) weak policy on delegation of authority for the management of obstetric emergencies;

(g) mismanagement of obstetric complications as a result of staff incompetence, negligence or poor attitude.

21. Access to EOC is a multisectoral, multidimensional issue involving not only the health sector but also non-health and private sectors as well as civil society in the provision of basic social infrastructural amenities. This calls for a comprehensive national sector-wide approach with effective partnerships, and an improved stewardship role for government.

22. There is need to identify and scale up sustainable community initiatives such as community mutual and insurance schemes that allow access to transportation and funds for emergency care. This will improve linkages between the family and the various levels of care.

DISCUSSION POINTS

23. What are the necessary steps to establish and sustain a comprehensive emergency obstetric care system?

24. Is it possible to increase awareness of the magnitude of maternal and newborn morbidity and mortality at community, national and international levels?

25. Is it possible to improve the skills of the available health professionals in order to provide emergency obstetric care through devolution of functions and activities? What are the human, material and financial resource implications of this strategy?

26. Is it possible to ensure appropriate resource allocation and use for the strengthening of EOC services? What measures can be taken to ensure availability of essential supplies, medications and equipment, including safe blood?

27. What could be the components of an obstetric emergency preparedness and response plan at community and facility levels?

28. What are the possible strategies to strengthen the role of the community in ensuring women's access to skilled attendance during childbirth?

EXPECTED OUTCOMES

29. Expected outcomes of the present Round Table are:

(a) strategic direction and practical actions to improve access to emergency obstetric care in order to reduce maternal and newborn mortality;

(b) a proposal for an advocacy strategy to increase awareness of the magnitude of the impact of maternal and newborn morbidity and mortality on families, the community and the nation;

(c) a recommendation on a human resource development plan to ensure delegation of functions to appropriate cadres of health professionals for the provision of emergency obstetric care;

(d) recommendations on ways to ensure an increase in resource allocations for the strengthening of EOC;

(e) community level strategies for increased and sustainable accessibility to and utilization of EOC services.