URGENT RESPONSE:

PROVIDING EMERGENCY OBSTETRIC AND NEWBORN CARE

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Introduction

Women everywhere face a risk in giving birth. Worldwide, about 15 per cent of all women suffer complications during childbirth that can become life threatening when not managed quickly and appropriately. In most cases, deaths are avoidable because complications can be identified early during pregnancy (antenatal care visits) and labor (partograph) when the pregnant women seek assistance by skilled professionals and can be treated with emergency obstetric care. This includes administering medicines or performing fetal extractions, Caesarean sections or blood transfusions, in particular.

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The absence of this care in many countries is a key reason why women and newborn continue to die at unacceptably high numbers. Every day, about 800 women, almost all in developing countries, die during pregnancy and childbirth.[1] Most of these deaths could be prevented. Moreover, for every woman who dies, approximately 20 women suffer short- or long-term illnesses or disabilities, like obstetric fistula, uterine prolapse, anemia or infertility.[2]

Saving women's and babies' lives requires two complementary strategies: the first is to prevent unwanted pregnancies by ensuring universal access to modern contraceptives. The second involves enabling all pregnant women to deliver in well-equipped health facilities with the assistance of skilled health professionals, including midwives, nurses and doctors trained to provide emergency obstetric care when a complication occurs. But in many of the world's poorest countries, women do not have access to this critical care. Poor women in remote areas are the least likely to make it to a health center or benefit from skilled assistance when emergencies arise during pregnancy and childbirth. While developing regions as a whole have made progress in recent years in increasing women's access to routine and emergency maternal health care, there are still major inequities, particularly in Sub-Saharan Africa and Southern Asia.[3] Experience demonstrates that advances in emergency obstetric and newborn care are achievable, even in the poorest and most extreme settings, given the political and financial commitment. Increased investment is required to make these life-saving services available to *all* women.

In countries where HIV prevalence is high, maternal mortality reduction can be hampered by the epidemic. Ensuring HIV prevention before pregnancy in all communities and households and access to information and Prevention of Mother-to-Child HIV Transmission (PMTCT) services during pregnancy, childbirth and the post-partum/natal period for infected and non-infected pregnant women and their babies is a critical element of the fight against maternal and neonatal mortality and morbidity.

What is Emergency Obstetric and Newborn Care?

Basic emergency obstetric and newborn care can be provided at first level when a skilled professional is present, in health centres, and includes:

- Administering antibiotics, oxytocics and anticonvulsants to manage bleeding, infections and fits;
- Manually removing the placenta;
- Removing retained uterine products following miscarriage or abortion;
- Assisting with vaginal delivery, with vacuum extractor or forceps; and
- Performing newborn resuscitation.

Comprehensive emergency obstetric and newborn care, typically delivered in district hospitals, includes all basic functions above, plus obstetric surgery (Caesarean section, in particular), safe blood transfusion and care to sick and underweight newborns.

Source: Monitoring emergency obstetric care, a handbook.

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The Current Situation

More than 80 per cent of maternal deaths worldwide are due to five direct causes: severe bleeding, infections, high blood pressure during pregnancy (pre-eclampsia and eclampsia), unsafe abortion and obstructed labour. Most of these complications are unpredictable but can be effectively prevented or treated by skilled health workers in properly equipped facilities.[4]

There is a shortage of health facilities providing the full range of emergency obstetric care. A study of 2.7 million deliveries across seven developing countries found that only one-third of women who needed lifesaving care for a complication received it.[5]

Women and their infants are at greatest risk of death during labour and delivery.[6] In Sub-Saharan Africa, where maternal mortality ratios are the highest, only 46 per cent of women are attended by a trained midwife, nurse or doctor during childbirth.[7]

Severe bleeding is the leading cause of maternal death.[8] This complication can kill a woman in less than two hours, so prevention at childbirth and control of bleeding (oxytocics), manual removal of placenta, a blood transfusion and/or fast emergency evacuation, are critical to save her life.[9] If the woman is giving birth at a facility, care and transportation can be organized in a timely manner to save her life. If the woman is giving birth without any assistance, she is likely to die from hemorrhage (bleeding).

Obstructed labor, when identified in a timely manner by the systematic surveillance of the labor (use of a partograph), and when the woman can be transported to a functioning Emergency Obstetric and Neonatal Care (EmONC) facility where a vacuum extraction, a forceps or a Caesarean section can be performed, both she and her baby have has great chances to survive without complications.

A woman's lifetime risk of death due to pregnancy is 1 in 52 in the least developed countries compared to 1 in 4,700 in industrialized nations.[10] There are also significant disparities within countries, with poor, rural, and uneducated women at greater risk than their wealthier, urban counterparts.[11]

Three Delays

Timing is critical in preventing maternal death and disability. Although post-partum bleeding can kill a woman in less than two hours, for most other complications, a woman has between 6 and 12 hours or more to get life-saving emergency care. Similarly, most perinatal deaths occur during labour and delivery, or within the first 48 hours thereafter.

The "three delays" model is a useful tool for determining what prevents women from getting care in time, and for designing interventions to respond to these obstacles.

The three delays include:

- Delay in deciding to seek care
- Delay in reaching appropriate care
- Delay in receiving care at health facilities

The first two "delays" involve a woman's access to care, encompassing factors in the family and the community, including transportation. The third "delay" relates to factors in the health facility, including quality of care. All three delays must be addressed to save women's lives.

Source: UNFPA website, "Emergency Obstetric Care."

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Emergency obstetric and newborn care includes Caesarean sections. In many countries, the number of Caesarean sections performed is lower than it should be: at least 5 per cent of childbirths according to World Health Organization estimates. In developing countries overall, less than one-third as many rural women as urban women have Caesarean sections.[12] Moreover, there are issues with the quality of care in developing countries, where Caesarean sections can be done too late or improperly.

It is estimated that 2 million women in Sub-Saharan Africa, South Asia and the Arab region are living with obstetric fistula, a hole in the vagina or rectum caused by labour that is prolonged—often for days—without treatment. Usually the baby dies. Because the fistula leaves women leaking urine and/or feces, it causes social isolation, depression and deepening poverty. Left untreated, fistula can lead to chronic medical problems. Like maternal mortality, fistula is almost entirely preventable, and its persistence is a sign that health systems are failing to meet the needs of women.[13]

In developing regions overall, the proportion of deliveries attended by skilled health personnel rose from 55 per cent in 1990 to 65 per cent in 2009. However, coverage remains low in Sub-Saharan Africa and Southern Asia, and poor women are least likely to benefit from this assistance.[14]

Maternal health and newborn health are closely linked. Each year, more than 3 million newborn babies die.[15] Between one-quarter and one-half of all newborn deaths occur within the first 24 hours after birth. Three-quarters occur in the first week.[16]

Poverty and gender barriers prevent many women from accessing emergency treatment when they need it. Women may not have control over financial resources or transportation and are thus dependent on their husbands and family for mobility and access to health services. When an emergency arises, they may not have the power or resources to get to a health centre.[17]

A central obstacle to progress is the lack of skilled care. Globally, there is a shortage of skilled health workers. The World Health Organization estimates that another 330,000 midwives are needed to ensure that all mothers have access to skilled attendance at birth.[18]

COVERAGE REMAINS LOW IN SUB-SAHARAN AFRICA AND SOUTHERN ASIA, AND POOR WOMEN ARE LEAST LIKELY TO BENEFIT FROM ASSISTANCE.

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What Must Be Done?

Experience shows that even in the poorest countries, maternal deaths can be dramatically reduced if there is high-level political will and appropriate funding. Moreover, reliable data to assess the situation, guide strategies, and track progress is crucial. This includes (1) counting each and every maternal death, at community and facility levels, (2) reporting and analyzing them, with the communities (verbal autopsies) and the professionals (maternal death reviews) to determine the causes behind specific maternal deaths in order to pinpoint obstacles that impede women from getting the skilled assistance they need and (3) correcting these obstacles and monitoring progress. Around the world, evidence demonstrates that investments in quality emergency obstetric care can significantly reduce avoidable maternal and newborn deaths and disabilities.

Emergency obstetric care requires skilled personnel and adequate health care infrastructure, including medicines and supplies and access to reliable and fast transportation. The long term goal is for all births to take place in appropriate health facilities, as is the case in all countries that have managed to significantly reduce their maternal mortality rates. In the interim, before this long-term goal is reached, universal access to emergency obstetric and newborn care means that all women and newborns with complications have access to well-functioning facilities such as a district hospital or maternity centre. Existing facilities can often, with just a few changes, be upgraded to provide emergency obstetric and newborn care.[19] Communities also play a critical role by contributing to the management of the health facilities, building local emergency transportation networks, monitoring the quality of care and creating shared community savings accounts that can be used in case of emergency.

An increasing number of countries are promoting free care policies for maternal and newborn health, for emergency obstetric and neonatal care or, sometimes, only for Caesarean sections. These strategies require the mobilization of adequate and sustainable resources and a close monitoring and evaluation in order to minimize the possible adverse effects and ensure effective access to services for the poor and marginalized.

EMERGENCY OBSTETRIC CARE REQUIRES SKILLED PERSONNEL AND ADEQUATE HEALTH CARE INFRASTRUCTURE, INCLUDING MEDICINES, SUPPLIES AND ACCESS TO RELIABLE AND FAST TRANSPORTATION.

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The quality of the EmONC services, aimed to be effective 24/7, is a major concern. Supportive supervision mechanisms, effective purchasing systems, staff deployment, retention and support are also critical elements.

Benefits of Action

Fully meeting the need for family planning and maternal health care, including emergency obstetric and newborn care when needed, would reduce maternal deaths by around two-thirds.[20] Some of the most dramatic gains would happen in Sub-Saharan Africa and South Asia.[21]

Upgrades in health systems that respond to obstetric emergencies would improve systems' responses to other urgent medical needs. Preventing maternal and newborn deaths requires that health facilities have the emergency supplies and equipment necessary to respond to life-threatening complications. It also demands that health professionals be well-trained and able to respond 24 hours a day. This preparation leaves health systems better able to respond to other medical emergencies. [22]

Meeting the need for improved maternal and newborn health care and family planning would cut in half the number of newborns who die each year. Mothers' health is intricately connected to that of their babies, and a mother's death has significant health, social and economic consequences for her children.[23]

Reducing maternal death and disability and improving women's reproductive health are critical for social and economic development. Healthy, planned pregnancies help girls and women finish an education, engage in productive work, and contribute to social and economic progress within their communities and nations.

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What is UNFPA Doing?

UNFPA works at many levels and with multiple partners to expand access to obstetric and newborn care. The Fund provides baseline data to inform evidence-based policies and programs, advocates for health reforms, upgrades health facilities, and mobilizes communities to prepare for and respond to obstetric and newborn emergencies.

In partnership with UNICEF and the Averting Maternal Deaths and Disability programme at Columbia University, UNFPA has supported several emergency obstetric and newborn care needs assessments in countries with high maternal death rates. UNFPA recognizes that saving women's lives requires addressing the social, economic and gender inequalities that prevent women and girls from making independent decisions to safeguard their health, such as deciding to go to a health center when a complication arises in childbirth. For more than 30 years, the Fund has been in the forefront of advocating for women, promoting legal and policy reforms and gender-sensitive data collection, and supporting projects that improve women's health and expand their choices in life. UNFPA also works alongside men and boys, policymakers and civil society, including faith-based organizations and cultural leaders to challenge harmful traditional attitudes and practices.

UNFPA also helps lead the Global Campaign to End Obstetric Fistula and directly supports the campaign's programmes in more than 40 developing countries. Moreover, in collaboration with the International Confederation of Midwives, UNFPA supports the critical work of midwives in savings women's lives around the world. Alongside UNICEF, the World Health Organization, UNAIDS, and the World Bank, UNFPA is an active member of the H4+, a leading maternal and newborn health coalition. The Fund is also an active member of the Partnership for Maternal, Newborn and Child Health and the Women Deliver initiative. UNFPA's work contributes to the "Every Woman Every Child" effort in support of the Global Strategy for Women's and Children's Health.

UNFPA ALSO HELPS LEAD THE GLOBAL CAMPAIGN TO END OBSTETRIC FISTULA AND DIRECTLY SUPPORTS THE CAMPAIGN'S PROGRAMMES IN MORE THAN 40 DEVELOPING COUNTRIES

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NOTES

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