Making pregnancy safer: the critical role of the skilled attendant

A joint statement by WHO, ICM and FIGO

Making Pregnancy Safer
Department of Reproductive Health and Research
World Health Organization
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1. Introduction

In 2000, the largest-ever gathering of heads of state at the United Nations in New York, USA, adopted the UN Millennium Declaration. This historic compact among nations includes eight critical goals—the Millennium Development Goals (MDGs)—for combating poverty and accelerating human development. Two of the eight MDGs relate to reducing child mortality and improving maternal health, respectively, pointing to the importance of these health factors in global development and poverty reduction.

The World Health Organization (WHO), the International Confederation of Midwives (ICM) and the International Federation of Gynecology and Obstetrics (FIGO) are pleased to see the inclusion in the MDGs of the target to reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio. This inclusion is the result of many years of advocacy (by WHO, ICM and FIGO, among others) for the need to recognize the link between maternal health and development.

The MDGs send yet another reminder to planners and policy-makers that for the world's poor motherhood still carries a high risk of morbidity and mortality. But years of previous work in making motherhood safer has not all been in vain. There is now a global consensus on what must be done to eliminate the menace of maternal deaths once and for all. Already in 1999, a joint WHO/UNFPA/UNICEF/World Bank statement[1] called on countries to "ensure that all women and newborns have skilled care during pregnancy, childbirth and the immediate postnatal period".

Skilled care refers to the care provided to a woman and her newborn during pregnancy, childbirth and immediately after birth by an accredited and competent health care provider who has at her/his disposal the necessary equipment and the support of a functioning health system, including transport and referral facilities for emergency obstetric care. Since skilled care as defined above can be provided by a range of health professionals, whose titles may vary according to specific country contexts, it has been agreed to refer to this health care provider as the "skilled attendant" or, "skilled birth attendant", so as to avoid confusion over titles. Thus:

> **a skilled attendant is an accredited health professional — such as a midwife, doctor or nurse — who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.**[2]

For a detailed list of the skills and abilities needed to become a skilled attendant see Section 2.

In issuing this statement, WHO, ICM and FIGO are advocating for skilled care during pregnancy, childbirth and the immediate postnatal period. This statement is especially aimed at countries in which the coverage of skilled attendance at birth is below 85%. The statement defines clearly who is a skilled attendant, what skills she/he should have and how she/he should be trained and supported.

The health care needs of pregnant women and newborns and the WHO, ICM, FIGO pledge

In childbearing, women need a **continuum of care** to ensure the best possible health outcome for them and their newborns. The continuum starts with the woman and her family in the woman's own home — i.e. self-care and prevention. It is followed by the first level of health care (at a health post, clinic or in the client's home) and involves the provision of high-quality midwifery care. This care can continue at the first level in cases in which the pregnancy, birth and postnatal period remain free

[1] *Reducing maternal mortality. A joint statement by WHO/UNFPA/UNICEF/World Bank*. Geneva, World Health Organization, 1999.

[2] This revised definition has been endorsed by the United Nations Population Fund (UNFPA) and the World Bank.

from complications. However, when complications occur, women and/or their newborns will need care at secondary or tertiary levels of the health system, depending on the seriousness of their respective condition.

The successful provision of the continuum of care requires a functioning health care system with the necessary infrastructure in place, including transport between the primary level of health care and referral clinics and hospitals. It also needs effective, efficient and proactive collaboration between all those involved in the provision of care to pregnant women and newborns.

The skilled attendant is at the centre of the continuum of care. At the primary health care level, she/he will need to work with other care providers in the community, such as traditional birth attendants and social workers. She/he will also need strong working links with health care providers at the secondary and tertiary levels of the health system.

Recognizing the pivotal role of the skilled attendant in reducing maternal and newborn mortality and morbidity, WHO, ICM and FIGO undertake to work together to increase access to skilled attendants for all women and newborns in pregnancy, childbirth and the immediate postnatal period. Working in collaboration with the member associations of ICM and FIGO and with WHO Member States, the three organizations will urge governments, policy–makers, health care providers, donors and communities to increase access of childbearing women and their families to a continuum of skilled care.

Why focus on skilled attendants?

At the community level, the skilled attendant will often be the only qualified and accredited health care worker with exclusive responsibility for the care of women during pregnancy, childbirth and the immediate postnatal period. Certainly, others — ranging from traditional birth attendants (TBAs), nurses to specialist physicians — will contribute to the care of women and newborns, but none of these will have either the wide-ranging competence or the mandate for all the tasks the skilled attendant is required to perform. By focusing on skilled attendants, WHO, ICM and FIGO hope to highlight the significance of this crucial function within the health care system for saving the lives of mothers and newborns. Unfortunately, in spite of overwhelming evidence from developed countries on the value of skilled attendants, and from the developing countries that in recent years have succeeded in lowering their maternal mortality ratio, sufficient numbers of skilled attendants remain unavailable in many developing countries.

Why focus on skilled attendants now?

Well intended efforts to reduce maternal and newborn mortality and morbidity have been under way for more than a decade. These efforts have resulted in success in a few countries, but regrettably, progress in most countries has been unacceptably slow. Experience from past projects and ongoing research point to the importance of access to a functioning health care system as a key factor in reducing maternal mortality. Currently, as part of economic development support linked to MDG targets, health systems are being reformed and strengthened in many developing countries. WHO, ICM and FIGO believe that this is an opportune moment to push the case for skilled attendants with a view to ensuring that this vital function is institutionalized in the newly reformed/developing health systems.

2. Skilled attendant: the required skills and abilities

Core skills and abilities

All skilled attendants *must* have the core midwifery skills.[3] The additional skills required will vary from country to country, and possibly even within a country, to take account of local differences such as urban and rural settings.

All skilled attendants, at all levels of the health system, must have skills and abilities to perform *all of the core functions* listed below.

- Communicate effectively cross-culturally in order to be able to provide holistic "women-centred" care. To provide such care skilled attendants will need to cultivate effective interpersonal communication skills and an attitude of respect for the woman's right to be a full partner in the management of her pregnancy, childbirth and the postnatal period.
- In pregnancy care, take a detailed history by asking relevant questions, assess individual needs, give appropriate advice and guidance, calculate the expected date of delivery and perform specific screening tests as required, including voluntary counselling and testing for HIV.
- Assist pregnant women and their families in making a plan for birth (i.e. where the delivery will take place, who will be present and, in case of a complication, how timely referral will be arranged).
- Educate women (and their families and others supporting pregnant women) in self-care during pregnancy, childbirth and the postnatal period.
- Identify illnesses and conditions detrimental to health during pregnancy, perform first-line management (including performance of life-saving procedures when needed) and make arrangements for effective referral.
- Perform vaginal examination, ensuring the woman's and her/his own safety.
- Identify the onset of labour.
- Monitor maternal and fetal well-being during labour and provide supportive care.
- Record maternal and fetal well-being on a partograph and identify maternal and fetal distress and take appropriate action, including referral where required.
- Identify delayed progress in labour and take appropriate action, including referral where appropriate.
- Manage a normal vaginal delivery.
- Manage the third stage of labour actively.[4]
- Assess the newborn at birth and give immediate care.
- Identify any life threatening conditions in the newborn and take essential life-saving measures, including, where necessary, active resuscitation as a component of the management of birth asphyxia, and referral where appropriate.

[3] Core midwifery skills have been defined by the International Conferderation of Midwives in adocument entitled Essential Competencies for Basic Midwifery Practice, available at http://www.internationalmidwives.org

[4] Active management of the third stage of labour includes: using oxytocic drugs, clamping and cutting the chord, and applying controlled chord traction.

- Identify haemorrhage and hypertension in labour, provide first-line management (including life-saving skills in emergency obstetric care where needed) and, if required, make an effective referral.
- Provide postnatal care to women and their newborn infants and post-abortion care where necessary.
- Assist women and their newborns in initiating and establishing exclusive breastfeeding, including educating women and their families and other helpers in maintaining successful breastfeeding.
- Identify illnesses and conditions detrimental to the health of women and/or their newborns in the postnatal period, apply first-line management (including the performance of life-saving procedures when needed) and, if required, make arrangements for effective referral.
- Supervise non-skilled attendants, including TBAs where they exist, in order to ensure that the care they provide during pregnancy, childbirth and early postpartum period is of sound quality and ensure continuous training of non-skilled attendants.
- Provide advice on postpartum family planning and birth spacing.
- Educate women (and their families) on how to prevent sexually transmitted infections including HIV.
- Collect and report relevant data and collaborate in data analysis and case audits.
- Promote an ethos of shared responsibility and partnership with individual women, their family members/supporters and the community for the care of women and newborns throughout pregnancy, childbirth and the postnatal period.

Skilled attendants working at the primary care levels in remote areas with limited access to facilities should also be able to do the following:

- Use vacuum extraction or forceps in vaginal deliveries.
- Perform manual vacuum aspiration for the management of incomplete abortion.
- Where access to safe surgery is not available, perform symphysiotomy for the management of obstructed labour.

Advanced (optional) functions that may also need to be performed by selected skilled attendants working at a referral facility include, but are not limited to, the following:

- Perform Caesareans sections.
- Manage complications during pregnancy and childbirth.
- Administer blood transfusions.

The exact set of additional and advanced skills must be determined and agreed upon nationally, depending on need, country context and policy and regulatory framework. In some cases, where the skilled attendant is the only primary health care worker, additional functions may also include, for example, identification and management of gynaecological problems, management of nutritional problems and initial treatment for injuries.

Surgery and anaesthesiology skills

Skills in surgery and anaesthesiology are critical for the management of complications in pregnancy and childbirth. Where skilled attendants do not themselves have these skills, they must be able to refer women to other health professionals who have them. In such cases, skilled attendants must work closely with these professionals in order to ensure that speedy action is taken, as soon as the need for surgery and appropriate follow-up and care have been established.

Some countries that are facing a severe shortage of physicians trained in surgery and/or anaesthesiology have successfully trained nurses, midwives and other cadres of health workers to perform or assist in Caesarean section operations and other pregnancy-related complications. Where people with these skills are health care workers other than the skilled attendant, the skilled attendants must be able to identify the need to operate and provide ongoing and follow-up midwifery care.

Supplementary skills and knowledge

In certain country situations — depending on the local epidemiological and/or socio-demographic factors (for example, areas where malaria is endemic and post-conflict or refugee situations), or on the capacity of the health system — there will be a need for some skilled attendants to have supplementary skills in areas such as psychiatry and paediatric neonatology. Also, in some instances, particularly at the referral level, skilled attendants may also need to have knowledge of genetics in order to advise couples about the risks of hereditary conditions.

The overall health of a woman (physical and psychological) and the environment in which she lives determine her needs during pregnancy, childbirth and the postnatal period and influence the progression of the pregnancy and its outcome. Thus, some women and their families will need and request additional, sometimes specialist, assistance — for example, when a woman has an underlying medical or psychological condition or when the woman or her family are experiencing severe social problems, including difficult relationships or violence in the home. The skilled attendant will need to be equipped to deal with such requests in settings where referral is not possible.

Collaboration with other health professionals

As stated on page 2, to be effective, the skilled attendant will need the collaboration of various health care professionals at different levels of the health system and other care providers (including TBAs, traditional healers, social workers, etc.), where they exist. Such collaboration will help to provide access to the full range of care women and/or their newborns may need, thus ensuring the required continuum of care. The collaboration, however, must be based on mutual respect and recognition of the specific contribution each type of care provider makes to the continuum of care. Also, the collaboration's effectiveness will hinge on, and will be underpinned by, the organization of health care and social welfare within a community. Where the skilled attendant operates as part of a team, there must be good collaboration between all team members.

3. Planning a strategy for the provision of skilled attendants

Critical factors in the planning process

In planning a strategy for the provision of skilled attendants for all childbearing women and their newborns, the following five factors are especially important:

- the geographical diversity within the country
- the types of health care professionals currently fulfilling the role of the skilled attendant
- the organization and structure of the health system
- the special needs of women with underlying health conditions
- monitoring of, and reporting on, the percentage of births attended by skilled attendants, and the percentage of women attended at least once during pregnancy by skilled health personnel for reasons relating to pregnancy.

Each of these factors needs careful consideration and should be decided upon in collaboration with all relevant stakeholders, including, among others, the various health professionals (and, where they exist, their professional associations) and women and their families (either through established community representatives or through community organizations, etc.). The specific issues within each of these factors are elaborated below.

The geographical diversity

Regions within countries often vary considerably, and it is unlikely that a strategy that works in, for example, an urban area will also work in a rural area. In sparsely populated rural areas, for instance, it may not be advisable to appoint a skilled attendant specializing only in midwifery skills. In such areas the health care worker may need to be multi-skilled. Also, for the very-hard-to-reach populations, the only way of ensuring that pregnant women have access to a skilled attendant may be to encourage them to move near a health care facility, especially as the time for birth approaches, and stay there until the child is born.[5] Geographical factors have important implications for the provision of the continuum of care, especially with regard to effective referral where infrastructure (roads, transport, etc.) is poor or absent. Hence, in the context of geographical diversity, infrastructural issues will be paramount in how care is organized.

Types of health care professionals serving the role of the skilled attendant

In many countries where pregnant women receive care from skilled attendants, various types of health professionals (accredited midwives, nurse-midwives, doctors and nurses with midwifery skills and specialist obstetricians — see Box 1 for definitions of these terms) are known to be fulfilling the role of the skilled attendant. To provide the required continuum of care, the health system needs to plan for care beyond what the skilled attendant can provide. In each country the

[5] Some countries have set up "maternity waiting homes" for women living in areas far from health centres. However, such a step should be decided upon after very careful thought. The potential of this advice for seriously disrupting the lives of women and their families is substantial.

Box 1

Types of skilled attendants and the mix of skills and abilities

While it is up to each country to decide on how maternity care should be organized, much depends on the availability of skilled attendants, the composite set of skills and abilities they possess and the resources available to recruit, train and retain these staff. The principal categories of skilled attendants found in many countries include:

- **Midwives (including nurse-midwives)**: Persons who, having been regularly admitted to an educational programme duly recognized in the country in which it is located, have successfully completed the prescribed course of studies in midwifery and acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.
- **Nurses with midwifery skills**: Nurses who have acquired midwifery knowledge and skills either as a result of midwifery being part of their nursing curricula or through special post-basic training in midwifery.
- **Doctors with midwifery skills**: Medical doctors who have acquired competency in midwifery skills through specialist education and training, either during their pre-service education or as part of a post-basic programme of studies.
- **Obstetricians**: Medical doctors who have specialized in the medical management and care of pregnancy and childbirth and in pregnancy-related complications, but not usually complications of the newly born infant. They have usually undergone additional education and clinical training to acquire these additional skills and have been certified or accredited in obstetrics.

mix of health professionals involved in the continuum of care needed by women and newborns at different levels of the health system will vary depending on the national or local structure of the health system and the respective skills and abilities of the health professionals (see also section on *Reporting on the proportion of births attended by a skilled attendant* on page 10). The role of each type of professional involved must be clearly defined within the strategy for the provision of skilled attendants. This will help to ensure team work and build trust and respect for each profession's role in the provision of care. To help the strategy to succeed, the health professionals should also develop a unified policy and joint action plans to work towards the establishment of national and local quality standards of care for maternal and newborn health. This work must address not only the provision of care, but also the actions required to strengthen the health system, including working with the community and its traditional healers and TBAs (see Box 2 below) where they exist. It is important to encourage good collaboration and an unbroken chain of care between the community and the health system, including referral between the different levels of care.

The organization and structure of the health system

In the provision of skilled care, the importance of a functioning health system cannot be overemphasized in terms of the need for an enabling environment. Thus, the outreach and organization of the health system are critical to the success of the strategy for the provision of skilled attendants. Also important are the evidence-based health policies that support the work of the health care workers, the standards and protocols that define their work, and the arrangements

Box 2

The role of traditional birth attendants (TBAs)

Who is a TBA?

Strictly, the term TBA refers *only* to traditional, independent (of the health system), non-formally trained and community-based providers of care during pregnancy, childbirth and the postnatal period.

Can TBAs provide the necessary care for women and newborns?

Because TBAs already exist in many developing country communities, it has been suggested that they could perform the role of the skilled attendant, where required with some training. Research indicates that training of TBAs has not contributed to reduction of maternal mortality. However, it is recognized that for some women TBAs are the only source of care available during pregnancy. And as experience from some countries such as Malaysia[6] has shown, TBAs can become an important element in a country's safe motherhood strategy and can serve as key partners for increasing the number of births at which a skilled attendant is present.

Incorporating TBAs into a strategy to provide skilled attendants

It is now generally accepted that one of the main reasons why many TBA-based maternity care programmes of the past did not work, or were unsustainable, was that the programmes failed to link TBAs to a functioning health care system. Hence, in many instances, the TBAs did not work within an "enabling environment"—one in which health care providers at primary, secondary and tertiary levels of the health system function as a team, and in which drugs and equipment are available and effective supervision and systems of referral are in place.

To be effective, all health care workers, regardless of the skills they possess, need a supportive enabling environment. Where the decision is made—for cultural or other reasons—to incorporate TBAs into a skilled attendant strategy, the above reasons for past failures must be considered. Experts believe that the best role for the TBA in the skilled attendant strategy is to serve as an advocate for skilled care, encouraging women to seek care from skilled attendants. TBAs will be able to perform this role effectively only when there are good working relations between TBAs, skilled attendants, and staff in referral facilities. The TBA must be welcomed by the health care system and seen as an extension of it.

Important note: Lessons learnt to date show that investing in strategies based *solely* on TBAs has historically caused governments to delay the development and implementation of strategies for ensuring that skilled attendants are available to all women and newborns. To avoid falling into this trap, the decision to incorporate TBAs into the strategy for the provision of skilled care should be an interim step of a longer-term plan for training and providing sufficient skilled attendants.

Continued

[6] Pathmanathan I et al. *Investing effectively in maternal and newborn health in Malaysia and Sri Lanka.* Washington DC, World Bank, 2003.

Box 2 (continued)

In practical terms TBAs, can help in the provision of skilled care to women and newborns by:

- serving as advocates for skilled attendants and maternal and newborn health needs
- encouraging women to enrol for essential pre- and postnatal care and to obtain care from a skilled attendant during childbirth
- helping women and families to follow up on self-care advice and other recommendations (nutrition, treatment, dietary supplementation, immunization, scheduled appointments, plan for births and emergencies, etc.)
- encouraging the involvement of the male partner in the care of the woman and their newborn
- disseminating health information through the community and families (danger signs, where and how to seek care, healthy life styles, where to seek assistance for other reproductive health needs such as family planning, neonatal immunization, etc.) where this role is not the mandate of the skilled attendant
- giving social support during and after delivery, either as a birth companion — for example, acting as a *doula* (a South African term for a specially trained woman providing social support to women in labour) — or by supporting the household while the woman is away for childbirth
- informing the skilled attendant about women who have become pregnant in the community so that the skilled attendant can make direct contact with them
- serving as a link between families, communities and local authorities and the reproductive health services
- encouraging community involvement in the development/maintenance of the continuum of care.

In many countries TBAs represent a resource that can be developed with appropriate support, education and training, but cannot replace the need for all women to have care from a skilled attendant. The younger and the most able TBAs, with educational backing and access to appropriate adult education programmes, may be able to enter a midwifery programme. Alternatively, they may become auxiliary midwives or support workers for skilled attendants.

for ensuring that the required supplies of essential medicines and equipment are available. A functioning health system also requires suitable buildings, enough staff, the right mix of professional skills, satisfactory terms of employment, etc. In addition, there needs to be in place a referral system and effective monitoring, supervision and training of staff. All these factors need to be considered in developing the strategy for the provision of skilled attendants.

The problem is further exacerbated in cases of health professionals working in isolated rural areas with no back up or with little or no support or supervision. It is important to note that skilled attendants must be able to provide care outside the regular working hours and deal with unpredictable work patterns. The need to provide a 24-hour service can be incompatible with routine scheduled clinic work, unless the midwifery workload is very low. In such cases the problem of maintaining midwifery skills and abilities may arise. For skilled attendants who work in rural areas unsupervised, local mechanisms should be found to provide opportunities for such staff to work for short periods in nearby maternity facilities in order to ensure that they are able to maintain their midwifery skills.

Special needs of women with underlying health conditions

The needs (and thus the required care) of women in good health with an uncomplicated pregnancy and childbirth will differ drastically from those with an underlying health problem or those requiring management of a complicated pregnancy or childbirth. Although in theory women with an underlying health problem are at a greater risk of developing a complication in pregnancy and/or childbirth compared with healthy women, the type of care needed depends on the actual underlying problem.

In many countries care of pregnant women with underlying health problems is considered to be the responsibility of doctors with midwifery skills or specialist obstetricians, with the care of healthy pregnant women with no complications being left to midwives or nurses with midwifery skills. This separation may be too simplistic and may create problems in the effective management of pregnant women. In reality the complementarity between the individual types of health care professional (medical and midwifery) needed to care for women with underlying health problems varies from one country to another, and sometimes even within a country. In this regard it is important to bear in mind that in places where a doctor with midwifery skills is unavailable at the primary care level, the skilled attendant will need to be able to care also for women with specific underlying health problems. In any case, regardless of their health status, all pregnant women need standard midwifery care, health education, emotional support, and help with preparing for pregnancy and childbirth (including emergencies). Doctors often do not have the skills required for the above tasks, unless they have been specifically trained in them. On the other hand, regardless of the health status at the onset of pregnancy, any woman can develop a pregnancy-related complication that needs specialist care by a trained doctor. Hence, decisions related to division of responsibilities should be based on the skills and abilities needed to serve women and their newborns, rather than on arbitrary professional classifications.

Reporting on the proportion of births attended by a skilled attendant

Since the world has set itself in the MDGs a specific target for the reduction of maternal mortality (see page 1), and since the proportion of births attended by a skilled attendant is a key indicator of progress towards that target, it is imperative that national health systems keep careful records of the progress made in the provision of skilled attendants to their populations. Hence, record-keeping and reporting systems for the proportion of births attended by skilled attendants must be an integral part of the strategy for the provision of skilled attendants.

One potential problem in reporting on the proportion of births attended by a skilled attendant has been the differing interpretations as to who is, and who is not, a skilled attendant (see Box 1 for the types of health professionals providing skilled care). Problems arise particularly in settings where there is no specific cadre of workers assigned to provide health care during pregnancy and childbirth. The precise skills and abilities of health care providers working under various titles and reported as providing "skilled care" can only be clarified at the local level. Simply counting the number of health care providers (such as doctors and nurses), or the number of deliveries in health facilities, in a country will not allow accurate measurement of the proportion of births attended by a skilled attendant. Although midwives are recognized as specialist skilled attendants, and therefore it should be possible to know how many are available in a given country, it is still important to review their actual skills and abilities against those required (see pages 3-5) to qualify as a skilled attendant.

In some countries there is no mechanism for licensing or regulating midwifery, because midwifery is not recognized as a specific speciality. In a number of these countries midwifery skills are included within the nursing curriculum, or nurses have the possibility of acquiring further training that also includes midwifery. In cases in which such extra training gives nurses sufficient midwifery skills, and where competency in midwifery can be assured (through formal accreditation) to meet the definition of the skilled attendant, the qualified nurses can be recognized and deployed as skilled attendants and counted as such in national figures.

The main difficulty arises in countries where midwifery is not regulated at the national level as a distinct area of medical practice — and hence often not included (or is not identifiable) in the curricula of any type of health professional. In these countries there is no clear way of distinguishing between nurses (and sometimes even doctors) that qualify as skilled attendants and those that do not. In such situations, deployment of staff can be an issue unless there is some way in which only the nurses with verified midwifery competency (where their competency in midwifery has been assessed by some independent and reliable method) are posted and permitted to work as skilled attendants. Problems can also arise where the nurse or the doctor is required to have skills in many other areas/specialities of health care apart from midwifery skills. Additionally, health professionals who hold multipurpose posts can have difficulty with "role-conflict" as they are often overburdened with many tasks.

Thus, for planning and reporting purposes, there must be a mechanism for recording the numbers of nurses and doctors who possess midwifery skills and abilities and the possibility of distinguishing which and how many health professionals are skilled attendants. Re-accreditation/licensing can also be an issue, especially for the health professionals who are multi-skilled and need to demonstrate competency in a number of areas.

4. Education and regulation of skilled attendants

Pre-service education

Pre-service education of skilled attendants must be based on teaching specific skills and abilities, including life-saving skills. The education process must include an assessment of the students' skills and abilities by reliable methods.

Apart from enabling students to acquire the required technical skills and abilities, the education programme must ensure the trained skilled attendants have the following attributes:

- A broader public health perspective, and not one that is focused on providing technical aspects of care only.
- Awareness of the full range of their professional and ethical responsibilities. The latter include not only respect for human rights, but also the understanding that skilled attendants have the moral responsibility to influence policies related to reduction of maternal and perinatal mortality and advocate for access to skilled care during pregnancy, childbirth and the postnatal period, especially for the poor.
- Capability to provide holistic care with a social as well as a technical/medical dimension. Also, it must ensured that the trained skilled attendants are capable of functioning within a multidisciplinary team in different types of settings. The latter is particularly important where resources are scarce as there is a need to operate at times in sub-optimal environments, especially initially while the health system is being strengthened.
- Knowledge, skills and personal attributes to provide quality care as defined in the national standards of care for maternal and newborn health, which must include being able to apply the core skills and abilities for a skilled attendant to perform the functions listed in Section 2 of this document.
- A sense of duty and the motivation to promote fairness, quality and equity in providing services.
- Ability to reflect on, and learn from, experiences.

Regulation and licensing of skilled attendants

In order to protect the public — and indeed the practitioners also — it is important to regulate and license the skilled attendants themselves, the institutions in which they work and the programmes and establishments used in their training. It is also essential not to give the licence or accreditation "for life". Hence, a licensing body and a set of accreditation requirements and procedures must be instituted for the accreditation (and re-accreditation) of skilled attendants, their places of work and their training programmes and training institutions, for fixed periods of time. For the individual skilled attendant this should be based on her/his ability to demonstrate that she/he has the required skills and abilities to practise the profession safely as per the national requirements. The licensing of training institutions and workplaces must be undertaken within the relevant regulatory/licensing frameworks in existence in the country.

The following mechanisms are currently in use in some countries for re-licensing or re-accreditation of skilled attendants:

- *Continuing education schemes* under which practitioners take specialized and approved education programmes aimed at strengthening or building new or additional skills and abilities.
- *Re-accreditation schemes*, such as providing a portfolio of work experience or training or other evidence that the practitioner has been functioning well as skilled attendant and is still able to demonstrate skills and abilities in midwifery.
- *Supervision models*, in which practice is subjected to periodic or more routine ongoing assessment either from the skilled attendant's supervisor or, increasingly, through peer assessment/review, clinical practice audits, or some other similar mechanism. The most successful supervision models are those that provide supportive supervision allowing for free exchange of ideas and feedback on performance (both positive as well as negative) and are not seen as punitive in nature.

Regardless of the type of mechanism used, it is important to ensure that the process is transparent, fair, and robust. To ensure that these attributes are sustained, the mechanism will need to be evaluated periodically. There will also be a need for instituting mechanisms that enable previously practising skilled attendants to return to service after a prolonged absence — e.g. long leave, career breaks, etc.

5. The need for an enabling environment

The health system

The "enabling environment" has sometimes being described as a well functioning health system. For the health system to function effectively, at least the following must be in place:

- Regulatory frameworks and policies that not only protect the public, but also support the provision of effective maternal and newborn health care and allow skilled attendants to provide all necessary care, including where required essential life-saving skills.
- Standards and protocols that define what is high-quality maternal and newborn health care.
- Adequate human resources and management systems. This includes ensuring that there are:
    - sufficient skilled attendants with all the necessary skills (including where required skilled attendants with additional skills) deployed where they are needed
    - satisfactory pay scales and career advancement opportunities
    - continuing education opportunities to maintain and upgrade skills
    - supportive supervision mechanisms to ensure skilled attendants can continually assess their own practice (as a mechanism for improvement of quality of their work), and obtain assistance in dealing with complicated cases, where they feel they are reaching the boundaries of their competence
    - possibilities for skilled attendants to refer women and newborns directly to higher-level care, should it be needed.
- Availability of all essential drugs, supplies and equipment and existence of mechanisms to replenish drugs and supplies and maintain equipment.
- Availability of, and established procedures for maintaining, facilities and infrastructure (e.g. buildings, vehicles, etc).
- A working transport and referral system to ensure timely access to higher level of care, especially in an emergency.
- Financial resources sufficient to ensure the provision of effective care, including transportation and emergency care.
- Functioning mechanisms for quality improvement that ensure and evaluate the effectiveness of the system, including practitioners' as well as women's and community's satisfaction with the care provided.
- Functioning linkages between the health services and the community to sustain interactions, communications and partnerships with community members and their representatives; these linkages serve in particular to ensure the quality of services.

Organization of care

It is up to each country to decide how best to organize its maternal and newborn health services. It is essential that whichever model is chosen it will allow all women — irrespective of their ability to pay — to access basic as well as comprehensive essential obstetric care, including emergency care for the management of complications in the newborn. Women and the community should be involved in designing the model of care. This will ensure that it meets their particular needs and that they will use the services.

Private for-profit services — ethical issues

The enabling environment must be available to all skilled attendants whether they work in the public or private sector. Consequently, it is important to ensure the private sector is aware of, and complies with, the national public health and maternal and newborn health policies and standards. The same rules need to apply to both the private and public sectors, especially regarding acceptable minimum standards for service provision and for reporting of health-related data (such as the proportion of births attended by skilled attendants) to the Ministry of Health.

Public health authorities have the duty to ensure that high-quality care is provided in both the public and private sectors. This is best done by regular supervision and/or (re)accreditation of all clinical facilities and educational programmes used to train skilled attendants.

Additionally, skilled attendants who work in the private sector should ensure that their work does not infringe on the provision of high-quality care in the public sector. Unfortunately, in many countries where salaries are low, especially in the public sector, health staff in the public sector often feel the need to supplement their salaries by taking up additional work in the private sector. In some instances this leads to a conflict of interest, affecting the quality of work of the skilled attendants (in both their private and public sector jobs) and the care provided to women and newborns.

It must be acknowledged, however, that some people choose to work in the private sector because it can offer more flexible working arrangements. This is particularly important to women health workers, who frequently struggle to meet the demands of family and outside work. In many settings, administrators in the public sector may need to review employment practices and staff retention schemes (such as offering monetary or non-monetary incentives) for skilled attendants who are posted in rural or other "hardship" areas. All these factors should be addressed in the country's national human resource development plan, which should include the specifics for providing skilled care.

Private not-for-profit organizations

Many of the dilemmas and issues surrounding the provision of care and service delivery by not-for-profit private organizations are similar to those for the private for-profit sector. However, the not-for-profit private sector can make available complementary services (to the ones offered by the public sector) at a low cost. For the not-for-profit private organizations and the public sector services to work in an effective, complementary manner for the benefit of a maximum number of people, it is important that there is a good relationship between the Ministry of Health and non-for-profit private organizations (at the national and/or local district health level).

Provision of health services, especially for the poor, is a core responsibility of governments. In settings where services of skilled attendants are provided through the private sector, it is essential that mechanisms exist to regulate their work in order to ensure that it compiles with national standards. Also, there is a need to institute systems (such as accreditation of training, licence to practice, etc.) to ensure that the skilled attendants in the private sector operate as an integral part of the national health system, especially in respect of the need to provide services to all women regardless of their ability to pay. Supportive supervision of skilled attendants would be especially important for those who work alone in isolated areas.

Role of professional associations

All practitioners, including those working in the private sector as well as their professional associations, and accrediting/licensing bodies (where these are separate from the associations) have an obligation to work with the Ministry of Health to ensure that quality of care is maintained at all times. These groups also have the responsibility to advocate for and, in as much as they are able to, ensure that there is equitable access to high-quality care for all pregnant women and newborns in all circumstances and situations, irrespective of whether the care is being provided via private for-profit, private not-for-profit , or public services.

WHO, ICM and FIGO believe that professional associations and WHO should work with governments to find ways to facilitate public and private sector collaboration in order to maximize service delivery capacities in countries. This will imply the establishment of good human resources management policies and regulations, as well as the involvement of professionals in determining service standards for the provision of high-quality care at all levels in both the private and public sectors.

6. The way forward

The major issue facing Ministries of Health, health managers, professional organizations and individual skilled attendants is how to respond to the challenge of providing ***all*** women with care from a skilled attendant, especially in the most resource-constrained settings.

For economic and other reasons (e.g. labour relations), in such settings governments will face pressures for quick-fixes and easy solutions. However, the reality is that achieving the target set in MDGs for skilled attendants — i.e. to have, by 2015, 90% of all births attended by a skilled attendant — is a complex issue and there can be no quick-fixes. Lessons from countries that have been successful, or that are on the way to achieving the goal of skilled attendants for all, have learnt that this takes time[7]. However, there are some interesting lessons that can be learned from these countries, including:

- Countries should start by assessing the existing human resources in order to identify which could be maximized immediately. The second step is to develop appropriate plans for redeployment of staff and updating or building the skills of all available staff.
- Non-governmental organizations and professional associations can help to advocate for changes in national safe motherhood programmes such that their focus shifts from short-term to middle- and long-term in terms of acquiring funding and making budgetary allocations for providing a skilled attendant model of care. This will have significant implications for policy and resources.
- The health system should develop a phased incremental human resource development plan. The first step should be to increase access to, and use of, skilled attendants where capacity is the strongest, followed by scaling-up of access in other parts of the country in a phased manner.

A critical issue is how to assist countries, policy-makers and programme managers in applying the above lessons, especially where funding to the area of safe motherhood is being provided through time-limited projects. Convincing donors to change funding allocations midway in the project cycle will not be easy. However, WHO, its sister United Nations agencies and The World Bank, along with its partners — in particular the professional associations such as the International Council of Nurses (ICN), ICM and FIGO — are actively working to ensure that all stakeholders are informed of the need to intensify actions for achieving skilled care for all.

Experience from countries such as Colombia, Malaysia, Sri Lanka, and Thailand,[8] to name a few, has shown that much can be achieved where there is political commitment and where this commitment is turned into action. All countries can move to a skilled-attendant-for-all model of service delivery, but the time it will take to achieve the model will depend on capacity of each health system to train and appoint skilled attendants and the funding available for this purpose. Providing skilled care for all, however, needs to be seen as a non-negotiable national priority. To build national and local consensus, dialogue must take place with all concerned on the reasons for making the skilled attendant programme a national priority. Once this basic issue has been agreed upon, then policies and programmes can be developed. It should be remembered, however, that in all the countries

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[7] Pathmanathan I et al. *Investing effectively in maternal and newborn health in Malaysia and Sri Lanka.* Washington DC, World Bank, 2003.

[8] Van Lerberghe W & De Brouwere V. Of blind alleys and things that have worked: history's lessons on reducing maternal mortality. *Studies in Health Services Organisation and Policy,* 2001; **17**:7-34.

that set out to provide skilled attendants for all, the goal was not achieved overnight: it took between 10 and 20 years. However, the impact on maternal mortality became evident even before skilled attendants became accessible to all women. In some cases, a reduction in the maternal mortality ratio was discernible when the coverage of skilled attendants was still only 40%, although in order to sustain the reductions achieved it was imperative to continue to increase the coverage.

Skilled care refers to the care provided to a woman and her newborn during pregnancy, childbirth and immediately after birth by an accredited and competent health care provider who has at her/his disposal the necessary equipment and the support of a functioning health system, including transport and referral facilities for emergency obstetric care. Since skilled care as defined above can be provided by a range of health professionals, whose titles may vary according to specific country contexts, it has been agreed to refer to this health care provider as the "skilled attendant" or, "skilled birth attendant", so as to avoid confusion over titles.

A skilled attendant is an accredited health professional - such as a midwife, doctor or nurse - who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.

In this statement, WHO, ICM and FIGO advocate for skilled care for all women during pregnancy, childbirth and the immediate postnatal period. This document is especially aimed at countries in which the coverage of skilled attendance at birth is below 85%. It defines clearly who is a skilled attendant, what skills she/he should have and how she/he should be trained and supported.

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