

## IN PURSUIT OF COVERAGE AND QUALITY

By Monir Islam  
Director  
Making Pregnancy Safer



Photo credit: WHO / Christina Zück.

A few months ago, in the run-up to the Women Deliver Conference in London, I was struck by a comment in the leading medical journal *The Lancet*. The conference was one of the most high-profile events that MPS was involved with in the past year, and a great deal was written about it, both before and after it was held. Yet in a very few words, the comment seemed to zero in on an important issue that bears thinking about: “Generally, we know what to do to save the lives of women and mothers – and, in 2007, we do not need another technical conference to debate the issue of basic strategy.”<sup>1</sup>

As it happened, *Women Deliver* was far from being just another technical conference (see page 24). But *The Lancet* provided a timely reminder of an important fact: the Making Pregnancy Safer agenda is a pretty simple and clear one, backed by a high degree of consensus among practitioners and researchers. In essence, organizations that care about maternal and newborn care need to concentrate on the three “pillars” of the agenda:

- family planning so that women only get pregnant when they want and are ready to do so;
- skilled care during pregnancy, and particularly during delivery;
- emergency obstetric care to deal with complications.

These pillars get even better results if they are accompanied by good antenatal and postnatal care.

From the services point of view, that’s basically it. As the teenagers say, “It isn’t rocket science”. The equipment and medicines required are not “high-tech”, the training is rigorous but not complicated, and the costs are predictable and manageable.

### ■ Gaps in coverage and quality

So why, 20 years after the landmark Safe Motherhood Conference in Nairobi, are so many countries in danger of missing the targets set by the Millennium Development Goals for reducing maternal and infant mortality? Why are there 75 million unwanted pregnancies each year, and 536 000 deaths from complications during childbirth? And why is it that a rising proportion – currently 40% – of child deaths are newborns?<sup>2</sup>

A large part of the answer is contained in one word: “coverage”. In some priority countries, there are simply not enough skilled personnel and not enough facilities (clinics, hospitals, etc.) to provide care for all mothers and newborns. In others, the coverage is unequally distributed between cities and the countryside. For instance, while approximately half of the world’s



women have a skilled birth attendant present during delivery, this proportion is highly skewed: while three quarters of urban women have an attended birth, only about one third of rural women do so. Coverage is also skewed by income – in fact, recent research in 50 countries shows that skilled care at delivery is the health service where the gap between rich and poor is the widest (compared to immunization or treatment of fever, for instance)<sup>3</sup>. Finally, coverage of specific services – even basic ones that are known to work well and do not cost much – is far too low.

Why do we have such inequities in coverage? On the “supply” side, perhaps the biggest problem is lack of trained staff, although other important factors include insufficient equipment and medicines, and poor distribution of facilities. But even if the staff and equipment are available, the fact is that many women are prevented from accessing services by cost barriers, and by obstacles related to women’s low status in many societies.

And of course the coverage gap is not the only problem. There is also a quality gap that needs to be confronted. Although we know of many examples of people doing great work in difficult conditions, the fact is that many health-care staff are under-paid, under-trained and under-motivated. Similarly, a great deal of equipment is badly

maintained, improperly applied, and simply not appropriate for the job. As a result many women and newborns are not getting an adequate standard of care, which has a negative impact on the care-seeking behaviour of women.

#### ■ Moving ahead

Both coverage and quality have to be addressed at the same time if we are ever to achieve the Millennium Development Goals 4 and 5. That will take a lot of work on the individual components that fall within the three pillars of maternal and newborn health. But it is unrealistic to imagine that the problem is purely technical in nature. The three pillars mentioned above need to be built on a solid foundation that includes advancing the rights of women, political commitment, a functioning health system and adequate financing.

In 2007 MPS continued its work with both the technical pillars and the foundations. On a purely technical level, we helped to improve some of the tools that can really make a life-or-death difference in a difficult delivery. See, for example, the field-testing of a lighter, simpler vacuum extractor (a cup attached to the head of the baby using suction to help guide the newborn out) which can be used by a single operator – a very helpful advance in

places where skilled personnel are scarce (see page 19). To help increase the availability and expertise of skilled birth attendants, the Department continued its strategy “training of trainers” with partners such as the Faculty of Nursing at Thailand’s Chiang Mai University (see page 45) and the University of Chile’s School of Midwifery (see page 37). We worked on improved approaches to using existing resources more effectively, such as in the FANC initiative in Africa (see page 30) which increases the benefits that women get from each visit to their antenatal clinic.

#### Footnotes:

1. Starrs, AM. Delivering for women. *The Lancet*, 2007, 370:1285-1287.
2. Unless otherwise specified, all figures are from: *The World Health Report 2005*, Geneva, World Health Organization, 2005; *Neonatal and perinatal mortality. Country, regional and global estimates 2004*. WHO, UNICEF, UNFPA, The World Bank, 2007.
5. Gwatkin, DR. How much would poor people gain from faster progress towards the Millennium Development Goals for health? *The Lancet*, 2005, 365:813-7.



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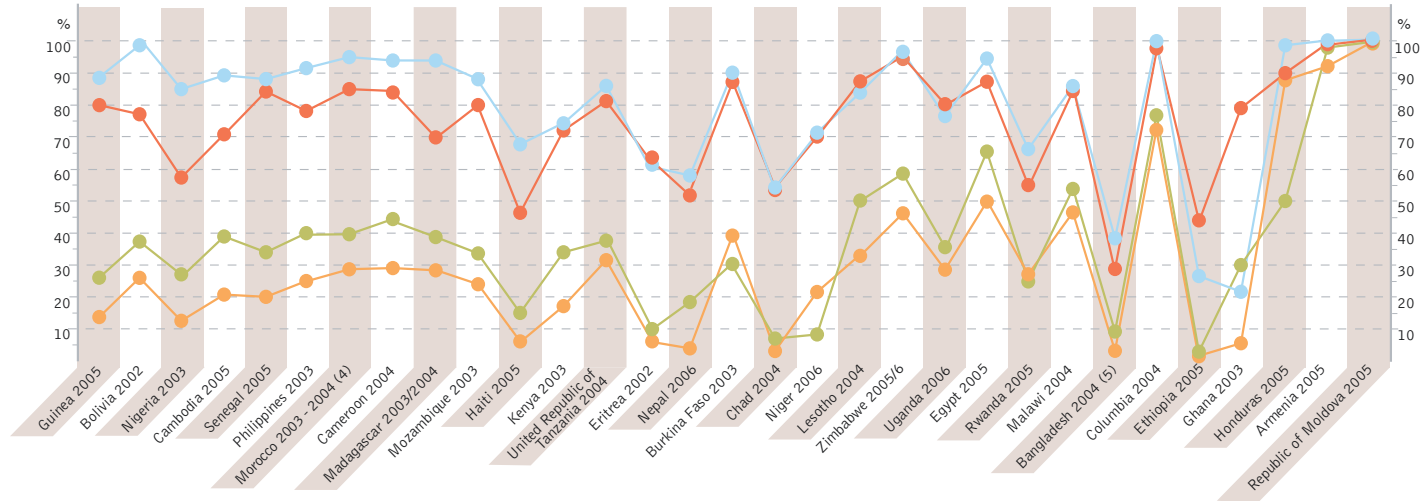
A particularly gratifying aspect of the year was the success achieved in raising the international profile of maternal and newborn health through conferences such as Women Deliver and the London Meeting of Women Parliamentarians (see page 24). We were very pleased to see the attention drawn to maternal health care at the World Economic Forum in Davos, when some very influential women from the worlds of politics, business and the arts spoke their minds on the tragedy of maternal mortality (see page 25). Such events are an effective means of prioritizing of the Making Pregnancy Safer issue not just among regional and national agendas but on the global stage. Less glamorous, but equally important, we continued to emphasize building the evidence base through epidemiological surveillance and other data-gathering approaches.

As we move forward in 2008 and beyond, MPS is also helping to raise awareness and response to maternal and newborn mortality and morbidity in countries experiencing crisis through natural or man-made disasters. Recent experiences following the Tsunami and the Pakistan earthquake have shown how maternal complications become far riskier for women in times of weakened or non-existent infrastructure and resources. Therefore our hope is to help build national and regional capacity to prepare for, respond to and recover

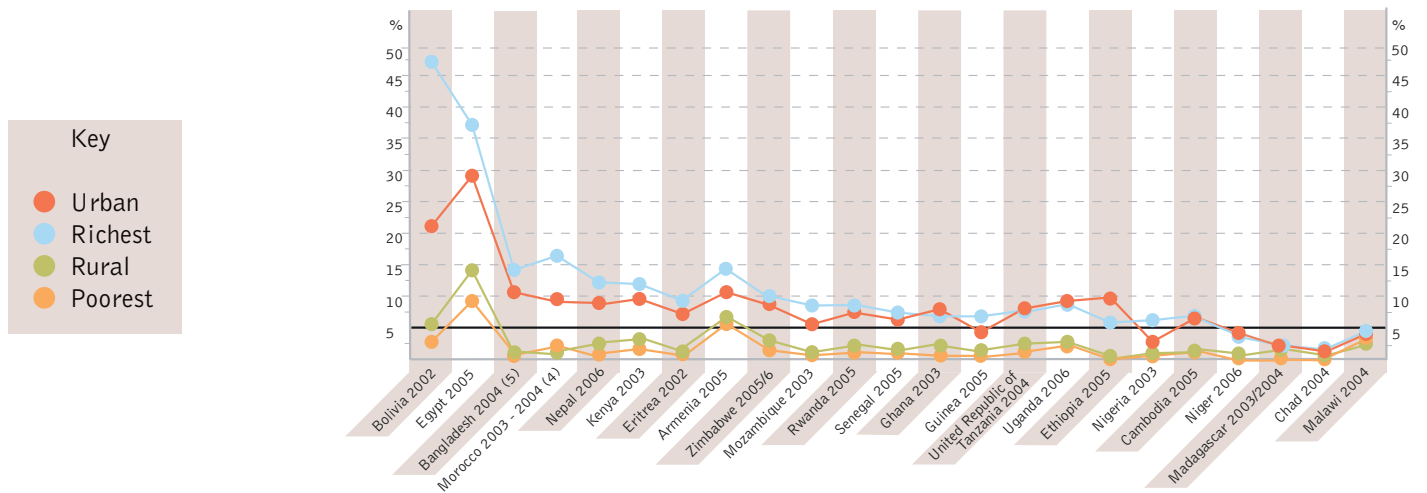
from such emergencies.

Let me finish by noting that our work is done in cooperation with a wide range of partners, and support comes from a variety of sources, many of whom are mentioned in this report. I thank them all for their help, and in the current year and those to come, I look forward to continuing these partnerships, making them stronger and developing new ones towards the global effort of promoting maternal and newborn health.

**FIGURE 1.**  
**Childbirths assisted by skilled birth assistant - DHS data from 2001 - 2006 (31 countries)**  
 Characteristic of delivery: Percent distribution of live births assisted by a skilled birth attendant in the last five years preceding the survey.



**Childbirths delivered by caesarean section - DHS data from 2001 - 2006 (23 countries)**  
 Characteristic of delivery: Percent distribution of live births delivered by caesarean section in the last five years preceding the survey.



Footnotes: 4) The Morocco Survey was a collaboration between MEASURE DHS+ and PAFAM of the League of the Arab States.  
 5) Data collected for women aged 10-49, indicators calculated for women aged 15-49.