WEBINAR: IMPROVING MATERNAL HEALTH IN REFUGEE OPERATIONS - PART 1

UNHCR

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Webinar Agenda

Part 1

- Overview and Rationale
- Epidemiology of maternal mortality
- Maternal health in refugee settings
- Emergency phase – implementing the MISP
- Components of comprehensive maternal health services
- Antenatal care – key components, common gaps, and monitoring
- Essential childbirth care
  - Respectful maternity care
  - Care during labour – partograph use
  - Active management of third stage of labour
- Routine postnatal care
- Emergency Obstetrics and Neonatal Care (EmONC) components and monitoring

OBJECTIVES of WEBINAR

TO UNDERSTAND THE GLOBAL BURDEN AND LEADING CAUSES OF OF MATERNAL MORTALITY

TO BECOME FAMILIAR WITH THE UNHCR MATERNAL HEALTH OPERATIONAL GUIDELINES

TO BE FAMILIAR WITH THE KEY COMPONENTS OF MATERNITY CARE (MISP AND COMPREHENSIVE SERVICES)

TO MOTIVATE YOU TO ASSESS YOUR OWN PROJECT SITES AND MAKE A PLAN TO FILL GAPS

TO SHARE YOUR EXPERIENCES AND IDEAS WITH ONE ANOTHER

Background and Rationale

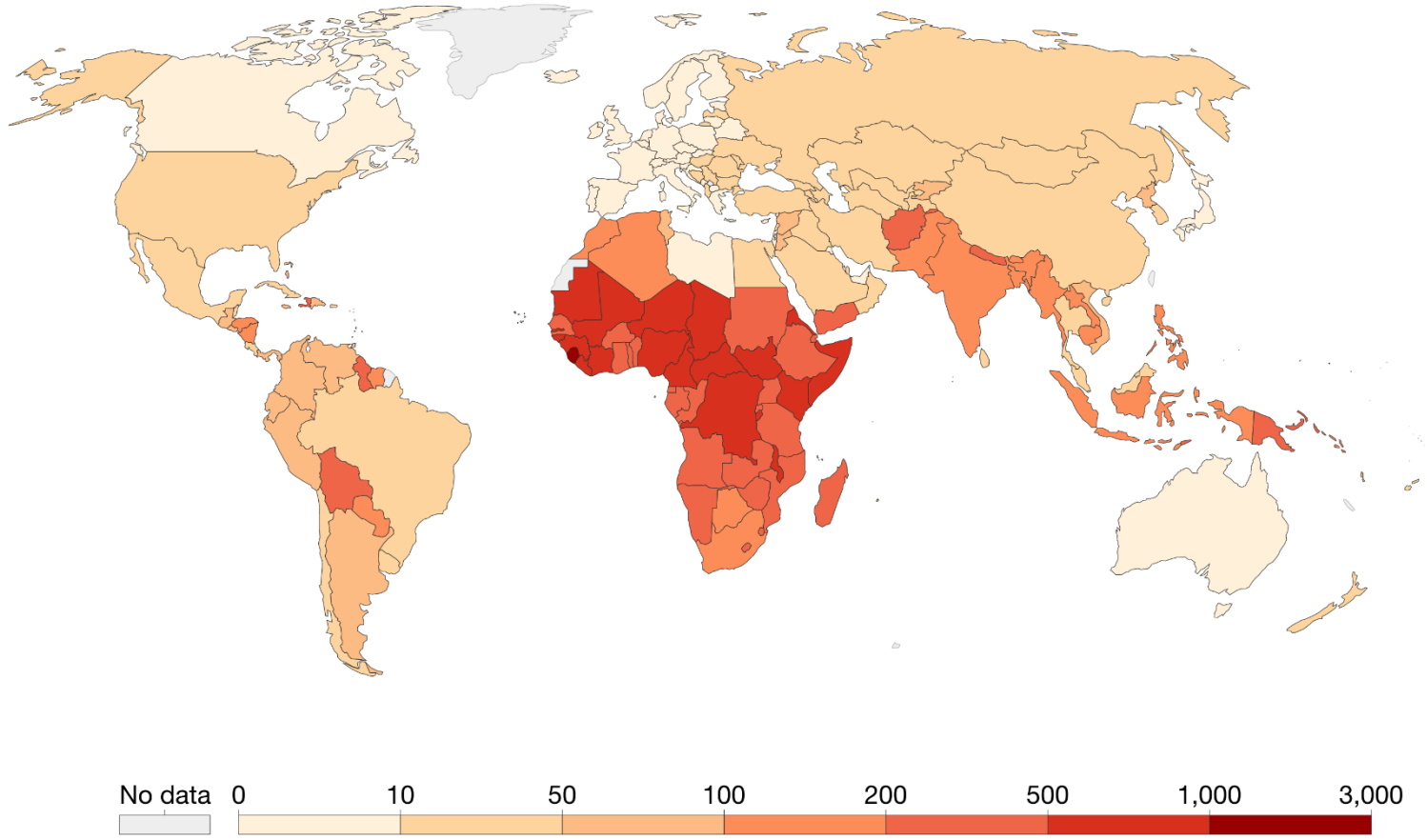
- In 2017 over 300,000 women around the world died due to complications of pregnancy and childbirth.
- 90% of these deaths occurred in low- and middle-income countries, and almost two thirds of those were in sub-Saharan Africa
- Most of these deaths are preventable with appropriate management and care
- UNHCR's *Operational Guidelines for Improving Maternal Health in Refugee Operations* were developed to provide direction to PHOs and partner program managers on key components of maternal health services

Maternal mortality refers to the death of a woman whilst pregnant or within 42 days of delivery or termination of pregnancy, from any cause related to, or aggravated by pregnancy or its management, but excluding deaths from incidental or accidental causes.

Global average MMR = 216 deaths per 100,000 live births

10 countries with the highest MMRs:

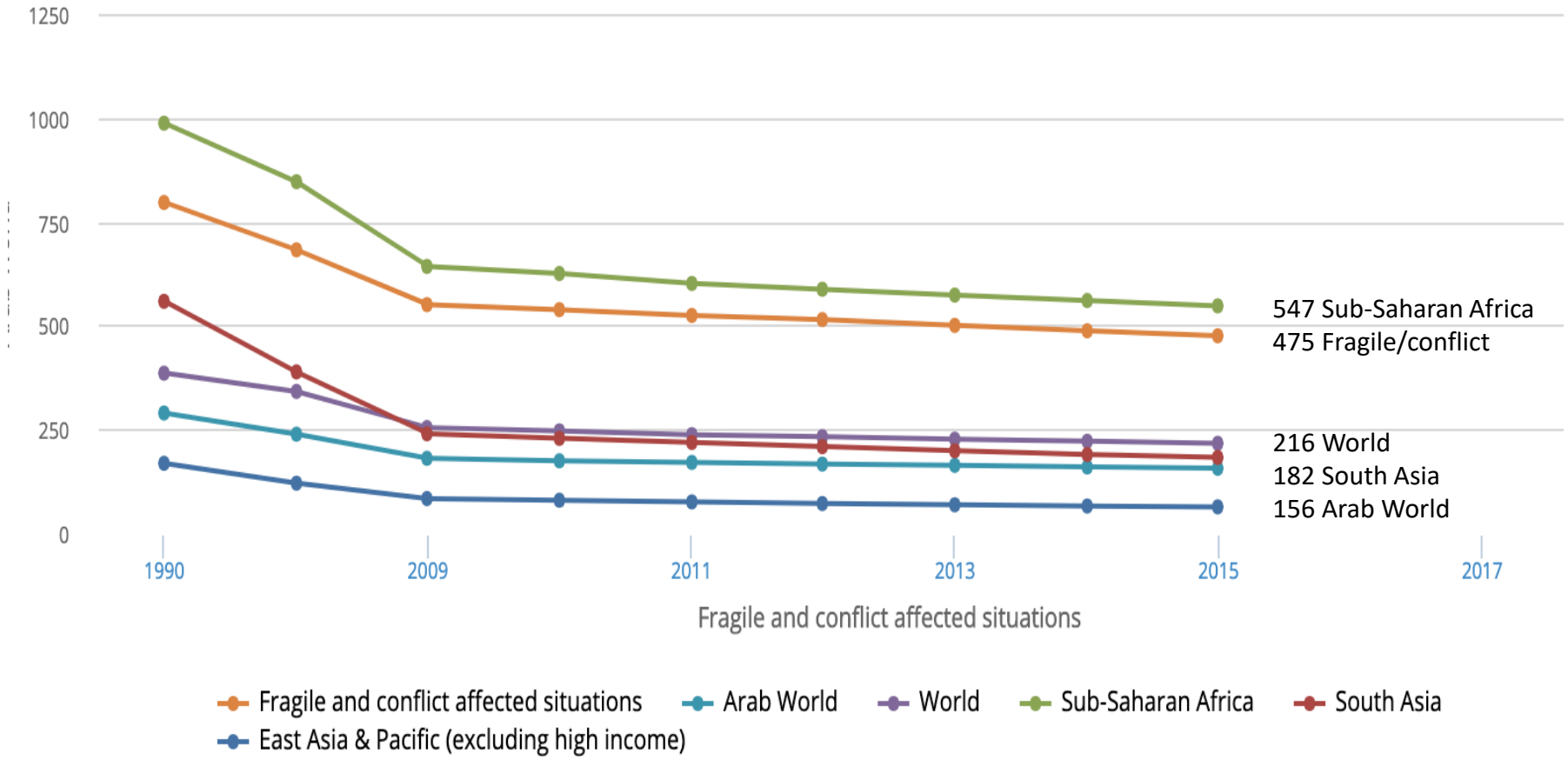
1. Sierra Leone (1360)
2. Central African Republic (882)
3. Chad (856)
4. Nigeria (814)
5. South Sudan (789)
6. Somalia (732)
7. Liberia (725)
8. Burundi (712)
9. Gambia (706)
10. DRC (693)



Source: Gapminder (2010) and World Bank (2015)

Sustainable Development Goal 3.1

SDG 3.1
2030 MMR Goal:
Global average <70 per 100,000 live births
Each country reduce by 2/3
No country > 140



Source: World Development Indicators. World Bank Group https://databank.worldbank.org/reports.aspx?source=2&series=SH.STA.MMRT&country=FCS#

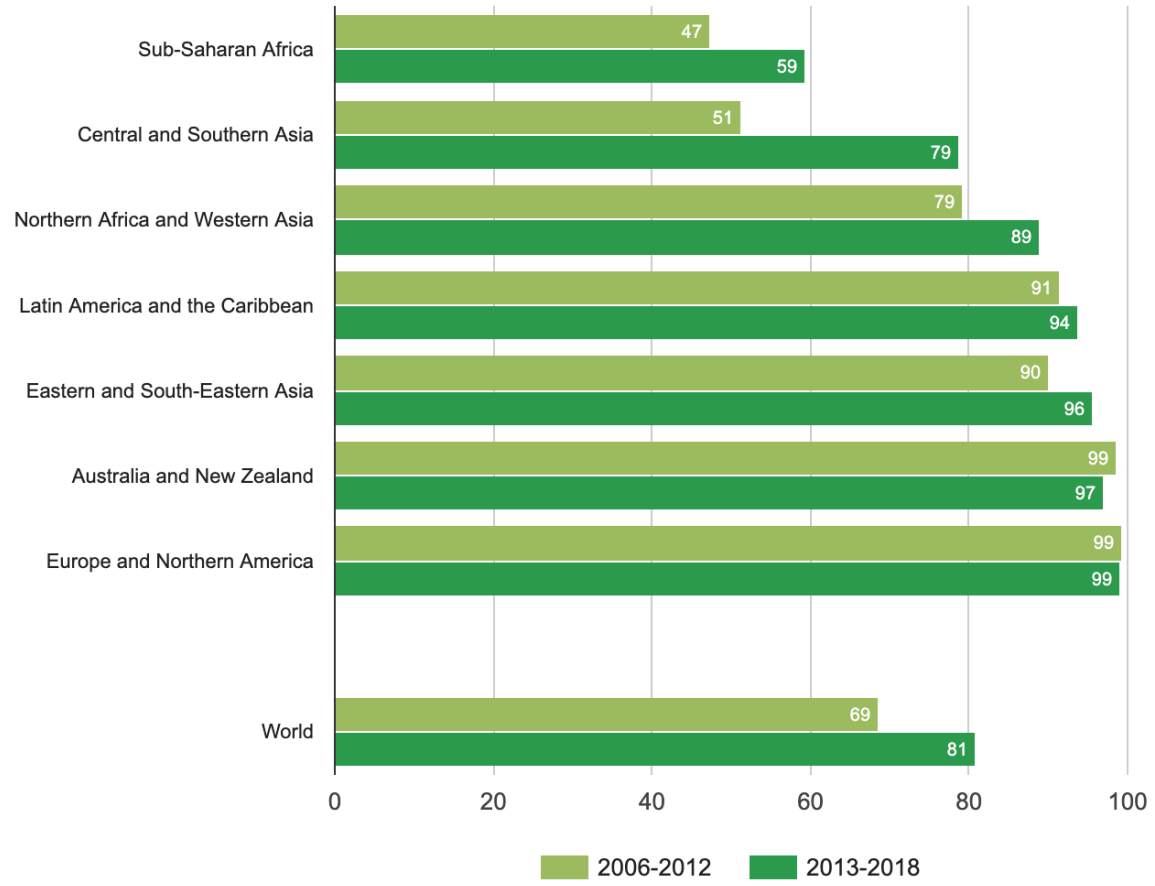
Are we on track to meet SDG 3.1?

- Maternal mortality ratios have decreased by 44% globally between 1990-2015
- However, most developing countries not on track to meet SDGs.
- Who has been successful and how? Cambodia and Rwanda – have 'accelerated' annual rate of maternal mortality reduction

Cambodia	**Rwanda**
Heavy government investment in transportation and health infrastructure	Deployment of 45000 trained community health workers nation-wide
Health centres now operating 24hrs/day; increased networks of referral hospitals; maternity waiting homes	CHWs incentivized based on indicators (number of women delivering at health facilities)
Financial incentives for health workers based on % skilled delivery rates	Introduction of comprehensive health insurance scheme
Increased training of midwives and strategic deployment across country	Strengthened data collection into national HIS

SDG indicator 3.1.2 Skilled Birth Attendance

Proportion of births attended by skilled health personnel, 2006 - 2012 and 2013 - 2018 (percentage)



Global average 81% (up from 69% in 2012!)
Sub-Saharan Africa: 59%

https://unstats.un.org/sdgs/report/2019/storymap/

What is a skilled birth attendant?

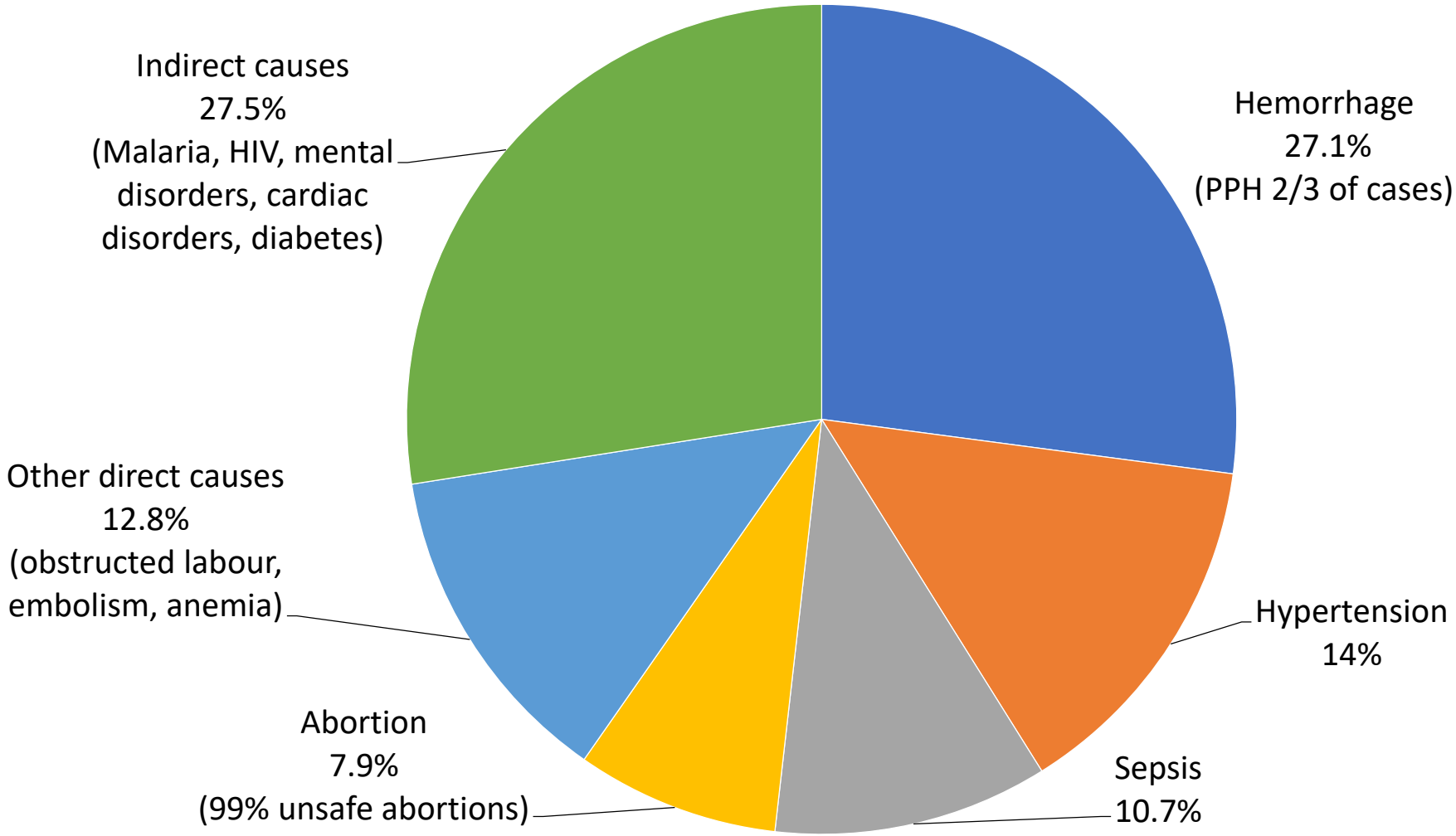
- ✓ Professionals educated, trained and regulated to national and/or international standards
- ✓ Able to perform all EmONC signal functions (as part of an integrated team of MNH professionals)
- ✓ Adequately equipped (drugs and medical material) and motivated

- ✗ TBA working in health facility (on-the-job training) does not qualify as a “skilled birth attendant”

2018 Joint Statement: Definition of skilled health personnel providing care during childbirth: WHO, UNFPA, UNICEF, ICM, ICN, FIGO and IPA

https://apps.who.int/iris/bitstream/handle/10665/272818/WHO-RHR-18.14-eng.pdf?ua=1

Leading Causes of Maternal Mortality



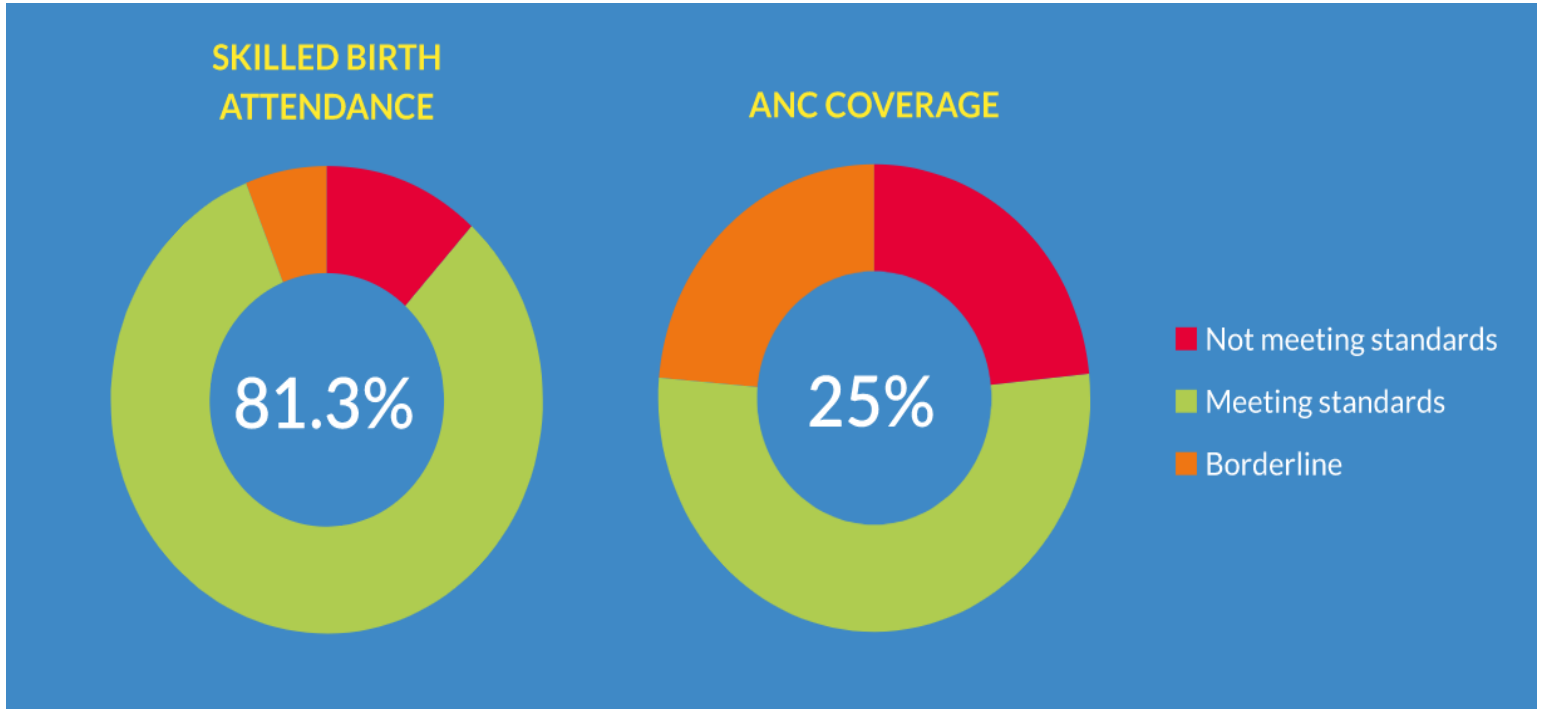
Say L, Chou D, Gemmill A, Tuncalp, O, Moller AB, Daniels J, et al. Global causes of maternal death: A WHO systematic analysis. Lancet Glob Heal. 2014;2(6):323–33.

Maternal Health in Refugee Contexts

- Many countries with the worst maternal mortality rates globally are also facing humanitarian crises
- Risks for women in emergency phase: loss of access to functioning health facilities, increase in SGBV/rape, distance, financial, cultural and language barriers, etc.
- Urban refugees may have limited access to national health services (costs, discrimination, lack of knowledge of available services)
- Post-emergency camp settings may see better health indicators than host (MMR, NMR, skilled delivery rates) due to concentration of services in camp settings

How does UNHCR compare? 2018 Annual HIS report

- 81% of reporting operations met target of >90% skilled birth attendance (increased from 75% in 2015)
- Only 25% of operations met target of >90% ‘complete ANC’
- Only 33% of operations met target of >90% ‘complete PNC’



Causes of Maternal Mortality UNHCR 2018

From UNHCR's audited maternal mortality reports (6 countries in East Africa):

- 94% deaths occurred in health facilities
- 59% occurred during postpartum period
- Leading causes of death: hemorrhage (44%); embolism (19%); and sepsis/infection (18%)
- **DELAY 3** was main contributor (need to strengthen EmONC services and referral system)

Delay 1: Decision to seek care

- Low health seeking behavior
- Cultural influences (use of TBAs, restrictions on women)
- Lack of awareness of risks
- Negative past experiences of care/care not acceptable

Delay 2: Reaching care

- Lack of transportation
- Security problems blocking access
- Problems with referral system

Delay 3: Receiving adequate care

- Lack of required staff, skills, or equipment, medications
- Lack of stabilization before transfer
- Poor quality of care

What is the Minimum Initial Services Package(MISP)?

1

The MISP is a set of priority SRH activities to be implemented at the onset of a humanitarian crisis

- Ideally implementation should take place within 48 hours
- Planning and preparedness is critical

2

The MISP can be implemented without an in-depth SRH needs assessment

- The identified SRH interventions are life-saving

3

The MISP represents a minimum set of activities

- Transition to comprehensive SRH services as soon as possible (possibly within 3 months)

Objectives of the MISP

Coordination	Ensure organisation to lead MISP implementation
SGBV	Prevent sexual violence and respond to the needs of survivors
HIV/STIs	Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs
Mat/ Newborn	Prevent excess maternal and newborn morbidity and mortality
Contraception	Prevent unintended pregnancies
Plan	Plan for comprehensive SRH services
Safe abortion	Note: It is also important to ensure that safe abortion care is available, to the full extent of the law, in health centers and hospital facilities

1. Ensure organisation to lead MISP implementation

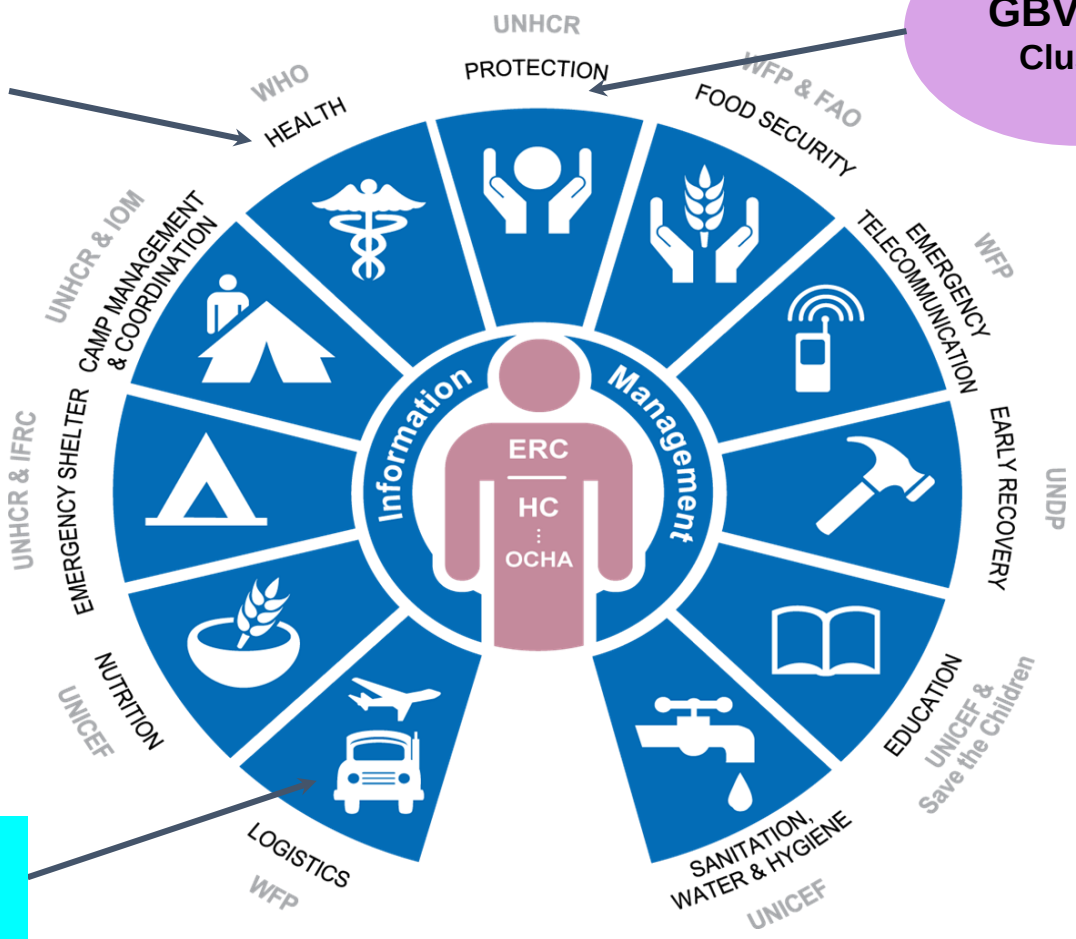
1. Lead SRH Organisation
   - Identified by health sector or cluster
   - Could be MoH , NGO, UN Agency
2. SRH Coordinator
   - Identified by lead SRH Organisation
   - Works within health sector/ cluster but also with other sectors/ clusters (WASH, logistics, camp management)
   - Clear Terms of Reference

Restore comprehensive services AS SOON AS POSSIBLE

Sexual and Reproductive Health in Cluster System

SRH Working group

GBV Sub-Cluster



IARH Kits and SRH supplies

2. Prevent Sexual Violence and respond to needs of survivors

1. Prevent: coordinate mechanisms to prevent Sexual Violence
2. Respond: clinical care & referral for survivors
3. Respond: confidential & safe spaces

Restore comprehensive services AS SOON AS POSSIBLE

Assume that GBV is taking place, even if no reliable data are available

3. Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs

1. Safe & rational blood transfusion
2. Standard Precautions
3. Condoms
4. ARVs
5. PEP
6. Co-trimoxazole prophylaxis
7. Syndromic diagnosis & treatment of STIs

Restore comprehensive services AS SOON AS POSSIBLE

4. Prevent excess maternal and newborn morbidity and mortality

1. Availability & accessibility of EmONC
2. 24/7 referral system
3. Post-Abortion Care
4. Supplies for clean delivery & immediate newborn care

Restore comprehensive services AS SOON AS POSSIBLE

5. Prevent Unintended Pregnancies

1. Ensure availability of a wide range of contraceptive methods at primary health care facilities to meet demand
2. Provide information
3. Ensure community is aware of availability

Restore comprehensive services AS SOON AS POSSIBLE

What's needed to make the MISP happen?

1. **Multisectoral collaboration** (health, WASH, protection, logistics)
2. **Funding** (MISP qualifies for Central Emergency Response Funding CERF)
3. **Supplies and commodities** from the onset of emergency
   - In-country supplies and commodities
   - Pre-positioned supplies and commodities
   - Inter-agency Health Kits (IEHK)
   - Inter-agency Reproductive Health Kits (IARH)
   - Newborn Health kits (to be ordered together with IARH Kits)

What's needed to make the MISP happen (2)?

4. Monitoring and evaluation

- MISP checklist
- Onset: basic data collected, analyzed rapidly
- Services established: routine monitoring
- Gaps and overlaps discussed within the SRH coordination meetings and with health sector/cluster

Basic Data You Need to Know: MISP

1. How many people are affected?
2. Where are they?
3. Where are the health services?
4. Can health facilities still function?
5. Are health services accessible?
6. What local resources are available?
7. What external resources needed?
8. Any information on the pre-existing SRH situation is a plus

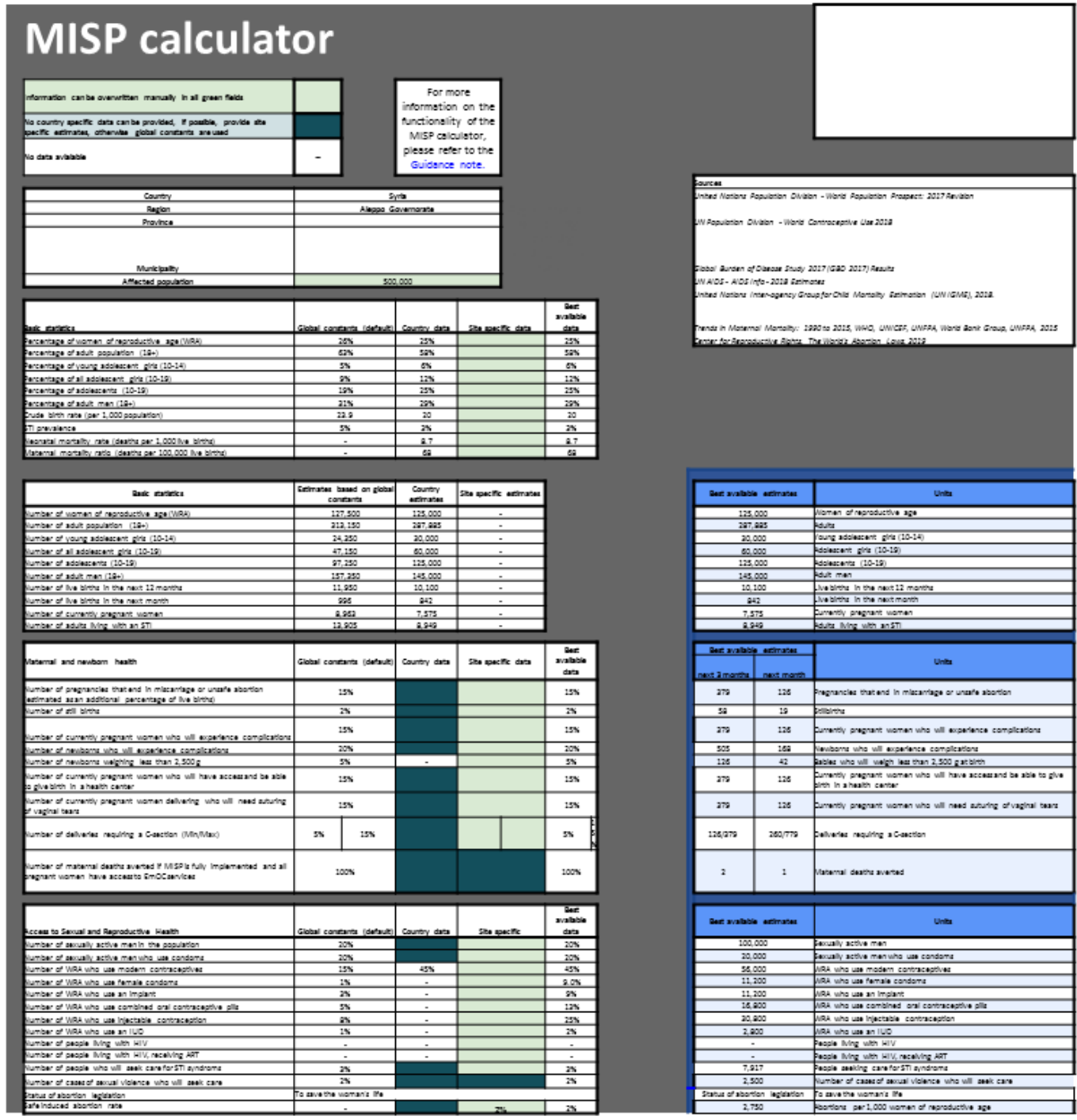
MISP calculator

http://iawg.net/resource/misp-rh-kit-calculators/

What is the MISP calculator?

At the very onset of an acute humanitarian emergency, data on the affected population can range significantly depending on the quality of the information available before the emergency and based on the known demographic mix of the target population. The Minimum Initial Services Package for SRH in Humanitarian Settings (MISP) Calculator is a tool that **can help coordinators and programme managers determine affected population demographics for advocacy, fundraising and programming at the very onset of an emergency**.

The MISP calculator ONLY requires from the user affected population numbers. The MISP calculator works by automatically providing the user with a simple way to access the 'best available data' for each population in a country and/or subnational area. If no quality data on that affected population exists from prior to the emergency the tool defaults to estimated global constants to base the response on. Additionally, the MISP calculator provides a space for the user to self input any site specific data that may be available on the target population.



MISP Lessons Learnt from the field

- Identify a strong and respected coordinator
- Transparent collaboration facilitates implementation!
- Prevention of SV requires a concerted effort, sensitivity and staff preparation
- People use condoms during an emergency
- Women want contraception during an emergency
- Clean delivery kits provide essential supplies for deliveries outside health facilities
- Logistics preparedness is essential for prompt use of RH kits
- Satisfactory implementation requires pre-planning
- Onsite technical assistance for MISP implementation helps translate training into practice

“Do not wait for an emergency to address the MISP”

Discussion – MISP Implementation

- What are the main challenges in implementing MISP in your experience?
- What are the main barriers in moving from the MISP to comprehensive health services?

Comprehensive Maternity Services

- Antenatal Care (ANC)
- Essential Childbirth and Newborn Care* (*see newborn webinar)
- Emergency Obstetric and Newborn Care (EmONC)
- Postnatal Care (PNC) for mother and newborn
- Other RH services: Abortion/post-abortion, HIV/STI, contraception/FP, SGBV
- Additional services: mental health, fistula prevention and repair, etc.

WHO ANC model	2016 WHO ANC model
First trimester	
Visit 1: 8-12 weeks	Contact 1: up to 12 weeks
Second trimester	
Visit 2: 24-26 weeks	Contact 2: 20 weeks Contact 3: 26 weeks
Third trimester	
Visit 3: 32 weeks Visit 4: 36-38 weeks	Contact 4: 30 weeks Contact 5: 34 weeks Contact 6: 36 weeks Contact 7: 38 weeks Contact 8: 40 weeks
Return for delivery at 41 weeks if not given birth	

Focused Antenatal Care (ANC)

- WHO recommendations in 2016 changed recommended number of visits from 4 to 8
- UNHCR HIS: considers 4 visits as “complete”
- Most settings will be following their national MoH schedule
- Low achievement (25%) of “>90% complete ANC” 4 visits means new 8 contact schedule unrealistic in many settings
- **Quality of care** during ANC more important than number of visits

Source: WHO recommendations on antenatal care for a positive pregnancy experience [Internet]. 2016.

Available from: http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/anc-positive-pregnancy-experience/en/

Key actions in antenatal period

Maternal fetal assessment

- Assess for maternal risk factors (hypertension, multiples, history)
- Monitor pregnancy progress and mat/foetal health
- Assess for mental health problems and domestic violence

Nutrition

- Screen for acute malnutrition
  SFP where available. Counsel on healthy diet
- Anemia screening and Iron/folic acid
- Counselling on breastfeeding

Infection

- Tetanus vaccination
- Screening and treatment syphilis, HIV, HBV asymptomatic bacteruria
- Malaria (ITBN, IPTp-SP)

Health education

- Make a birth and emergency plan
- Danger signs in pregnancy and postnatal
- Postpartum family planning
- Healthy behaviours (avoiding tobacco, alcohol)

Common Quality Gaps in ANC Services

Anemia

Lack of checking hemoglobin or checking only during 1st visit.

- Clinical observation (pale conjunctiva) found to be inaccurate measure of anemia – not recommended
- Lack of protocols on managing mild/moderate/severe anemia in pregnancy.
- Providing only small amounts of iron/folic acid and not during postpartum

Syphilis

- Syphilis testing (syphilis is a main contributor to miscarriage, stillbirth, and neonatal death). Screening in pregnancy is recommended/cost effective even in low prevalence settings
- Testing often not done/missed

Health education

Very little health education such as danger signs, birth and emergency plan

Poor recognition of high risk conditions. High risk women should be identified, charts flagged, increase frequency of appointments, and consider early referral for delivery at hospital level

Monitoring Quality of ANC care

- Balanced Score Card ‘RH comprehensive’ module (uses observation of ANC visits) particularly good for observation of patient counselling

  --> use results to plan trainings and for supportive supervision
- Review of ANC registers for completion/correct management
- Review HIS data (early ANC, complete ANC).

  --> where rates are low need increased community mobilization
- Ensure clear written protocols on content and timing of ANC care; management of commonly encountered complications (anemia)
- All the above equally applies to outpatient PNC care

Discussion- ANC

- What are the main barriers in your setting to early and complete ANC care?
- What QUALITY factors are the most relevant in your settings?
- Who has completed Balanced Score Card RH module – including observation of ANC visits? What were your findings?

Essential Childbirth Care

- Skilled birth attendance
- Respectful maternity care
- Hygiene
- Monitoring labour (partograph)
- Active management of 3rd stage of labor
- Essential newborn care (*see neonatal webinar)
- Access to EmONC functions

What is Respectful Maternity Care?

- **All women receive information** and are given an opportunity to make informed decisions about their care.
- **Ensure privacy** and confidentiality
- **Allow freedom of movement** in labour and choice of birth position.
- Access to appropriate **pain management** (pharmacological/non-pharmacological)
- **Provide continuous social support** for improved outcomes (shortened labour; reduction in instrumental delivery/CS; better APGAR)
- **Avoid harmful labour practices**. Routine episiotomy; perineal shaving; restricting food and water in low-risk women; lying flat position for labour and birth; fundal pressure during labour; 'active management of labour' are *non-evidence based* and may be harmful
- Care is free from discrimination (age, marital status, refugee status, ethnicity) and disrespect/abuse

Respectful Maternity Care – Why is it important?

Play first 2:25 mins of video

1. Human rights abuse

2. Negative effects on the woman (physical/psychological)

3. Loss of trust of community in health services → contributes to home deliveries

Study of 8 health facilities (n=1779) in NE Tanzania found (Kruk et al. 2018):

- 19% of women reported disrespect/abuse in exit interviews and 28% in re-interview in community
- Most common: Neglect; shouting; negative comments; threats; non-dignified care; pinching, slapping

Disrespect and Abuse in Childbirth

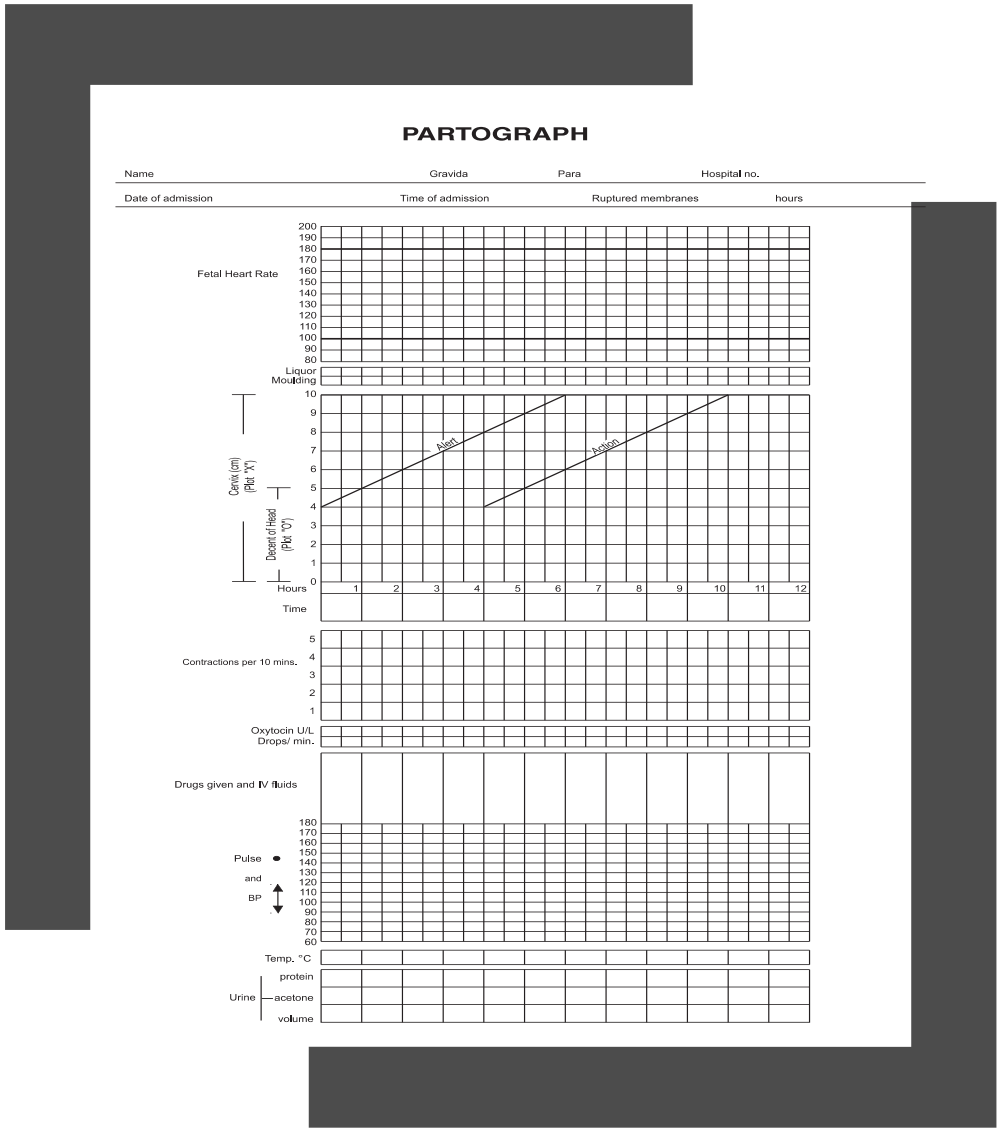
Category of Disrespect and Abuse [i]		Corresponding Right
1.	Physical abuse	Freedom from harm and ill treatment
2.	Non-consented care	Right to information, informed consent and refusal, and respect for choices and preferences, including companionship during maternity care
3.	Non-confidential care	Confidentiality, privacy
4.	Non-dignified care (including verbal abuse)	Dignity, respect
5.	Discrimination based on specific attributes	Equality, freedom from discrimination, equitable care
6.	Abandonment or denial of care	Right to timely healthcare and to the highest attainable level of health
7.	Detention in facilities	Liberty, autonomy, self-determination, and freedom from coercion

For more information and resources: www.whiteriboonalliance.org

Addressing Disrespect and Abuse in Childbirth

What can be done?

- Management/supervisors to be ‘on alert’ for disrespect and abuse.
- Conduct focus group discussions with women to find out their perceptions of health services. Observe care provision.
- Ensure women are aware of their rights (behaviour may be “normalized”)
- Ensure safe feedback mechanism for community members (e.g. refugee health committee)
- Training activities for health workers on respectful care and communication
- Developing a ‘Charter of Respectful Care’ collaboratively with health workers, management and community members/leaders
- Address specific needs like increased privacy
- Allow a companion of choice during labour and childbirth



Partograph

- Recommended by WHO. Used to monitor wellbeing and progress of labour and to ensure timely intervention
- Partograph – starts in **active phase** (start filling it once in active labour >4/5 cm)

What does the research say (Bedwell, 2017)?

- Evidence is mixed on impact on health outcomes (some say no impact, others shorter labour and fewer complications)
- Midwives often do not understand how to fill
- Training is shown to increase use
- Heavy workload and lack of enabling environment plays a role in lack of use
- Recommended: training and review filled partographs as a part of supervision

Labour monitoring - what and how often?

Measuring Fetal Well Being During Labour	
• Fetal heart auscultation (by doppler or Pinard fetoscope in healthy women)	• q 30 mins in 1st stage and q 5 mins 2nd stage (expulsion)
Measuring Maternal Well Being During Labour	
• Pulse, temperature, blood pressure, respiration	• q 4 hours
• Urine output, ketones, protein	• As needed
• Pain and coping	• Ongoing
• Fluids and medications (including oxytocin)	• As needed
Measuring Progress of Labor	
Cervical dilatation	q 4 hours
Rupture of membranes and colour of amniotic fluid (clear, meconium, bloody)	Initially and q 4 hours
Moulding	q 4 hours
Descent of presenting part	q 4 hours
Contractions: duration, frequency, strength	q 30 mins

Active management of third stage of labour (AMTSL)

3rd stage of labour is the time between delivery of baby and delivery of placenta

AMTSL should be provided to ALL women

AMTSL involves:

- Prophylactic administration of a uterotonic agent prior to delivery of the placenta (preferable 10 IU oxytocin, possible 400-600 mcg misoprostol SL)

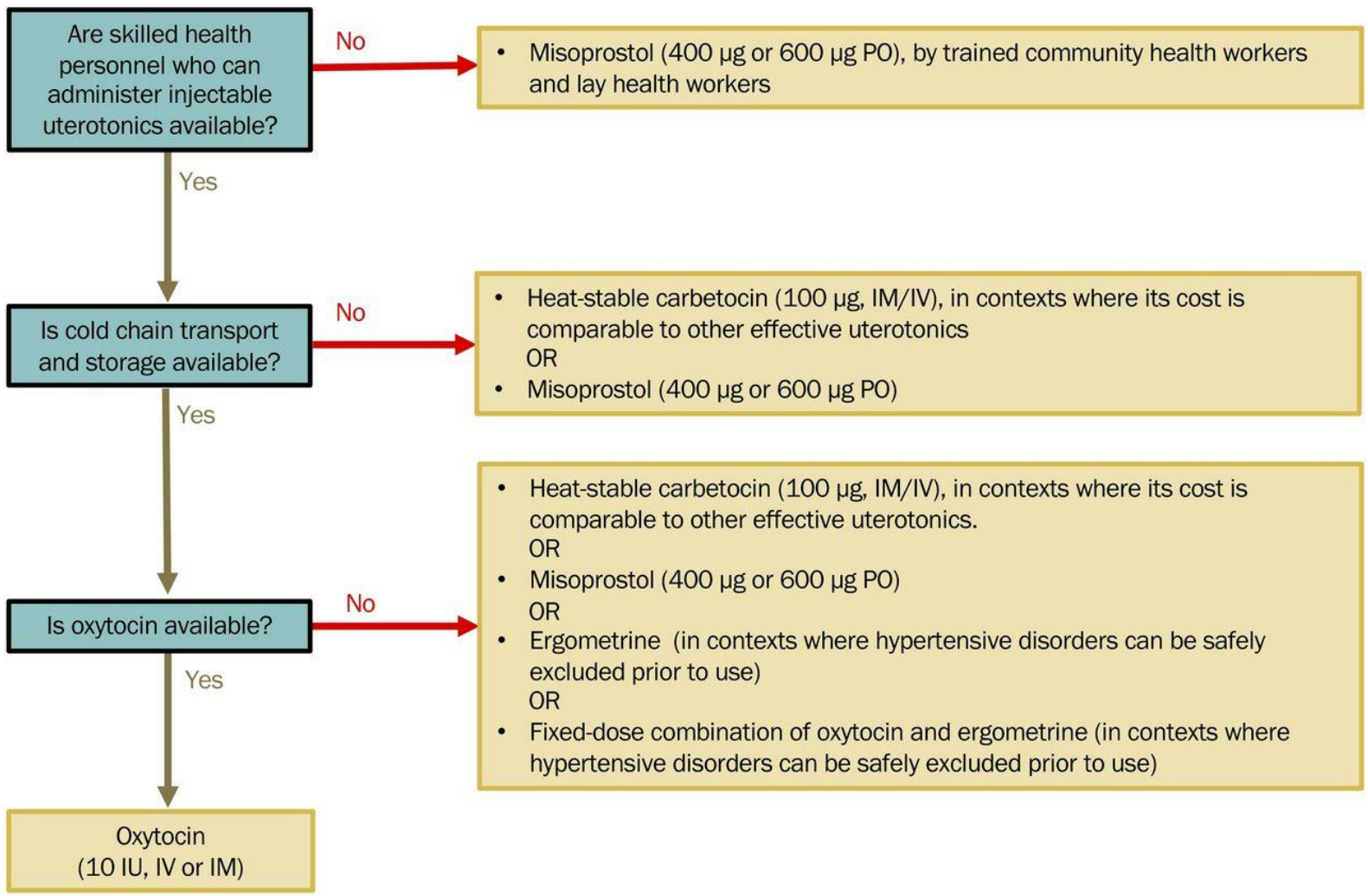
- Delayed cord clamping (1-3 minutes to increase iron stores in newborn as well as other benefits)

- Controlled traction of the umbilical cord (optional - for skilled birth attendants only)

Uterotonic Choice for Prevention of PPH

WHO Recommended (2018):

- **Oxytocin** (gold standard; needs cold chain*)
- Carbetocin (heat-stable; very expensive)
- Misoprostol (can be given by lay-persons; legal restrictions; side-effects; humidity)
- Ergometrine/
- methylergometrine (not heat stable; cannot use if hypertensive)
- Oxytocin and ergometrine fixed-dose combination (not heat stable; cannot use if hypertensive)



Joshua P Vogel et al. BMJ Glob Health 2019;4:e001466

Advanced distribution of misoprostol

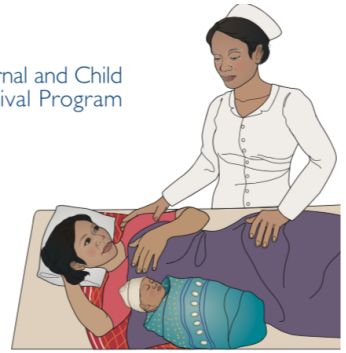
- Where access to health facilities or skilled birth attendants is poor, advanced provision of misoprostol to prevent PPH in case of home delivery
- Misoprostol does not need cold chain and is given orally (sublingually is best)
- May be distributed by health workers in ANC, by TBAs or CHWs
- Must be accompanied by strong educative component
- Requires reliable supply and distribution chain for misoprostol
- Research has shown advanced provision to be effective and safe, does not decrease facility delivery rates

Discussion: Any experience in the group with advanced distribution of misoprostol?

USAID FROM THE AMERICAN PEOPLE | MCHIP Maternal and Child Health Integrated Program | Maternal and Child Survival Program

POSTNATAL CARE PRE-DISCHARGE CHECKLIST

Do not discharge until at least 24 hours after a normal vaginal birth.



Complete checklist items for every mother and newborn, regardless of when they are discharged.

Assess Mother for Problems	No	Yes	Recommended Actions
The mother has a danger sign: • Heavy bleeding • Severe abdominal pain • Unexplained pain in chest or legs • Visual disturbance or severe headache • Breathing difficulty • Fever, chills • Vomiting		→	Assess the cause(s) and initiate care or refer. Delay discharge until all danger signs have been resolved for at least 24 hours and there is a follow-up plan in place.
The mother's bleeding is heavy or has increased since birth (e.g., bleeding soaks a pad in less than 5 minutes).		→	Delay discharge. Evaluate and treat possible causes of bleeding (e.g., uterine atony [not contracted], retained placenta, or vaginal/cervical tear).
The mother has an abnormal vital sign: • High blood pressure (SBP > 140 mmHg or DBP > 90 mmHg) • Temperature > 38.0°C • Heart rate > 100 beats per minute		→	Evaluate the cause of abnormal vital sign(s) and treat or refer. Defer discharge until vital signs have been normal for at least 24 hours and no danger signs remain.
The mother is not able to urinate easily or is leaking urine.		→	Defer discharge; continue to monitor and evaluate the cause; treat or refer as needed.
The mother is being treated for a complication, and her condition has not stabilized (e.g., vital signs are not normal or she has a danger sign).		→	Delay discharge until the mother's condition has been stable for at least 24 hours, with normal vital signs and no danger signs remain. Refer if necessary.
Assess Baby for Problems	**No**	**Yes**	**Recommended Actions**
The baby has any of these danger signs: • Fast breathing (> 60 breaths/minute) • Severe chest in-drawing • Fever (temperature ≥ 37.5°C axillary) • Hypothermia (temperature < 35.5°C) • Yellow palms (hands) or soles (feet) • Convulsions • No movement or movement only on stimulation • Feeding poorly or not feeding at all		→	Assess cause of danger signs and initiate care or refer. Delay discharge until all danger signs have been resolved for at least 24 hours and there is a follow-up plan in place.
The baby is not breastfeeding at least every 2–3 hours (day and night).		→	Delay discharge and evaluate the causes. Treat or refer. Delay discharge until the baby has been breastfeeding well for at least 24 hours.

Routine Postnatal Care

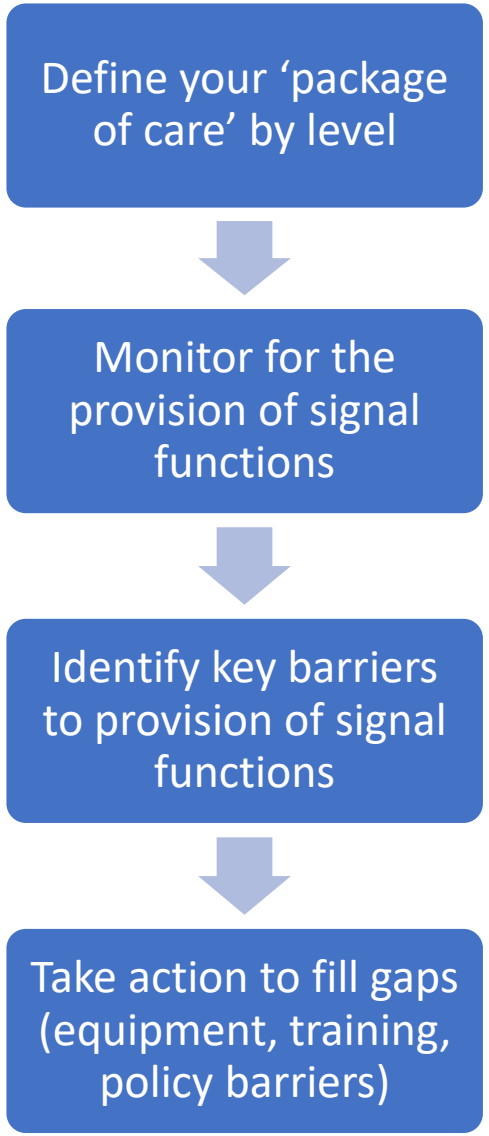
- Many maternal and neonatal deaths occur in the 24 hours after delivery
- For uncomplicated deliveries, remain in health facility **for 24 hours post-delivery**
- Assessments in 6 countries found few stay 24 hours AND very little care is being given/ no documentation after leaving the delivery room and before discharge.
- A **structured protocol of care** should be in place for assessments and health education to be provided during the first 24 hrs in health facility. Ensure a clinical record is completed
- Implementing a postnatal care pre-discharge checklist may be useful
- Important opportunity for health education and postpartum family planning
- Follow-up visits for mother and baby on Day 1, 3, 7-14 of life; and 6 weeks*

Emergency Obstetric and Neonatal Care (EmONC)

		Signal Function	Essential materials
COMPREEHENSIVE	BASIC	1. Administration of parenteral antibiotics *	Various (ampicillin, gentamycin)
		2. Administration of parenteral anticonvulsants	Magnesium sulfate, calcium gluconate
		3. Administration of uterotonics for treatment of hemorrhage	Oxytocin, misoprostol
		4. Manual delivery of the placenta	Prophylactic antibiotics
		5. Evacuation of uterine contents (MVA)	Manual vacuum uterine aspirator (MVA), misoprostol
		6. Instrumental assisted delivery (vacuum/ventouse)	Vacuum extractor (Kiwi, Omni-cup)
		7. Maternal and neonatal resuscitation	Resuscitation bag and mask (sizes 0 and 1 for neonates); suction; adult size for mother
		8. Blood transfusion	Tests: blood type, infectious diseases (HIV, HBV, HCV, syphilis)
		9. Caesarean section	Surgical kit

Emergency Obstetric and Neonatal Care (EmONC)

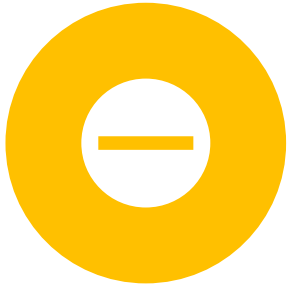
- Approximately 15% of all pregnancies will experience a life-threatening complication
- Rapid access to emergency care is needed
- Basic EmONC (BEmONC) functions should be provided at health centre level* (depending on size, distance to higher level of care, context etc.)
- Comprehensive EmONC (CEmONC) functions at referral hospital (district hospital or comparable)



Monitoring EmONC Status of Health facilities

Availability: 5 health facilities providing EmONC per 500,000 population (4 basic and 1 comprehensive) with an equitable distribution of facilities and services

Use a structured checklist to check for provision of services and **associated medications and equipment**



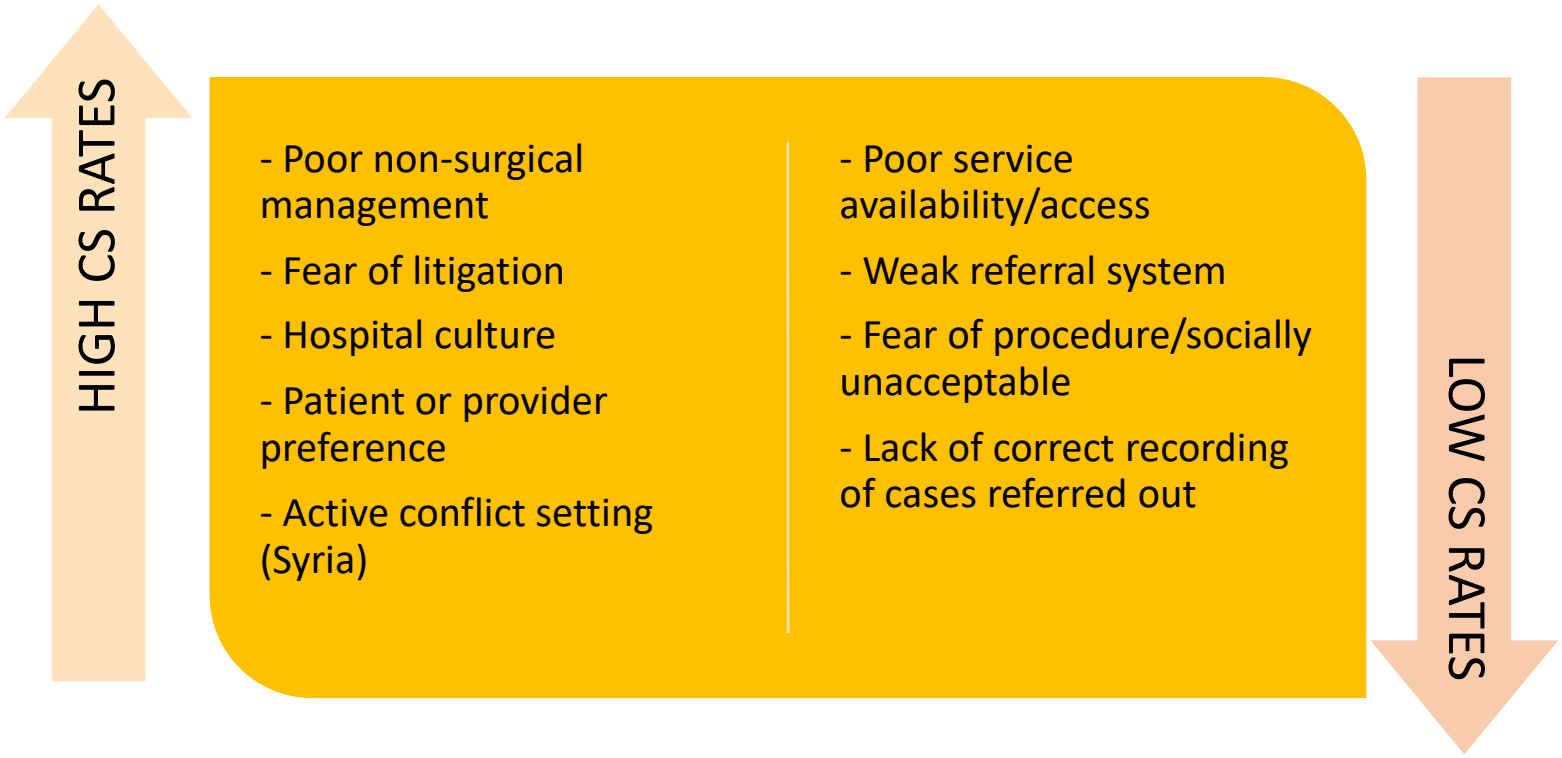
Must have provided all 7 signal functions in the past 3 months to be considered BEmONC facility; 9 functions for CEmONC

Common reasons for not achieving BEmONC status include: small health facilities who don't encounter all complications within 3 months; lack of required equipment; lack of trained staff; policy restrictions. Vacuum/venteuse skills/equipment common gap

What are your caesarean section rates?

- It is expected that between 5-15% of births will require caesarean section (population-level rates – not health facility rates)

- Rates significantly above or below these levels do not provide additional benefit but can contribute to increased mortality



Robinson classification : https://www.who.int/reproductivehealth/topics/maternal_perinatal/robson-classification/en/
The Robson classification implementation manual: https://www.who.int/reproductivehealth/topics/maternal_perinatal/robson-classification-implementation/en/

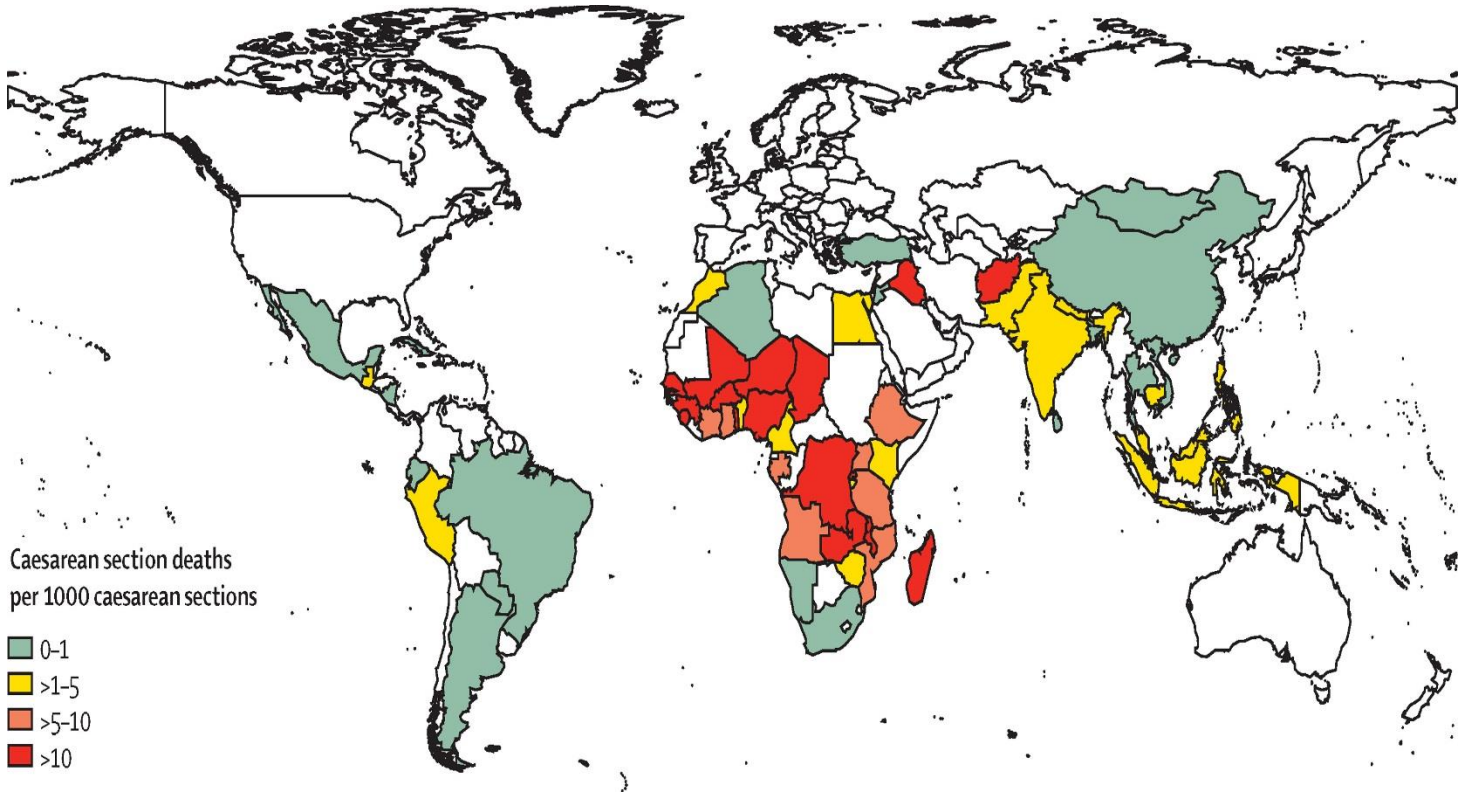
Caesarean Sections – Quality Actions Needed!

Deaths from caesarean sections 100 times higher in developing countries: global study

Outcomes for women "*far worse*" than expected

28 March 2019 – Maternal deaths following caesarean sections in low- and middle-income countries are 100 times higher than in high-income countries, with up to a third of all babies dying, according to data from 12 million pregnancies. A new review, published in *The Lancet*, has considered 196 studies from 67 low- and middle-income countries.

32% of all deaths following caesarean section were attributed to postpartum haemorrhage
19% to pre-eclampsia
22% to sepsis
14% to anaesthesia related causes
Up to 1/3 of all babies dying



Sobhy et a. (2019) *Maternal and perinatal mortality and complications associated with caesarean section in low-income and middle-income countries: a systematic review and meta-analysis* .The Lancet; V393 (101084); p 1973-1982

Discussion – EmONC Services

- What are the main barriers to providing BEmONC functions in your operations?
- What are the Caesarean section rates in your operations? Are they within the expected range?
- What are some barriers/difficulties you face regarding access/availability or quality of caesarean sections?

Summary – Part 1

- Maternal mortality is a major health burden
- Most deaths are preventable with basic interventions across the continuum of care (ANC – Delivery – Postnatal)
- Emergency phase – MISP implementation is priority
- Post-emergency: Ensure core/essential services are available to all women/at every birth (ANC, PNC, Essential childbirth and newborn care, EmONC)
- Quality of care factors need to be addressed from a management level
- Identify gaps and make action plan to fill gaps (training, supply chain or essential equipment, clinical guidelines/protocols, clinical charts)

Agenda - Part 2 (October 2019)

- Maternal mortality audits – Dr. Edna Moturi, epidemiologist
- Addressing the 4 leading causes of maternal mortality (hemorrhage, preeclampsia/eclampsia, sepsis, unsafe abortion) from a management perspective
- Community based interventions for maternal health
- Improving quality of care – key components
  - Defining package of care
  - Capacity building for staff (training courses and approaches)
  - Key clinical guidelines/protocols
  - Equipment and supplies
  - Monitoring maternal health services (Balanced Score Card/HIS)

THANK YOU FOR YOUR ATTENTION

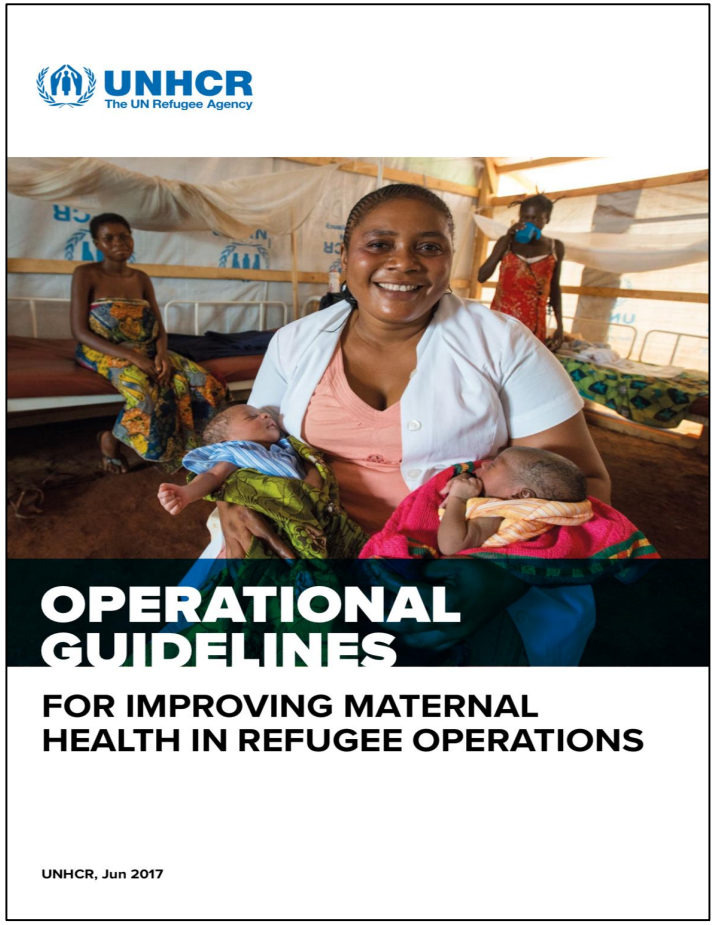
Questions?

Training developed as part of “Saving newborn lives in refugee situations”, project supported by the Bill & Melinda Gates Foundation. The technical guidance is the authors and do not necessarily reflect positions or policies of the Bill & Melinda Gates Foundation.

ANNEXES

Operational guidelines

http://iawg.net/wp-content/uploads/2019/01/2018-inter-agency-field-manual.pdf



Coming soon……

“Standard“ population

- Adult males 20%
- Women of reproductive age (WRA) 25%
- Crude birth rate 4%
  - *Number of pregnant women*
  - *Number of deliveries*
- Complicated abortions/pregnancy 20%
- Vaginal tears/delivery 15%
- Caesarean sections/delivery 5%
- WRA who are raped 2%
- WRA using contraception 15%
  - *Oral contraception* *30%*
  - *Injectables* *65%*
  - *IUD* *5%*

Inter-Agency RH kits

	Kits	
Community and Primary Health Care Level 10 000 pop	0	• Training and administration
	1 A & B	• Condoms (male & female)
	2 A & B	• Clean delivery - home
	3	• Post-rape care
	4	• Oral and injectable contraception
	5	• STI drugs
Health centre or hospital level (BEmONC) 30 000 pop	6 A & B	• Delivery - midwife
	7	• IUD insertion
	8	• Complications of abortion
	9	• Suture of cervical and vaginal tears
	10	• Vacuum extraction
Referral Hospital level (CEmONC) 150 000 pop	11 A &B	• Obstetric Surgery
	12	• Blood transfusion

Kits contain supplies for 3 months

EMONC FUNCTIONS			
Were the following services performed at least once in the last three months?		NUMBER of Cases or YES/NO	If NO, what is the reason (a-e)
Basic (BEmONC) (functions 1-7)	1.Provision of parenteral antibiotics		
	a. Ampicillin and Gentamycin in stock		
	2.Parenteral uterotonics drugs for **treatment** of PPH		
	a. Oxytocin in stock (and in cold chain)		
	3.Provision of parenteral anticonvulsants		
	a. Magnesium sulfate in stock		
	4.Manual removal of placenta		
	5.Removal of retained products of conception (e.g. manual vacuum aspiration)		
	a. MVA equipment in stock/functioning		
	6.Instrumental vaginal delivery (e.g. vacuum or forceps delivery)		
	a. Vacuum/venteuse in stock		
	7.Perform basic maternal and newborn resuscitation (e.g. with bag and mask)		
	a. Neonatal size bag and masks size 0 (preterm) and 1 (newborn)		
Comprehensive (CEmONC: all functions 1- 9)	8.Blood transfusion		
	a. Rapid tests for HIV,HCV, HBV		
	9.Caesarean section		
	a. Obstetrical surgical kit and adequate sterilization capacity		
TOTAL NUMBER OF SIGNAL FUNCTIONS PROVIDED (AND SUPPLIES IN PLACE):			
EMONC STATUS (NONE/BASIC/COMPREHENSIVE)			
Reported reason for not providing function in past 3 months: a. Lack of appropriate health care workers b. Lack of training for health care workers (hcw is available but not trained in that function) c. Lack of necessary equipment or medication d. Health policy prevents the provision of this function e. No appropriate patient needing this function presented in past 3 months			

Type of Guideline	Example (local MoH guidelines have preference if available and updated)
ANC guidelines	WHO. 2015. Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice, Third Edition Available from: https://apps.who.int/iris/bitstream/handle/10665/249580/9789241549356-eng.pdf?sequence=1 For policy makers: WHO. 2016. WHO recommendations on antenatal care for a positive pregnancy experience. https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/anc-positive-pregnancy-experience/en/
PNC guidelines	WHO postnatal Care guidelines: https://www.who.int/maternal_child_adolescent/publications/WHO-MCA-PNC-2014-Briefer_A4.pdf?ua=1 PNC :Pre-discharge checklist Bedside poster: https://www.healthynewbornnetwork.org/hnn-content/uploads/PNC-Bedside-Pre-Discharge-Poster_Asia-2016-1.pdf Pre-discharge checklist: https://www.healthynewbornnetwork.org/hnn-content/uploads/PNC-Checklist_Asia-1.pdf
Labour and delivery/Newborn guidelines	WHO. 2015. IMPAC: Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice, Third Edition Available from: https://apps.who.int/iris/bitstream/handle/10665/249580/9789241549356-eng.pdf?sequence=1
Emergency obstetric and new-born care guidelines (EmONC)	WHO. 2017. Managing Complications in Pregnancy and Childbirth: A guide for midwives and doctors.2nd edition. Available from: https://apps.who.int/iris/bitstream/handle/10665/255760/9789241565493-eng.pdf?sequence=1 MSF: Obstetrical and Neonatal Care: http://refbooks.msf.org/msf_docs/en/obstetrics/obstetrics_en.pdf
Guidelines for Care of Sick newborns	Outpatient: Integrated Management of Newborn and Childhood Illnesses (IMNCI): WHO. 2014. IMNCI Chart booklet (English). (Includes separate section on 0-2 months) Available from: https://www.who.int/maternal_child_adolescent/documents/IMCI_chartbooklet/en/ WHO. 2003. Managing newborn problems: a guide for doctors, nurses, and midwives. https://apps.who.int/iris/bitstream/handle/10665/42753/9241546220.pdf?sequence=1 WHO. 2013. Pocket book of hospital care for children https://www.who.int/maternal_child_adolescent/documents/child_hospital_care/en/ MSF. 2015. Advanced Neonatal Care https://www.healthynewbornnetwork.org/hnn-content/uploads/MSF_Advanced-Neonatal-Care_2015.pdf MSF: Obstetrical and Neonatal Care: http://refbooks.msf.org/msf_docs/en/obstetrics/obstetrics_en.pdf
Guidelines for care of pre-term or low birth-weight new-borns	WHO. 2003. Kangaroo Mother Care, a Practical Guide. https://www.who.int/maternal_child_adolescent/documents/9241590351/en/ KMC Implementation guide: https://www.mchip.net/sites/default/files/mchipfiles/MCHIP%20KMC%20Guide.pdf WHO. 2011. Guidelines on optimal feeding of low birth-weight infants in low- and middle-income countries. (for policy makers) https://www.who.int/maternal_child_adolescent/documents/9789241548366.pdf?ua=1