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MATERNAL AND NEWBORN CARE

Human resources and access to maternal health care

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Abstract The lack of human resources is one of the main bottlenecks to achieving the Millennium Development Goals on maternal and child health. A coherent national policy, recognized across government, needs to be in place to overcome this especially in countries severely affected by HIV/AIDS. Such a policy should cover selection of pre-service students, the qualifications of trainers and training sites, supportive supervision, career path development, a package of carefully thought-out incentives for the retention of staff, strategies for interaction with communities, and an agreed-upon health staff HIV/AIDS policy. Without such coherent human resource planning, a large number of countries will fail to reduce maternal and newborn mortality.

Every year, more than half a million women and around 3.5 million newborns die from causes related to pregnancy and childbirth. In addition, 3.3 million stillbirths occur, and the mortality risks have hardly changed over the past few decades. Although a few countries have been able to make major advances in decreasing maternal and infant mortality, most have not even started to achieve the Millennium Development Goals (MDGs) globally agreed upon in 2000. Two of the eight MDGs aim at a reduction of maternal mortality by three quarters compared to the 1990 figures and, at the same time, a two-thirds reduction of child mortality. It is important to recollect that the MDGs are agreed goals for global societal development. Not meeting them means hindering human development on multiple fronts.

Unfortunately, the devastating effects of HIV/AIDS on both the general population and the health care providers in many African and Asian countries make it even harder to achieve the MDGs. Indeed,

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in some countries of sub-Saharan Africa, HIV/AIDS is already exerting a huge toll on health workers. At the same time, few governments have realistic plans on how to balance this loss against the need for more health workers due to the massive scale-up of antiretroviral treatment [1].

This paper provides an overview of the most important challenges of providing the human resources necessary to reach the Millennium Development Goal on maternal health. As newborn health constitutes a major part of the MDG on child health, human resources for maternal health will to a large extent also determine if that goal will be reached.

1. The need for human resources in the health system

The clinical interventions necessary to reduce maternal, new-born and child deaths in low- and middle-income countries are not complex, nor are they expensive or yet to be discovered. Rather, they are known, cost-effective interventions that are widely available in high-income countries. However, their delivery can only be successfully achieved within a functioning health system and via a skilled birth attendant with emergency back-up services.

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, childbearing and the immediate postnatal period and in the identification, management and referral of complications in women and newborns. [2]

A list of the core skills and abilities of skilled attendants is enumerated in the referenced Joint Statement developed by WHO, ICM and FIGO in 2004 [2]. This statement identifies skilled attendants as midwives (including nurse—midwives), nurses with midwifery skills, doctors with midwifery skills, and obstetricians.

Importantly, the WHO World Health Report in 2005 [3] erases some of the previous separation between skilled birth attendants caring for "normal births" and those who provide emergency care for severe complications. It concludes that skilled staff is needed for both circumstances, as unskilled staff cannot cope effectively with either severe complications or pending, potentially life-threatening conditions. The road to improve maternal health is clearly through skilled human resources within the formal health system.

2. What about traditional birth attendants?

WHO, FIGO and ICM all identify traditional birth attendants as "...independent of the health system, non-formally trained and community-based providers of care during pregnancy, childbirth and the post-natal period" [2].

The regions in the developing world with the highest mortality figures are countries in sub-Saharan Africa and Southeast Asia. Many have health systems that function at a small percentage of what is required to provide care to the inhabitants or access to emergency services for those who need it. Over the years, many quick-fix solutions have been tested to increase health systems' capacities. One was the training of traditional birth attendants (TBAs)—the women who lived in the community and traditionally dealt with pregnancy and childbirth. Many such individuals received a short course to upgrade their skills, a box of instruments and materials, and were sent back into the community to save the lives of women and children. They were not successful [4]. The documented failure of this attempted solution has a number of causes, only a few of which will be mentioned here. Foremost is that the onus of saving lives cannot be put on the shoulders of a single provider. TBAs were not given access to the rest of the health system, so that when the time came to refer to a higher level of care, they had no means of accessing the system, were not accepted as certified care providers, were not taken seriously, were ridiculed and/or turned away. They had no access to communication systems nor could they count on transportation for their patients should referral to a hospital be needed. Another reason for the failure of the training of TBAs is, paradoxically, that the health system may not be able to receive the additional numbers of women being referred to it. Many communities have learned that women need to be near a health facility when giving birth, so delivery suites in hospitals are overloaded with physiological births and the staff in those facilities cannot cope with the large numbers of patients. Thus, an already weak health system is put under even greater pressure [5].

These problems became abundantly clear when the failure of TBA training programs emerged. Despite much investment, mortality remained static. When choosing cost-effective, evidence-based solutions, i.e., the skilled birth attendant with emergency backup, it is important to remember the lessons from the TBA failure. Skilled birth attendants must be linked to and valued by community; must be part of a functioning health