

Women-friendly health services Experiences in maternal care

Report of a WHO/UNICEF/UNFPA Workshop

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FOREWORD

The acceleration of efforts to reduce maternal mortality is a priority for UN agencies and their partners, both at national and international levels. The commitment to ensure the rights to life and good health lies at the root of the Safe Motherhood Initiative, which was launched in Nairobi in 1987. The International Conference on Population and Development in 1994, the Fourth World Conference on Women in 1995 and the Tenth Anniversary Safe Motherhood Consultation in Colombo in 1997 all helped redefine maternal mortality as a social injustice that infringes on women's right to quality maternal health services. More recently the review of ICPD+5 achievements for example reiterated the need to improve access to quality obstetric care and well-trained staff to attend deliveries.

Building on country experiences, WHO, UNFPA and UNICEF, with support from The World Bank, organised a forum to review lessons learned and discuss criteria of good quality maternal care that respect women's rights and needs. An international workshop on "Building Women-Friendly Health Services" was held in Mexico City from 26 to 28 January 1999. One hundred and eight participants from 25 countries attended the workshop, providing a wide array of expertise including policymakers working in ministries of health, representatives from UN agencies and bilateral donors, non governmental organisations, and academic institutions. To ensure a wider representation of opinions, an electronic discussion by Internet was conducted for two months preceding the workshop, facilitated by WHO, UNICEF and UNFPA, with assistance from Management Sciences for Health.

The Mexico meeting concluded that women-friendly services should provide care of high technical quality, be accessible, affordable and culturally acceptable, empower and satisfy users, as well as support and motivate providers. Participants discussed in detail each of four sets of criteria, and agreed on the need to further develop standards and indicators of progress.

A major achievement of the workshop is the realisation that the health sector reform process can be combined with a women's rights perspective in order to reach a consensus on criteria for quality of care, acceptable standards, and indicators to monitor compliance. The Mexico workshop focused on maternity care, within the context of reproductive health care. Participants recommended that the experience with quality improvement of family planning programmes be used to apply the women-friendly approach to the complete range of reproductive health services.

Much remains to be done. This report should be read in the perspective that progress can only be achieved through a combination of policy and legislative actions, provision of women-friendly care and community interventions. We in WHO, UNICEF, and UNFPA, are committed to work in partnership with policymakers and health providers to make this happen.

Paul Van Look
Director, Department of
Reproductive Health and Research
Family and Community Health
WHO

David Alnwick
Chief, Health Section
Programme Division
UNICEF

Nicholas Dodd
Chief, Technical Branch
Technical and Policy Division
UNFPA

EXECUTIVE SUMMARY

A woman's rights to timely, affordable, and good quality health care is affirmed as a basic human right by international conference declarations and legal instruments, as well as by national and international treaties. An international workshop on "Systematising Experiences in Implementing Women-Friendly Health Services" was held in Mexico City on 26-28 January, 1999, to advance ongoing efforts by governments to improve the quality of maternal health services, in the broader context of reproductive health.

One hundred and eight participants from 25 countries attended the workshop. These included policy-makers, programme managers, health professionals as well as representatives of multilateral and bilateral agencies, non-governmental organisations, and academic institutions. They reviewed lessons learned from country experiences in implementing safe motherhood programmes, and outlined criteria and strategies for achieving women-friendly maternal health services.

Four working groups achieved consensus on the major components of women-friendly health services. Women-friendly health services should: (i) be available, accessible, affordable and acceptable; (ii) respect technical standards of care by providing a continuum of services in the context of integrated and strengthened systems; (iii) be implemented by staff motivated and backed up by supervisory, team-based training, and incentive-linked evaluation of performance; and (iv) empower users as individuals and as a group by respecting their rights to information, choice, and participation.

Participants agreed on the need to translate these criteria into measurable indicators and universally acceptable standards for maternal care. These standards should be evidence-based and be adapted to the context of each country. However, they should be universal in so far as to represent the minimum care that must be provided to every woman, regardless of her income, age, ethnic origin and place of living.

This approach to improve women-friendliness of maternal care takes a long-term perspective and builds on the mandates and recent experiences of countries, by including all stakeholders involved in planning and implementing country programmes. This rights-based approach to maternal and neonatal health will enable governments and international agencies to improve women's access to safe motherhood and reproductive health services.

A broad range of measures is required to improve women's health services because of the diversity of situations, both within and between countries. Participants shared experiences of interventions to improve quality and women-friendliness of maternal care. These experiences fall into five categories:

- (a) Decreasing barriers to access to care by overcoming the financial constraints, improving transport and communication systems or reorganising services;
- (b) Improving staff skills by increasing the availability of skilled personnel, reviewing the legal framework of staff responsibilities, developing guidelines of care and improving training through mentoring, team-work, and increased participation;
- (c) Ensuring compliance with standards through certification or accreditation either by outside evaluators or on the basis of self-assessment;

- (d) Problem-solving and self-assessment for the continuous improvement of quality using maternal mortality audits, community-based monitoring mechanisms and qualitative self-assessment; and
- (e) Improving user satisfaction to increase demand, and accompanying it with the empowerment of women by addressing the underlying factors of maternal morbidity and mortality.

Lessons learned from the development and implementation of measures that increase the friendliness of health services to women include the following steps:

- (a) analyse the situation to identify opportunities and possible bottlenecks;
- (b) build on successful strategies;
- (c) adapt experiences and models learned from other countries to the local context;
- (d) involve stakeholders at all stages of the process;
- (e) implement several interventions simultaneously but switch emphasis from one intervention to another based on monitoring results or changing needs;
- (f) take advantage of political opportunities; and
- (g) build self-esteem and create incentives for health staff to improve their performance and to further develop their capacities.

A major achievement of the workshop was the realisation that the health sector reform process can be combined with a woman's rights perspective for developing criteria for quality of care, acceptable standards, and indicators to monitor compliance.

The Mexico workshop focused on maternity care, within the context of reproductive health care. Participants recommended that the experience with quality improvement of family planning programmes be used to apply the women-friendly approach to the complete range of reproductive health services. Additionally, the workshop provided networking opportunities to facilitate information sharing among countries in order to improve the planning and implementation of interventions.

The workshop participants also recommended that the results of this workshop be shared with other partners and that similar workshops be conducted in other regions. This would help to continue the dialogue with all stakeholders, to build information-sharing networks, and to conduct operational research for documenting the effectiveness of this approach.

CHAPTER I: INTRODUCTION

A. The need for women-friendly health services

Maternal health reflects the level of social justice and the degree of respect for women's rights in a society. Women's right to receive good-quality health services is guaranteed when their basic human rights -- to education, nutrition, to a safe environment, to economic resources and to participation in decision-making -- are met. In the broader context of reproductive health, safe motherhood is a critical component of the efforts to help women realise their full potential not only as mothers, but also as contributing members of society.

The rights perspective

The International Conference on Population and Development (1994), the Fourth World Conference on Women (1995), and the Safe Motherhood Technical Consultation (1997) have redefined maternal mortality as a social injustice that infringes on women's rights to quality maternal health services. This re-definition lays the foundation for an integrated, intersectoral approach to maternal health by relating interventions to fundamental rights embodied in international conventions and national constitutions.

A human rights approach provides a legal and political basis for governments to ensure access to quality maternal health services and information for all women. Combined with global monitoring, this gives a solid framework for interventions to reduce maternal mortality.

The four main categories of human rights relevant to maternal health are:

- 1) The right to life and security.
- 2) The right to foundation of family and of family life.
- 3) The right to highest standard of health and benefits of scientific progress.
- 4) The right to equality and non-discrimination on grounds such as sex, marital status, race, age and class.

Box 1: International Conferences and Human Rights Instruments

1948: Human Rights Declaration

1979: Convention on Elimination of All Forms of Discrimination Against Women

1987: Safe Motherhood Initiative Conference (Nairobi)

1989: Convention on the Rights of the Child

1990: World Summit for Children

1993: International Conference on Social Development (Copenhagen)

1994: International Conference on Population and Development (Cairo)

1995: Fourth World Conference on Women (Beijing)

1997: Technical Consultation on the Safe Motherhood Initiative (Colombo)

The causal framework

Eighty percent of maternal deaths all over the world are directly attributable to haemorrhage, sepsis, eclampsia, obstructed labour and unsafe abortion. These direct factors are similar in all settings. However, multiple factors underlie women's capacity to survive pregnancy and childbirth. They include women's health and nutritional status, their access to and use of health services, household practices, and community behaviours with regard to women's health. The status of girls and women in society underlie all of the above. All of these factors have an impact on women's access to quality obstetric care.

B. Actions to reduce maternal mortality

Reducing maternal mortality requires co-ordinated, long-term efforts at the household and community levels as well as at the level of national legislation and policy formation, especially in the health sector. Long-term political commitment is essential for reviewing national laws and policies in the area of family planning and adolescent health ensuring availability of skilled attendants at birth, regulation of health practices, and the organisation of health services. At the community level, mechanisms must be established to promote the participation of women in achieving desired planned pregnancies. These steps should be complemented with plans to improve communication and referral of maternal complications, ensure basic supplies for safer home deliveries, and improve nutrition for women and girls.

Making high-quality obstetric services available to all women during pregnancy and childbirth is critical to supporting the above actions. Health services for women should focus on the prevention of unwanted pregnancies, the prevention of complications during pregnancy, and the appropriate management of any complications that do occur. This implies:

- **Client-centred family planning information and services** that offer women, men, and adolescents the choices that meet their needs.
- **Basic prenatal and postpartum care** to detect and manage nutritional deficiencies, and to treat endemic diseases such as malaria, helminth infestations, and sexually transmitted diseases. Prophylactic care should include tetanus-toxoid immunisation, anti-malarial tablets, iron/folate supplementation, and voluntary counselling/testing for HIV.
- **A skilled attendant with midwifery skills** present at every birth, with the capacity to provide first aid for obstetric complications and emergencies, including life-saving measures when needed.
- **Good-quality obstetric services at referral centres** to treat complications, including facilities for blood transfusions and caesarean sections.
- **Contraceptive counselling for women** after childbirth and for those who have experienced obstetric complications.

Quality of maternal health services

Maternal morbidity and mortality are clearly related to poor technical quality of maternal and reproductive health services including cultural, time, financial or geographical barriers of access to care.

Box 2: Building Women-friendly Societies to Make Motherhood Safer

*Maternal mortality must be considered a **violation of women's human rights** necessitating changes in the legal, political, health, and education systems to provide more equitable, women-centred health services through strong partnerships between governments and communities.*

***Greater investments** in basic social services (health, education, nutrition, water and sanitation) are essential to achieving safe motherhood.*

*National and local governments need to provide **high-quality health care** and nutrition for infants as well as women that is responsive to women's needs and respectful of their rights.*

*Men, parents, in-laws, families, and neighbours need to join efforts to **support women in improving their lives and health**. They must also help break down barriers to health care by mitigating distance, cost and socio-cultural obstacles by providing education, integrating customs and traditions, and enhancing women's status and decision-making powers.*

Reference: Programming for Safe Motherhood, UNICEF, 1999.

Common barriers that contribute to the low utilisation of health services include the lack of compliance of services with defined standards, the shortage of supplies, infrastructure problems, deficiency in detection and management of complications or emergency cases, and poor client-provider interaction. Furthermore, services are also underutilised when they are perceived to be disrespectful of women's rights and needs, or are not adapted to the cultural contexts.

Providing good-quality care is one of the most effective ways of ensuring that maternal health services are used, and that women's lives are saved.

This can be achieved by assuring respect of standards of care, decreasing barriers to care, ensuring the empowerment and satisfaction of users and motivation of providers by involving them in decision-making, and improving provider responsiveness to cultural and social norms. In other words, the provision of good quality care improves the "**women-friendliness**" of health services.

The "women-friendly" approach focuses on the rights of women to have access to quality care for themselves as individuals and as mothers, and for their infants. It is part of a broader strategy to reduce maternal and neonatal morbidity and mortality and requires strong partnerships between governments, health systems and communities (see Box 2). This approach pretends to build on knowledge and lessons learned from country experiences in safe motherhood programmes.

C. The Mexico workshop

Until the 1980s, efforts by the health care sector for improving the quality of health care relied on government licensing of institutions and services, professional credentials, and in some countries, internal audits and external inspections. These efforts left out two major elements of quality that were being addressed by the private sector to improve productivity and product utilisation: staff motivation and user satisfaction. Over the last two

decades, however, the movement to enhance quality in health care has been integrating both the medical approach to quality of care and the private sector approach that relies on involvement of staff and users for programmatic success. This comprehensive user-centred approach to quality has been applied in the areas of family planning and primary health care in many developed and developing countries and is now being expanded to include maternal and other reproductive health services.

In the process of implementing safe motherhood action plans, governments of several countries have supported the development of innovative approaches to improve the quality of maternal health services. To complement these efforts and to build on earlier attempts to conceptualise quality into programmatic action, WHO, UNICEF, and UNFPA organised a workshop for “Systematising Experiences in Implementing Women-Friendly Health Services” in Mexico City from 26-28 January 1999. This workshop specifically focussed on maternal health in the broader context of reproductive health. It was an attempt to put into practice the recommendations of the Safe Motherhood Initiative and the ICPD Programme of Action for improving the reproductive health and well being of women.

D. Workshop objectives

The goal of the workshop was to recommend better practices for improving the quality of maternal health care by drawing on lessons learned in implementing women-friendly health services in several countries. The following two objectives were established for reaching the goal of the workshop.

- a) Reach a consensus on a set of universal criteria to achieve women-friendly health services, particularly in the area of maternal health.
- b) Recommend strategies for implementing women-friendly health services.

One hundred and ten participants from 25 countries (see Annex 4) including policy-makers, programme managers and health professionals, representatives of multilateral and bilateral agencies, non-governmental organisations, and academic institutions attended the workshop.

E. The consensus building process

The process focussed on: (i) experience sharing through the presentation of country case studies in plenary sessions; and (ii) small group discussions to define a minimum set of standards for ensuring women-friendly services and review strategies to achieve them.

All countries invited to make a presentation at the workshop had systematically documented their experiences using a standard template. Information on the significant aspects of the programme, the strategies used, constraints faced, lessons learned, and future steps were entered into the template. Presentations were also made by agencies involved in safe motherhood or reproductive health on different models that could be used to implement women-friendly health services (see Annex 3).

Participants were divided into four working groups, each assigned to the task of defining the criteria for one aspect of women-friendly health services, based on the working definition (see Box 3). They were also asked to specify the indicators for verifying the achievement of these criteria. These indicators were to be selected based on the feasibility of their measurement and their sensitivity. Wherever possible, participants also agreed on a universal standard as a reference for the measurement.

The working groups achieved a broad consensus on the criteria and were able to give benchmarks for some indicators. It was unanimously agreed that while standards are universal in their nature because of the universality of rights, there is a need to adapt them to local conditions and resources. The participants suggested that this could be achieved by establishing intermediate goals or standards as a condition for success at country level.

The recommendations of the working groups were synthesised and presented in a plenary session. The workshop concluded with the preparation and presentation of a consensus document in plenary (see Chapter 5) with recommendations and next steps for developing and implementing women-friendly health services.

Box 3: A Working Definition of Women-friendly health services

Health services can be considered women-friendly when they:

- *Are available, accessible and affordable -- they are located as close as possible to where the women live and are reasonably priced for both the women and the health care system;*
- *Provide safe and effective health and maternal care that complies with the highest possible technical standards, and makes use of the necessary supplies and equipment; even at the lowest level facility;*
- *Motivate providers, encourage their participation in decision-making, and make them more responsive to user needs; and*
- *Empower users and satisfy their needs by respecting their rights to information, choice, safety, privacy and dignity and by being respectful of cultural and social norms.*

CHAPTER 2: DEFINING CRITERIA FOR WOMEN-FRIENDLY SERVICES

One of the major achievements of the workshop was establishing the criteria of a "women-friendly" health facility or service. These criteria were developed based on the country presentations (summaries attached), the experiences of the participants, and the evidence-based research that was used for drafting a discussion paper. Results of the working groups are outlined below.

A. Accessibility of health services

Women-friendly health services must be available, geographically accessible, affordable, and culturally acceptable in order to reduce maternal morbidity and mortality. Services should include essential obstetric care (EOC) at the primary and referral levels (see Box 5) in order to minimise delays in deciding to seek care, reach a treatment facility, and receive adequate treatment at the facility.

Box 4: Some Quality-related Definitions

Criterion: Principle or value that is used to judge a service.

Indicator: An objective variable that is used to measure a situation or characteristic of a service.

Standard: Reference value for judging the quality of a process or variable, also defined as the degree of excellence of a particular component.

Availability

The most important criterion for women-friendly health services, and especially maternal health services, is to be as close as possible to the community. Some level of health infrastructure exists in most developing countries; however, even where health services are available, they may be under-utilised reflecting a dearth of trained personnel, non-availability of drugs and supplies, or poor quality of care provided.

All women should have access to a skilled attendant during pregnancy, childbirth, and the postpartum period. This attendant should be able to provide basic EOC and refer women to comprehensive EOC, in case of complications. No woman should be denied access to life-saving essential obstetric care when complications occur during pregnancy or childbirth.

Developing countries may take longer to meet this second criterion and should therefore establish intermediate goals.

Box 5: Functions of Essential Obstetric Care (EOC)

| Facility Level | Signal Functions |
|---|---|
| Health Centre/ Dispensary Basic EOC | Antibiotics (injectable) Oxytocics (injectable) Anticonvulsants (injectable) Manual removal of placenta Removal of retained products Assisted vaginal delivery |
| District Hospital or Maternity Home Comprehensive EOC | All basic EOC functions plus Caesarean section Blood transfusion |

One indicator for measuring the availability of maternal health services could be the proportion of women who receive essential obstetric care (see Box 5). Another indicator for measuring the availability of maternal health services could be the proportion of births attended by a skilled attendant. The universal standard for these indicators would be 100% of women. However, as this may not be immediately attainable for all countries, intermediate goals should be set.

Geographical accessibility

The geographical accessibility of the health facility and the availability and efficiency of transportation affect women's ability to access health services. Speedy and easy access to health services is particularly critical when it comes to the treatment of life-threatening complications. Women with pregnancy complications need to be transported to and treated in a facility providing essential obstetric care.

One indicator for measuring accessibility could be the percentage of complications treated in EOC facilities. The standard is 100%. Another could be the existence of a transportation system, for example, an ambulance network or a reliable public transportation system. Meeting this criterion implies a strong commitment from the authorities to provide EOC facilities, including communication and transportation components.

Affordability

Access to health services is influenced by both direct costs (e.g. services, drugs and supplies, food during hospitalisation) and indirect costs (e.g. transport). When a complication occurs, the woman often needs to access specialised care at additional costs to her and her family. A poorly equipped facility requires the woman to purchase the necessary drugs and supplies herself which imposes an unexpected and untenable financial burden on the woman and her family. This often results in the woman going to the facility at a stage when it is too late to treat her.

Vital to making maternal care (prenatal, delivery and postpartum care) accessible, therefore, is to ensure that no woman is denied care, even if she is unable to pay for it. The indicator for measuring affordability could be the proportion of women refused urgent essential obstetric care for financial reasons.

Cultural acceptability

Cultural barriers to health care, relating to the lack of autonomy and decision-making power, often constrain women's access to health care. In some areas, for example, women are not allowed to leave home unaccompanied, while in others, women are not permitted to be attended by male health care providers. Sometimes, the fear of not having her cultural values respected inhibits a woman from accessing the services she needs. To eliminate these barriers, health services should be organised in a way that respects women, their culture, religion, and beliefs.

Men often hold the strings to financial as well as other assets. They decide what women can and cannot do, and, consequently, how they will be treated. In order to improve women's health, therefore, men must be targeted with Information, Education, and Communication (IEC) messages on pregnancy and childbirth to make them aware of their responsibilities. Male attitudes concerning

girls and women in schools, households, the community, and the health system must also be changed.

The rate of utilisation of services, i.e., at least one prenatal visit, could serve as an indirect indicator for gauging the cultural sensitivity of health services. However, more research is needed to define effective indicators for measuring this criterion.

B. Respect of technical standards of health care

The second criterion for women-friendly health services is the provision of quality care, as measured by the respect of standards. This refers to compliance with measurable technical norms, to the way services are organised, and to whether the health policies support the standards. The workshop recommended the following criteria:

Review of existing national policies

Political commitment at the highest level is necessary in order to achieve respect for women's rights to good quality care. National policies on maternal and child health must be reviewed with an eye toward "women-friendliness" and revised or amended in the context of ongoing health sector reforms in the country. They must respect the rights of women that are guaranteed in international conventions and human rights instruments.

The indicator and the standard for this criterion could be compliance of national policies with declarations of international conventions and legal instruments.

Integrated and continuous maternal care

Health services, especially in large facilities, are often arranged in such a way that women have to see different providers for related services. In urban areas, the lack of communication between providers and the complexity of the system tend to increase delays in care-seeking and timely treatment. In rural areas, maternal care also tends to be inadequate where one multipurpose worker has to attend to all health needs of the population. Better integration of maternal care into a package of services offered will help to improve this situation. For women with obstetrical complications, this should be complemented with a proper referral system that builds continuity of care provided at the community level to care at the hospital level.

A life-cycle approach--using integrated interventions directed at the girl child, the adolescent girl and the adult woman (from conception through the postpartum period, including family planning)--should be used in the planning and organisation of health care. This would ensure a more holistic approach that addresses the underlying causes of maternal mortality as well as continuum of care for women and integration of services.

Examples of measuring this criterion are contraceptive prevalence rate and the coverage of prenatal, delivery, and postpartum care. Because of the importance of referral, a specific indicator such as the percentage of referred women who are actually treated at the next level of care, could be used.

Infrastructure

Good basic infrastructure and an adequate quality and quantity of personnel, drugs, supplies, and equipment, including clean birth kits, will ensure good-quality health care and enable women to use the health services effectively. Infrastructure should include basic EOC and referral facilities. A hygienic environment, an adequate supply of clean water, and proper waste disposal mechanisms will help ensure that safe health care service is provided.

Indicators to measure adequacy of infrastructure could include the ratio of facilities to population and the average time required to reach an EOC facility (see Box 6).

Box 6: Standard for Essential Obstetric Care Coverage

For every 500,000 population, there should be:

- *At least 4 basic EOC facilities*
- *At least 1 comprehensive EOC facility*

Source: UNICEF/WHO/UNFPA Guidelines for Monitoring the Availability and Use of Obstetric Services, 1997.

Written guidelines

Experience shows that written protocols of care facilitate the training of staff at all levels of the health care system and improves their performance. Additionally, such protocols will provide the basis for the evaluation of staff performance. These guidelines should be based on international state-of-the-art information and should be adapted to the local context.

The indicator could be the proportion of staff properly using protocols for various components of maternal health care.

Performance criteria

Performance criteria, or achievement indicators, must be established for each aspect of women-friendly health services. Services should be monitored for compliance with technical guidelines measuring inputs, processes, and outputs, and with user expectations, although this needs further development.

Performance could be measured indirectly by the frequency of use of prenatal care, hospital mortality, and proportion of rooming-in. The definition of the indicators and related standards should be done in close co-ordination with the development of the certification/accreditation of health services underway in many countries.

C. Motivation and support of staff

Providing health services entails constant human interaction between the health personnel and the users. Staff must feel wanted and empowered to respond effectively to the needs of their clients. In addition to supervision and training, involving staff in problem-solving and giving them the tools to solve problems will motivate them to improve their performance and the quality of care.

Supportive environment

Institutional policies must be gender-sensitive and non-discriminatory. Often the staff at health facilities is largely male. Sometimes there is only one female provider at the facility and she works around the clock and under difficult circumstances. Responsibilities of staff should therefore be clearly outlined in a plan of action that reflects the national policy of promoting a women-friendly environment. This implies the need for detailed job descriptions stating the role of the staff in the organisation or facility and their duties and responsibilities.

Indicators could include the number of staff who are familiar with the action plan and who have specific job descriptions.

Team-based training

All staff members are entitled to receive training so that they can continuously update their skills. Health personnel must be trained in putting the women-friendly approach into practice. Training must be competency based, culturally sensitive, geared to community and provider needs, and enjoy continuous access to information. It must emphasise both technical and interpersonal skills. It should use a team approach to solving problems and be interactive, allowing for sharing experiences.

An indicator to measure the fulfilment of this criterion could be the proportion of trained teams who are using these methods.

Supportive supervision

A supervisory system must be established with written guidelines to support staff development. However, supervisors should not use these guidelines as a mere checklist to measure performance and compliance with norms. Instead, supervisors and subordinate staff should work as a team using the guidelines as a tool for identifying constraints faced by staff in fulfilling their responsibilities. Such supervision must be complemented with a problem-solving approach that involves staff in finding and implementing solutions. This will make the solutions much more effective and durable.

Indicators could include the existence of a supervisory system with clear reporting lines and guidelines.

Incentive-linked performance evaluation

Linking performance evaluation to an incentive system is critical for improving staff performance and inspiring motivation. The evaluation should rely on clear and transparent indicators. The process should assess fulfilment of duties as outlined in the job descriptions, compliance with standards outlined in the health care guidelines, and respect for users' rights. However, this evaluation system should be balanced with confidence-building interventions described previously in order to promote self-esteem and responsibility of the staff.

Indicators could include the proportion of staff who were evaluated the previous year or the existence of a scheme for rewarding performance.

D. Empowerment and satisfaction of users

It is important to provide access to good-quality care by trained and motivated personnel, but this alone will not ensure the adequate use of services. To empower women to demand the services they need and are entitled to, it is critical to respect their rights and encourage their active involvement in making decisions about their own health care. When women's rights are respected and they have access to information, they tend to use the health services that satisfy their needs.

Information and counselling

Women, men, and families must have access to accurate information about care during pregnancy, childbirth, and the postpartum period to ensure the survival and well-being of women and infants. Bleeding, fits, and fever, the warning signs for complications during pregnancy, should be recognised by both women and men.

To build women's self-esteem, information must be factual and unbiased and counselling must address the health needs of the whole life cycle, including educating the girl child and the adolescent girl. The purpose is to create an environment within the family and in society that will empower a woman to make choices, and support her in her choices.

The indicator for access to information would be the percentage of men and women with knowledge of danger signs. The standard is 100 per cent.

Choice

Every woman must have the right to choose a well-timed and wanted healthy pregnancy and delivery. She must also be able to choose the type, place, and provider of health services that will support her choice. Every woman must also have the right to choose a companion to accompany her during labour and delivery.

An indicator could be the proportion of women who received counselling on treatment options before consenting to a particular treatment or procedure.

Participation

Women must have the right to participate in decisions affecting their health. In particular, women must have the right to participate in the planning, implementation, monitoring and evaluation of the services that they are entitled to, and should receive. This implies that local committees for health services should be balanced in gender and ethnic representation.

An indicator could be the proportion of female members having a decision-making role on the health care management committee.

Respect

Women must be respected as individuals -- irrespective of their race, ethnicity, culture, age, marital status, and abilities. They deserve to be treated with dignity, to have their privacy and confidentiality ensured. Abuse of women by providers in health settings must be prevented. At the same time, all health services must be culturally sensitive, and respect the needs of different age groups, particularly adolescent girls.

The indicator would be the presence of mechanisms to assess the satisfaction of women with the services provided.

Compliance with conventions

It is necessary to take political, social, and legal actions to promote the compliance of State Parties with national and international rights conventions. Women's groups and community-based organisations can be very helpful in ensuring that State Parties comply with their commitments. Additionally, health services may be an entry point for addressing related issues such as women's social status and violence against women.

Conclusions

There was broad consensus among participants on the need to translate these criteria into practice and have measurable indicators and universal standards to assess women-friendliness of health services. However, participants felt that the consensus-building process to decide on indicators carried a risk of lowering standards to suit local needs. Setting "minimum" standards, they feared, also carries the risk of creating complacency among countries that had already attained good performance levels, and would remove the incentive to further improve services. Participants, therefore, suggested that universal standards should be based either on the state-of-the-art evidence or on the rights of women espoused in international conventions and conferences. Intermediate goals would be set and revised periodically to adapt these standards to the particular context of each country.

CHAPTER 3: LESSONS LEARNED FROM SOME INTERVENTIONS

The lessons learned from implementing women-friendly health services which are presented in this chapter have been drawn from the presentations made by several countries, the working group discussions at the workshop, and the electronic discussion forum held prior to the workshop. The individual presentations are presented in Annex 3. This chapter also presents related lessons learned from some countries that had shared their experiences but were unable to participate in the workshop.

The interventions that countries have undertaken for improving the women-friendliness of health services fall into five categories: (a) increasing access to care; (b) improving staff skills; (c) complying with standards; (d) self-assessment and problem-solving; and (e) ensuring user satisfaction and empowerment. Most countries implemented a combination of these measures.

A. Increasing access to care

One of the most common methods to enhance women-friendliness is to increase access to care. Barriers to access to health care were lowered either by (i) overcoming the external barriers by reducing cost to users or by improving transport and communication systems; or (ii) by reorganising services to overcome internal barriers inherent in the system.

Overcoming external barriers

Most governments subsidise maternal and child health services to some extent in order to reduce cost barriers. While some countries are able to provide free maternal and child health services, others depend on the support of communities or the private sector to develop innovative cost-reducing initiatives. Improving communication and referral services between the different levels of the system will also help lower barriers of access.

Bolivia, for example, implemented a National Maternity and Child Health Insurance Scheme in order to increase utilisation of health services by women and children (see Annex 3, page 45). In 1996, when the Scheme was initiated, the occupation rate of public-sector maternity wards was only 45%. One explanation for this low rate was the price of services. Patients were required to pay their medical fees, and for their own anaesthetics, antibiotics and materials such as cotton or gloves used by staff. The insurance is financed by municipalities and provides universal and free access to the network of public assistance and social security for women of child-bearing age and children under five years of age. Consequently, prenatal coverage and institutional deliveries doubled over the next two years.

The government of Mali increased utilisation of maternal and child health services by promoting community co-financing of health services and establishing a rapid referral system under the Perinatal Programme. Building on the Bamako Initiative's cost-recovery mechanisms, communities contribute towards the cost of maternal health care, which gives them a stake in improving the access to, and quality, of the services. Special funds have been set up as loans for pregnant women to use and reimburse. Furthermore, when a woman or infant at the health centre requires emergency care, the health provider telephones the district hospital. The hospital

dispatches an ambulance to transport the patient to the hospital where a pre-packed medical kit is available to enable surgical interventions as needed.

Reorganising health services

In some countries, there has been an attempt to re-organise services to either improve efficiency or satisfy user-needs. Attempts to lower internal barriers to access to care have included improving admission procedures, reducing waiting time for treatment, and allowing pregnant women to bring a companion of their choice to prenatal visits as well as to the delivery.

In Bangladesh, a very low percentage of delivery complications are being tended to in health facilities due to poor local infrastructure. In order to reduce barriers to access to maternal care, the Government has decentralised essential obstetric care in 11 districts (Thanas). This process involved making obstetric first aid available at the community level and upgrading referral facilities to be able to treat women with complications of pregnancy and childbirth.

In Ecuador, the team-based quality design approach was used to redesign the system and improve essential obstetric care. User needs and expectations were assessed through focus groups, interviews, brainstorming sessions, and questionnaires. Six months after the programme was initiated, major improvements have been charted. Emergencies have been centralised in one area and a common referral and follow-up form is used in all the facilities. An agreement between facilities to share ambulances has improved transportation. Husbands are now permitted to attend prenatal visits and IEC messages are based on local needs of the community.

B. Improving staff skills

Improvements in the quality of care were achieved by upgrading staff skills and inspiring better performance. Interventions included: increasing the availability of skilled personnel; reviewing the legal framework to authorise the midwifery staff to perform EOC functions; developing guidelines of care; and improving training through mentoring, team-work, and increased participation.

In Uganda, government officials reviewed guidelines and laws governing midwifery practices. Although midwives are key actors tending births, they lacked the skills and authority to provide needed services. They lack access to referral services and advanced medical care as well as the legal authority to perform critical life-saving procedures such as intravenous infusion, manual vacuum aspiration, and administration of antibiotics. However, in most cases, they are the only staff available to offer basic care. Reviewing the Midwifery Handbook, modifying the Nursing Bill, and more extensive training and certification of midwives will enhance user access to skilled birth attendants.

In Indonesia, in response to the scarcity of skilled midwifery providers, the Government developed a new mid-level category of providers: the '*bidan di desa*' or village midwife. A mentoring-based training was organised using the clinical midwives as trainers. Although the clinical midwives are more skilled and experienced than the *bidan di desas*, most pregnant women do not have access to them because of geographical constraints. Using clinical midwives as trainers and mentors will not

only expand coverage and improve the quality of work of village midwives, but will also, in effect, upgrade the skills and status of the clinical midwives themselves.

In Tunisia, a thorough review of clinical guidelines pertaining to all aspects of maternal care, training of staff, and the use of partographs for monitoring labour has effected improved decision-making skills of providers and increased referrals. These efforts, combined with an efficient transportation system, have led to an increased use of referral facilities as measured by the proportion of referrals and caesarean sections.

C. Complying with standards

Certification and accreditation processes can be employed to ensure that services are women-friendly. Countries such as Bangladesh, Brazil, Mexico, and Peru have put in place a systematic process for assessing and certifying maternal health services as a means of improving quality of care and enhancing women-friendliness. Further details on the specific experiences of countries are described in Annex 3.

Box 7: Assuring Compliance

Certification is defined as the recognition of an individual or facility that has advanced capacity or knowledge to provide a particular service to an institution or to a particular population.

Accreditation is defined as consensus-based standards applied by an independent agency to an entire facility.

The certification of maternal care can be **modelled on existing initiatives** such as the Baby-Friendly Hospital Initiative (BFHI). Several countries in Latin America, for example, have broadened the BFHI approach to include specific steps to improve maternal and reproductive health. The Mother and Baby-Friendly Hospital Initiative initiated by the Mexican Social Insurance System in 1992, monitors 28 activities that provide integrated care to pregnant women and their children. As of 1997, 187 hospitals have been certified as Mother and Baby-Friendly Hospitals. Re-certification of hospitals began in 1994, and 57 hospitals have thus far been re-certified.

In Peru, the Government set up a 10-step system for safe deliveries to improve the quality of maternal health care. This approach requires a review of health policies, better communication systems, standardised training modules for health providers, monitoring, and supervision. The certification process starts with a monitoring and supervision module, external evaluation module, including interviews with staff and users, and observation visits. Process and output indicators are surveyed and 80% compliance leads to accreditation.

In Egypt, the Gold Star programme was initiated in 1994 to upgrade the quality of family planning services and to create public demand for better services. The programme has a management and supervisory system in place to monitor regularly all family planning units using 101 indicators of good-quality service. A computerised management information system (MIS) tracks quality indicator scores for each service delivery site. As of 1998, about 1,450 family planning units have met more than 90% of the 101 indicators for two quarters in a row and are entitled to display a gold star.

Assessment of quality can also be developed in the context of a **broader accreditation of health facilities**, as in Bangladesh and Romania, where indicators and standards are being defined

with the involvement of professional associations and the Ministry of Health. The involvement of respected professional associations such as the Obstetric and Gynaecological Society in Bangladesh and the Order of Medical Doctors in Romania in developing guidelines and mentoring has led to increased acceptance of and compliance to standards by professionals.

Assessment, the first step in the certification process, can be made by outside evaluators as in the case of Brazil where Ministry of Health officials assess private and public health facilities. Alternatively, self-assessment guides can be used to perform internal assessments of services as done by the Instituto Mexicano del Seguro Social in Mexico. In this case, staff use a checklist to assess the quality of the services they provide, identify gaps, and improve services. After six months, external evaluators come in to assess performance and certify the services.

Financial incentives such as reduced reimbursements induce compliance with standards as in Brazil, where the cost of caesarean births must be borne by the institution when they represent more than 40% of all deliveries. Alternatively, staff can be motivated to comply with standards by rewarding them as employee of the month as in Mexico, or by benchmarking their services with other facilities offering similar services, as in Peru.

D. Self-assessment and problem-solving

Self-assessment and problem-solving are central to the continuous improvement of quality. Indicators used to assess whether the situation presents a problem can be based on: outcomes (e.g. maternal deaths), outputs (e.g. coverage of care), or the whole process (e.g. qualitative self-assessment).

The Sri Lanka presentation describes the value of a collegial approach to **maternal mortality audits** by identifying problems and shortcomings in a non-threatening manner in order to take corrective actions. Maternal audits give insights into direct and indirect causes of death. However, this approach has inherent limitations as death is a final outcome and investigation of a death can be sensitive for both families and health providers.

In Vietnam, the process of developing consensus is a springboard to solving problems. The district action plan for safe motherhood is developed in collaboration with all stakeholders: the representative of the district, community leaders, and health professionals. Participants brainstorm about the status of health services and how to improve it, and about the respective roles of the community members and the health professionals. Common problems and solutions are identified, together with roles and responsibilities of the health staff and the community.

In Tunisia, health staff use composite process indicators to assess particular aspects of prenatal care. The example provided in Annex 3 shows the use of three indicators of coverage: availability, accessibility, and utilisation; and three indicators of quality of care: number of early visits, intensity of use, and adequacy of care. The analysis of these indicators enables the staff to pinpoint the bottlenecks and provides some insights into the underlying causes of the problems. It also enables them to monitor effectiveness of the solutions.

All aspects of care can be assessed using a comprehensive qualitative self-assessment guide as shown by the Client-Oriented, Provider-Efficient (COPE) methodology where all levels of staff

members, including management, operations, and administration, participate in identifying problems. Staff members use the self-assessment guides to examine the situation and, together with the training team, they analyse the problems and identify solutions.

All these methods have one thing in common: they rely on the health staff themselves to perform the assessment using a guide and standards for reference purposes. When a problem is detected showing a deviation from the standard, the problem-solving process is implemented. Though the process may be somewhat complex, it relies on an Assessment, Analysis, and Action (AAA) approach.

E. Users' satisfaction and empowerment

Improving the satisfaction of users, and thereby stimulating demand for services, is pivotal to improving the quality of health care. However, it must be accompanied by a process that empowers women by addressing the underlying factors of maternal morbidity and mortality.

On the supply side, services can be better matched with user needs by involving users in problem-solving or by redesigning services around their expectations. This could be achieved by:

- Involving users in problem-solving. In the COPE model, the users are interviewed before a solution is contemplated. In Tunisia and Vietnam, users are involved in community-based monitoring of services.
- Redesigning the health services. In the Quality Assurance Model (QA), the needs of users and the community are analysed and acknowledged as the starting point for the redesign. The key features and activities of the redesigned programme satisfy these needs with available resources.

Involving communities, especially women's groups, in problem-solving, will empower them to demand better services and respect for their rights as in the case of the management committees in Mali. And in Bangladesh, for example, communication and social mobilisation efforts that address violence against women are complementing efforts to reduce maternal mortality. In Vietnam, open dialogue with political leaders, women's unions, youth union leaders, and health professionals at the district and community levels with respect to developing the district action plan and joint management of resources and activities is fostering community empowerment.

CHAPTER 4: LESSONS LEARNED IN IMPLEMENTATION

Using the same process as in the previous chapter, this chapter presents lessons learned in development of interventions as well as in the process of their implementation. The most important lesson learned is that it is not important what type of model is used to develop the plan of action for a programme. What is important is adapting the model to the local context and securing consensus among the stakeholders. The following are the steps in building a programme plan of action.

A. Analyse the situation

Before planning any intervention, a rapid analysis of the situation must be made to identify opportunities and possible bottlenecks. The Three Delay Model (see Box 8) is extensively used in identifying factors that lead to non-utilisation or under-utilisation of maternal health services. Women, especially those with obstetric complications, face a variety of barriers to using health services -- financial, geographical, and cultural. This model is useful for developing indicators to analyse access to maternity care. Bangladesh has used this model to develop its Women and Maternal Health Project.

The Quality Assurance model or approach (see Box 9) can be used to assess whether the programme could be organised differently to meet the expectations of the users as was the case in Ecuador. Similarly, underlying or predisposing factors of maternal mortality can be analysed using a more conceptual framework.

B. Build on previous successful strategies

Countries sometimes build on strategies that have been successful for achieving other health goals. The most common example is the Baby-Friendly Hospital Initiative (BFHI) which was designed to improve breast-feeding practices. Several Latin American countries have expanded the BFHI model to a "mother- and baby-friendly" initiative that includes some critical components that improve the quality of

Box 8: The Three Delay Model

1. **Delay in Seeking Care:** A woman may delay deciding to seek care because of ignorance, inability to recognise danger signs, or because of cultural inhibitions.
2. **Delay in Accessing Care:** A further delay occurs when a woman is unable to reach a health facility due to distance, poor communication, inability to mobilise transport or to pay for services.
3. **Delay in Receiving Care:** The third delay occurs at the facility, when trained personnel and supplies are not immediately available to provide critical, life-saving care.

Box 9: The Quality Assurance Model

The Quality Assurance model is a systematic, quality design approach to improving care. The model focuses on what to do differently rather than on what to do to make things better. The needs, expectations, and wishes of different clients are determined and subsequently matched with service features that maximise the satisfaction of these needs with available resources.

maternal care. As mentioned in previous chapters, Peru, Mexico, and Brazil have taken steps to assure the quality of maternal and child health services through accreditation and certification of facilities and services. Mali has expanded on the Bamako Initiative, originally intended to revitalise primary health care facilities, to improve district health systems.

C. Adapt existing tools and methods to local context

Considerable time, effort, and resources can be saved and better used by adapting existing tools, guidelines, and standards to the local context. Several countries have used this approach to accelerate progress. Bangladesh, for example, adapted the standards of maternal care. Alternatively, countries can adapt international indicators and standards to local infrastructure and resources. In Tunisia, the access indicator that measures distance from place of residence to facility has been reduced from 4 km to 2 km because of better road infrastructure. Tunisia, Vietnam and other African countries use the “monitoring curve”, a community-based tool adapted from the Bamako Initiative. Health staff sit with community members to examine indicators of coverage, output and quality, and jointly identify bottlenecks and devise solutions. This tool can be easily adapted to monitor any health service or activity.

The Client-Oriented, Provider-Efficient (COPE) model based on self-assessment and teamwork, helps staff identify problems and find solutions (see Box 10). The model was designed to improve the quality of family planning services but is also being used to improve the quality of maternal and child health services.

Maternal mortality audits are used in Sri Lanka as well as in Indonesia to investigate the extent to which maternal deaths could have been avoided. In Brazil, the Maternal Death Committee has determined that the poor quality of health services is one of the factors responsible for maternal deaths.

D. Involve stakeholders at all stages

Political decision-makers, professional associations, staff, civil society organisations, i.e. NGOs, women’s groups, the community, and users should all be involved in the process. This does not mean that everybody must be involved at the same time and in all stages of the process, but the stakeholders who make a critical difference must be involved.

Box 10: The Client-Oriented, Provider-Efficient (COPE) Model

The COPE model is a process of continuous quality improvement through site-level problem solving. It relies on self-assessment involving all levels of staff at the delivery site. Staff members work as a team and focus on the client who is also a key actor in the implementation of change. Supervision is facilitative and relies on coaching, mentoring, and two-way communication.

The tools include self-assessment guides based on the rights of the client and a staff-needs framework. Client interviews, client flow analysis, and medical records’ review are tools that staff use to identify problems, analyse them, and develop solutions.

Stakeholders who can be instrumental in catalysing the implementation of any given stage of the process should be involved in:

- **Developing strategies:** In Mexico, NGOs, the relevant Ministry, and the Social Security Institutions were involved at the development stage of the process;
- **Developing tools or standards:** In Bangladesh, the Government, UNICEF and the Obstetric and Gynaecological Society of Bangladesh were partners in the EOC project;
- **Implementing training:** In Kalimantan, Indonesia, the authorities, as well as the health centre midwives and village midwives, were involved;
- **Solving problems:** In Tunisia and Mexico, the QA Model was used where everybody who uses or provides the services, including users and community, staff of the centre, and the supervising staff, is involved in improving them.

E. Change focus over time

In addition to obstetric conditions that are direct causes of maternal deaths, evidence points to several underlying factors of maternal mortality including illiteracy, low status of women, and poverty. The implementation of several interventions simultaneously should be considered as it can create a multiplying effect and maximise the impact of interventions. The emphasis of the programme could switch from one intervention to another based on monitoring results or changing needs. Countries can change the focus of a programme over time to respond to emerging opportunities or constraints. For example, although Bangladesh, Bolivia, Mexico, and Tunisia have used different models to implement their programmes, they have all addressed the direct and indirect factors that influence the utilisation of services.

The social security system in Bolivia introduced an insurance scheme for mothers and children to reduce the high costs that had been preventing them from using the services. Once the cost factor was addressed, it was found that poor quality of services still prevented optimal use of services. The Government of Bolivia is now planning to address this issue by certification of facilities. In Peru, on the other hand, the Government implemented a certification process in order to improve quality of care and increase utilisation of health services, but found that cost was still a constraint. The Peruvian Government is now planning to introduce a health insurance scheme for mothers and children.

F. Consider the political context

It is critical for the programme to be flexible and to be adept at tapping political opportunities to further its objectives. The support of a political champion to introduce a new programme element or support change in a programme process, increases its chances of success.

Opportunities that are offered by ongoing health sector reform or decentralisation processes in the country must be tapped when planning, designing or implementing women-friendly health services. In Bolivia, for example, the decentralisation process led to increased sharing of financial responsibilities by municipalities for providing free access to care for low-income women. Under this co-financing scheme, the Government pays the salaries of health personnel and the 311

municipalities participating in the scheme cover the variable costs of medicines and medical and surgical supplies. The municipality automatically deposits 3% of its funds each year into a special account that, by law, can only be used to cover the insurance costs.

Since the political context keeps evolving, the definition of strategies for improving quality of care must also be a continuous and dynamic process. Critical indicators of quality of care must be monitored to provide constant feedback for implementing the strategy and modifying the programme focus when necessary.

G. Create staff incentives

The support of staff is critical for success, not only because staff implement most of the interventions, but also because they are the focus of the interventions. There are two ways of creating incentives for staff to improve performance.

- (a) Tools can be used to build self-esteem and efficiency among staff as well as to boost their status within the organisation and the community. For example, the self-assessment guide used by COPE and the monitoring tool used by Tunisia, help staff to build self-confidence and to address constraints that hamper their performance.
- (b) A formal or informal incentive system can be created to induce staff to improve their performance and to further develop their capacities. In Brazil, for example, economic incentives are used to limit the number of caesarean sections performed by health staff. In Mexico, certification is a means to induce staff to comply with standards and to achieve excellence in their work.

CHAPTER 5: CONCLUSION AND NEXT STEPS

A major achievement of this workshop was that it brought closer together the health sector approach and the women's rights approach to the criteria for women-friendly health services for reducing maternal mortality. Additionally, the workshop provided networking opportunities which fostered information-sharing among countries, which hopefully will improve the planning of future interventions to reduce maternal morbidity and mortality. At the end of the workshop, the participants agreed on the following document.

Preamble

The Safe Motherhood Initiative in Nairobi (1987), the World Summit for Children (1990), the International Conference on Social Development (Copenhagen, 1993), the International Conference on Population and Development (Cairo, 1994), the Fourth World Conference on Women (Beijing, 1995), and the Technical Consultation on the Safe Motherhood Initiative (Colombo, 1997) all called for global commitment and action to improve women's health and well-being. The right of women to good-quality, timely, and affordable health services is affirmed as a basic human right by these conferences as well as by national and international treaties including the Human Rights Declaration (1948), the Convention on the Rights of the Child (1989), and the Convention on the Elimination of All Forms of Discrimination Against Women (1979).

Although much progress has been made in implementing safe motherhood programmes, there is a continued need for both quantitative and qualitative research to ascertain the effectiveness and sustainability of interventions and to monitor standards of performance. Safe motherhood requires a broad-based, integrated approach and simultaneous implementation of a mix of interventions at various levels of the health system. Setting universal standards for maternal health services, identifying a set of indicators to measure compliance and progress, and recommending best practices at country level, become complex tasks in view of the broad range of interventions needed to respond to diverse situations both within and between countries.

An international workshop devoted to "Systematising Experiences in Implementing Women-Friendly Health Services" was held in Mexico City on 26-28 January, 1999, as a follow-up to the efforts of governments, international agencies and non-governmental organisations to improve women's health by implementing programmes to reduce maternal morbidity and mortality. This workshop focussed specifically on maternal health in the broader context of reproductive health and strengthening health systems in general.

One hundred and eight participants from 25 countries, including policy makers, programme managers and health professionals, representatives of multilateral and bilateral agencies, non-governmental organisations, and academic institutions reviewed lessons learned from country experiences in implementing safe motherhood programmes. They drew up criteria and outlined strategies for achieving women-friendly maternal health services.

Women-friendly health services should provide accessible, high-quality health care, be respectful of cultural and social norms, and empower users and motivate providers by involving them in decision-making, thereby enhancing all-around satisfaction. This approach does not constitute a new global initiative, but builds upon existing concepts and recent experiences of

countries, including all stakeholders involved in planning and implementing long-term country programmes. This is a rights-based approach to maternal and neonatal health care, which will enable governments and international agencies to monitor women's access to quality maternal and reproductive health services.

Criteria of women-friendly health services

Four working groups set forth the following criteria for the major components of women-friendly, or women-centred, health care services:

(a) Availability, access, and affordability of health services

- All women should have access to skilled attendants during pregnancy, childbirth, and the postpartum period.
- No woman should be denied maternity care because she cannot pay for it.
- Women with obstetric complications should be transported to and treated in an essential obstetric care facility.
- Health services must respect cultural norms.
- A referral system should be established between the community and hospital, emphasizing participation of the community and families.

(b) Establishing high standards of health care

- National policies that provide women-friendly health services should be developed and integrated into existing frameworks.
- A life-cycle approach, including all aspects of reproductive health, should be considered in planning and implementing women-friendly health services.
- Infrastructure of women-friendly health services should be adequate.
- Written protocols should be available outlining all levels of the health system (community, health facility and district).
- Standards and performance criteria should be set for health services, and a system established to measure the quality of service delivery in terms of inputs, processes, and outputs.

(c) Motivation and support of staff

- Every health facility should have a plan of action which embodies the national standards that promote a women-centred environment.
- Staff should be assigned clear roles and have the right to work in a supportive and protective environment.
- A system should be in place for monitoring, evaluating and rewarding staff performance.
- Team-based training of staff should impart the women-friendly approach to health care.
- A supportive supervisory system should be in place to address staff development needs and to facilitate local problem-solving.

(d) Empowerment and satisfaction of users

- Reliable information and counselling that support a woman's health needs throughout her life-cycle should be provided to individuals and to communities.
- Information and knowledge about danger signs during pregnancy, childbirth, and the postpartum period should be widely disseminated, especially among women of childbearing age.
- All women should have the right to choose whether and when to bear children, as well as to choose the type, place, and provider of the appropriate services.
- All women should have the right to participate in the planning, implementation, monitoring, and evaluation of the services that they are entitled to receive.
- All women should be respected as individuals, irrespective of age, marital status, race, religion, ethnicity, culture, and abilities. Particular attention should be paid to fostering dignity and self-esteem, and to providing privacy and confidentiality, safety, and continuity of care. Services must be sensitive to local culture and laws, needs of different age groups, particularly of adolescent girls, and they must prevent abuse by providers.
- National and international conventions should be supported by political, social, and legal actions.
- Mechanisms should be in place for the assessment of client satisfaction.
- Community participation should be encouraged via gender and ethnically balanced representation on local health management committees. The role of the committees should be clearly defined.

Recommendations for follow-up actions

Participants of the meeting recommended that:

1. The women-friendly health services approach should be applied to maternal health as well as to other components of reproductive health services such as family planning and reproductive tract infections.
2. A global framework should be developed to provide guidance for improving the quality of women's health services.
3. International organisations, such as WHO, UNICEF, UNFPA and The World Bank, should jointly call on governments to make health services women-friendly.
4. Continued consultations regarding women's health issues with governments, professional organisations, NGOs, and other interested groups, including users, will assist in developing and advocating the women-friendly health services approach.
5. Policies and plans for the local implementation of women-friendly health services must be developed at the country level.
6. Task forces should be established at the national level to develop strategies and co-ordinate activities in collaboration with existing quality assurance committees.
7. An information-sharing network, including electronic conferences, should be established to promote discussion of various aspects of women-friendly health services among individuals in various countries.
8. Operational research must be conducted to ascertain the effectiveness of the 'women-friendly health services' approach in order to influence policy.
9. A strategy must be developed immediately to follow up the above recommendations and monitor progress at the global and national levels.

Mexico City, 28 January 1999

ANNEX 1: AGENDA OF THE WORKSHOP

Tuesday, 26 January, 1999

REGISTRATION

OFFICIAL INAUGURATION OF THE WORKSHOP

| | |
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| <i>Opening Speech</i> | Jose Carlos Cuentas Zavala UNICEF Representative for Mexico |
| <i>Message from the National Program for Women</i> | Lic Dulce Maria Sauri Riancho Executive Coordinator of the National Program for Women |
| <i>Inaugural Declaration</i> | Juan Ramon de la Fuente Secretary of Health, Mexico |
| <i>Objectives of the Workshop</i> | David Alnwick Chief, Health Section Programme Division, UNICEF |

PANEL : MOTHER AND CHILD FRIENDLY SERVICES IN MEXICO

| | |
|--|---|
| Chair: Jose Luis Zeballos | Rapporteur: Manuel Moreno |
| <i>Integrating Reproductive Health Services: Mother and Baby-Friendly Hospital in Mexico</i> | Gregorio Perez-Palacios SSA Health Services |
| <i>Successful Experiences of the Mother-Baby Friendly Friendly Hospital Initiative in the Social Security Facilities</i> | Jorge Arturo Cardona Perez IMSS |
| <i>The Committee for a Safe Motherhood in Mexico</i> | Maria del Carmen Elu and Elsa Santos Safe Motherhood Committee |

PANEL : IMPROVEMENT OF ACCESS TO AND TECHNICAL QUALITY OF MATERNAL CARE

Chair: David Alnwick

Rapporteur: Guillermo Navas

*The Women-Friendly Hospital in **Bangladesh***

Yasmin Ali Haque
UNICEF

*National Mother and Child Health Insurance in **Bolivia***

Jaime Telleria, Ministry of Health
Jorge Mariscal, UNICEF
Jorge Jara, UNICEF

*Implementing the Mother-Baby Package in **Uganda***

Emmanuel Kaijuha
Ministry of Health
Olive Sentumbwe, WHO

*Using Maternal Audits to Improve Quality of Maternal Health Care in **Sri Lanka***

Hiranthi de Silva
Ministry of Health

PANEL: USER RIGHTS AND EMPOWERMENT OF STAFF

Chair: Lindsay Edouard

Rapporteur: Flora Sibanda-Mulder

*The Path to Woman Friendly Health Service in **Jamaica***

Affete Mc Caw-Binns
University of West Indies

*Increasing Use and Improving Quality of Maternal and Child Health Services in **Tunisia***

Moncef Sidhom
Ministry of Health

*Improving Quality of Care in **Georgia***

Keti Nemsadze
University of Tbilisi

*The **COPE** Experience in Improving Women-Friendly Services*

Amy Pollack
AVSC International

PANEL: TOOLS AND PROCEDURES FOR ASSURING QUALITY

Chair: Carol Collado

Rapporteur: Rosemary Kigadye

*The **Quality Assurance** Approach to Improve Essential Obstetric Care: An Experience in Latin America*

Barbara Kerstiens
URC-CHS

***MotherCare**'s Approach to Building Quality into Services Through Training and Continuing Education Systems*

Marge Koblinsky
MotherCare

*Implementing the Ten Steps Programme for a Safe Delivery in **Peru***

Olga Frisancho
UNICEF

*Improving the Quality of Maternal and Perinatal Health in **Brazil***

Tania Lagos, Ministry of Health
Caroline Sui, UNICEF

Wednesday, 27 January 1999

PANEL: PRESENTATION OF INTERNATIONAL EXPERIENCES ON STRATEGIC APPROACHES TO IMPROVE THE QUALITY OF MATERNAL CARE

Chair: Gregorio Perez-Palacios

Rapporteur: Patricia Stephenson

WHO: *Development of Standards for Improving Quality in South East Asia*

Jelka Zupan
WHO

UNICEF: *Lessons Learned from the Baby-Friendly Hospital Initiative*

Helen Armstrong
UNICEF

UNFPA: *Experiences from UNFPA-supported Projects on Safe Motherhood*

Lindsay Edouard
UNFPA

World Bank: *Lessons from The World Bank's Review of Safe Motherhood Assistance*

Anne Tinker
The World Bank

WORKING GROUPS

Group 1

Access, Availability and Affordability of Health Services

Moderator: Aurora Martinez

Rapporteur: Maria Pia-Sanchez

Group 2

Respect of Technical Standards of Health Care

Moderator: Fernando Amado

Rapporteur: Samuel Flores Huerta

Group 3

Motivation and Support of Staff

Moderator: Jorge Jara

Rapporteur: Tamar Gotdsadze

Group 4

Empowerment and Satisfaction of Users

Moderator: Elsa Santos

Rapporteur: Rosemary Kigadye

PRESENTATION IN PLENARY OF THE RESULTS OF THE WORKING GROUPS AND DISCUSSION

Chair: Anne Tinker

Rapporteur: Yasmin Ali Haque

PREPARATION OF STATEMENT/DECLARATION BY DRAFTING GROUP

Thursday, 28 January, 1999

WORKING GROUP SESSIONS

Recommended practices for implementation of women-friendly health services, with the same four groups.

WORKING GROUPS REPORT TO PLENARY

DISCUSSION OF THE STATEMENT PREPARED BY THE DRAFTING GROUP

PLENARY: *Next Steps:*
Follow-up and support process needed for implementation of recommendations in countries

Chair: France Donnay

Rapporteur: Rema Venu

PRESENTATION OF RECOMMENDATIONS TO NATIONAL AUTHORITIES AND OFFICIAL CLOSURE

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ANNEX 2: WORKING PAPER

DEVELOPING A JOINT WHO-UNICEF-UNFPA APPROACH TO WOMEN-FRIENDLY HEALTH SERVICES

1. Problem statement

Maternal mortality in developing countries is clearly related to deficient technical quality of maternal or reproductive health services and to cultural, time, financial or geographical barriers of access to care. Major immediate causes of maternal deaths — infections, haemorrhage, obstructed labour, eclampsia, unsafe abortion — are related to multiple factors, which the following interventions seek to correct:

- Maternal mortality is a **social injustice** as well as a health issue. It needs to be understood as an infringement of women's human rights. This requires changes in legal, political, health and education systems for providing more equitable, women-centred services through strong partnerships between governments and communities.
- **Higher investments** in basic social services are essential to achieve safe motherhood. WHO estimates that, in low-income countries, an investment of \$3 per capita per year in health services would suffice to prevent almost all maternal as well as neonatal deaths.
- National and local governments need to provide **high-quality health care** and nutrition for infants and women, that is responsive to women's needs and respectful of their views.
- Men, parents, in-laws, families and neighbours need to join in efforts to **support women in improving their lives and health**. They must also help break down barriers to health care: distance, cost and socio-cultural factors including education, customs and traditions and women's status and decision-making power.

Providing good quality care is one of the most effective ways of ensuring that maternal health services are used and that maternal mortality and morbidity is reduced. This can be achieved by assuring technical quality of care, decreasing the barriers to care, ensuring satisfaction of users and providers through their involvement in decision-making, and improving provider-responsiveness to cultural and social norms; in other words, by improving the “**women-friendliness**” of **health services**. These interventions are to be implemented at different levels of public and private health services: homes, health posts and health centres, maternity homes and district hospitals, and national health systems.

WHO, UNFPA and UNICEF are determined to work in partnership with governments and professional associations, NGOs and communities, and other development agencies to improve the "women-friendliness" of maternal and newborn health services. This approach is part of a broader strategy recommended by these agencies to reduce maternal and perinatal mortality.

2. Women-friendly health services: an integrated approach to quality of care

What is quality of care? Quality of care is defined as compliance with **high technical standards** of care, provided at an **affordable cost** for clients and the health care system, and ensuring the **satisfaction** of both users and providers.

Key determinants of quality include the technical competence of providers and their interpersonal skills, the continuous availability of basic supplies and equipment, the physical infrastructure of facilities, the existence of a functional referral system, and community involvement in design and monitoring of health services.

The following **criteria** have to apply for health services to be considered **women -friendly**:

- comply with the highest possible **technical standards**, according to the level of care, and have the needed **supplies and equipment**;
- be **accessible** and **affordable** to women by respecting their constraints and ability to pay;
- ensure the **satisfaction of both users and providers** through involvement in decision-making, and responsiveness to cultural and social norms; and
- **respect** women's and children's **rights** to information, choice, safety, privacy and dignity.

3. Experience to date with interventions to improve quality of care

Experience to date in improving women-friendliness of health services shows that countries have implemented one or more of the following interventions:

- Promote the **provision of quality technical care** by strengthening health systems. This can be achieved by designing national protocols of maternal care, as in Uganda where staff have been trained in the use of guidelines and algorithms adapted from the WHO Mother-Baby Package. It can also be done by improving access to Essential Obstetric Care and improving essential supplies and equipment, as was the case in Bangladesh. Or it can be achieved by decreasing economic barriers to access, as with the Mother and Child Health Insurance Scheme in Bolivia.
- Develop capacity of countries for assuring **compliance** of health staff **with standards of care and user rights**. This has been achieved by capitalising on the Baby-Friendly Hospital Initiative to promote quality of care and user rights, as in Mexico, Peru, Indonesia or Brazil. Or it could be accomplished by developing a nationally owned process of accreditation as in Bangladesh.
- Empower staff, users and communities to **improve continuously the quality of services** through **participatory problem-solving processes** at district and facility levels. For example, Vietnam and Tunisia have developed community-based monitoring tools for improving coverage and quality of perinatal health services, adapted from Bamako Initiative tools. Sri Lanka uses maternal mortality audits as a gateway for improving quality of care. Niger uses traditional quality assurance tools and techniques for improving quality of care in health centres.

4. WHO/UNFPA/UNICEF collaboration

WHO, UNFPA and UNICEF will explore ways of developing a close collaboration for helping countries to make their health services more women-friendly, in accordance with the respective mandates of the organisations and by building on their comparative advantages. The overall context of this collaboration is the health sector reform process, and more particularly the sector-wide approaches (SWAP), being developed in countries. The framework for collaboration between agencies will be the UNDAF and the Inter-agency Group of Safe Motherhood, focusing on quality of care as an articulation of human rights.

Pending the results of the forthcoming inter-agency discussions and the needs of countries, the roles of the agencies could be the following:

- ◆ WHO could develop the overall strategic context, review scientific and technical accuracy of standards of practice as well as develop the content of pre-service and in-service training of health care workers.
- ◆ UNFPA could support training of staff, adaptation of protocols of care to local context, strengthening of infrastructure and communication, etc.
- ◆ UNICEF could support the process with advocacy, provision of critical supplies and equipment, communication activities and technical support, in the context of health sector reform and community involvement in design and management of services.

5. Expected outcomes

The result of the collaboration will be improved respect for women's rights and **accelerated progress** towards **maternal and perinatal mortality reduction** in countries.

6. Strategy of implementation

The strategy of implementation will support and strengthen ongoing activities in countries, help them expand the scale of actions and replicate successful approaches in other countries, in a true bottom-up fashion. One of the basic principles would be to develop country strategies on the basis of local context and ongoing processes and with participation of all stakeholders. Actions could be implemented along the following lines:

- Several countries in each region have been implementing different approaches and projects for improving quality of maternal health care. These experiences will be **systematised** for drawing **lessons learned**, recommending **best practices** and developing **minimum universal standards**.
- For accelerating progress in those countries, partners will support the development of **networking** and **information-sharing**, promote intersectoral approaches **through regional inter-agency support teams**, and develop **tools and guidelines** that can be shared efficiently among those countries.

- For **increasing the number of countries** involved in this process, partners will use case studies and success stories to perform **advocacy** in priority countries, increase **fundraising**, and support **strategy development** on the basis of specific national contexts and lessons learned.

7. Monitoring and evaluation

In every country, assessing and monitoring quality of care needs to be an integrated component of the process of providing health services and controlling quality of care. It will be based on process indicators and as such will draw on existing health and management information systems. The development of monitoring and quality control systems, applicable to both public and private providers of health services, will be encouraged.

With regard to monitoring progress, national and global indicators will be developed jointly among partners and country authorities, on the basis of the workplans.

8. Activities to be implemented (to be reviewed on the basis of the Mexico meeting)

8.1 At country level

Along the three strategic lines of action, some, or all, of the following activities could be implemented in countries, according to their context.

- Promote **the provision of good quality care** by health services:
 - Advocate for developing (or adapting) national guidelines and protocols of care
 - Co-ordinate among agencies and with partners the training of staff in case management
 - Support provision of critical resources (transport, drugs, infrastructure...) and improve access to Essential Obstetric Care by upgrading facilities and improving referral care
 - Support strengthening of communication between different levels of the health system for improving referrals
- Develop the capacity of countries for assuring **compliance** of health staff **with standards and user rights**:
 - Advocate for women-friendly services at national level
 - Develop a certification system for women-friendly services with a limited number of process indicators and steps
 - Adapt standards of care to national context and national H/MIS, including a rights-dimension
 - Promote staff self-assessment of standards of care and user rights
 - Develop systems for monitoring and enforcing standards in public and private services
 - Link the accreditation/certification process with the financing of health services, directly, through the budgeting process, or indirectly, through the health insurance reimbursement
 - Promote a charter of user's rights as a way of assuring quality

8.2 Global and regional levels

The following activities are expected from partners in support of country activities:

- Support WHO in **developing protocols for case management**, by participating in reviews and developing consensus among partners and national authorities on standards for women-friendly services
- **Develop policy** and **partnerships** at global and regional levels by building consensus on strategies, by sharing information, and by developing joint workplans with key partners
- **Raise supplementary funds** from bilateral agencies for supporting the development process
- **Disseminate** state-of-the-art **information** and recommended practices to countries, using traditional (hard-copy) and emerging technologies (email, internet websites and intranet)
- **Co-ordinate** technical assistance and follow-up on a regional basis
- Promote **networking** among countries and regions by e-mail, electronic forums and regional/global meetings
- **Systematise** experiences and lessons learnt by monitoring, encouraging documentation with common methodology and implementing case studies

9. Tentative budget

9.1 Country workplans

After the upcoming meeting in Mexico for systematising lessons learned, countries will further develop their workplans and budgets. However, since most of the costs of routine quality assurance of health services are already accounted for by the national budgets (mostly H/MIS), the marginal costs for assuring women-friendly health services is estimated at US \$200,000 per year per country for three to five years.

9.2 Global Budget

Activities at global and regional levels include consensus building, information sharing, systematisation, networking, advocacy and marketing. These costs should be assumed by the participating agencies in their regular budgets of headquarters and regional offices, under the activities of Safe Motherhood. For UNICEF, they are estimated at US\$ 250,000 at headquarters level and US\$ 200,000 at regional level over the next three years. Partners' contributions to the project budget will be based on the workplans after the Mexico City meeting.

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ANNEX 3: SUMMARIES OF PRESENTATIONS

INTEGRATING REPRODUCTIVE HEALTH SERVICES: MOTHER AND BABY-FRIENDLY HOSPITAL IN MEXICO

*A presentation by Gregorio Perez-Palacios, Reproductive Health General Director,
Ministry of Health, Mexico*

Background

The Mother and Baby-Friendly Hospital Initiative was started in 1992, and since then, Mexico has incorporated a total of 25 interventions aimed at providing integral care to pregnant women and their children. In 1995, in response to the 1994 Programme of Action of the International Conference on Population and Development (ICPD), three more activities were added, bringing the total to 28, focussing on the reproductive health of adolescents, post-obstetric contraception, and neonatal reanimation.

The Structure for Implementation

The Ministry of Health has created the Reproductive Health General Direction, where operations linked to Safe Motherhood initiative are managed. In order to strengthen the co-ordination of activities between the different political administrative levels and to develop guidelines for the **National Programme for Reproductive Health**, Mexico established an **Inter-Institutional Group for Safe Motherhood**. This committee was conformed by all the institutions of the National Health System and non-governmental organisations such as the Mexican Youth Foundation, Mexican Federation of Private Health and Community Development Associations, and Catholics for a Free Choice.

The Process

The Inter-Institutional Group developed the 1995-2000 Reproductive Health and Family Planning Programme that encompasses activities of the Mother and Baby Friendly Hospital Initiative. The Inter-Institutional Group is divided into five committees that address different activities:

1. Ten activities aim to foster, protect, and support exclusive breastfeeding.
2. Focuses on medical care, prenatal monitoring with a risk approach, institutional care for delivery and abortion, the care of puerperium, post-abortion contraception, and neonatal heart-lung reanimation.
3. Aims at the prevention of defects at birth, stressing the neonatal aspect for timely detection of mental retardation due to congenital hypothyroidism, the importance of vaccinations, surveillance of growth and development, detection of uterus and breast cancer, and care for teenagers.
4. Activities aimed at Health Education and Promotion.
5. Fosters the investigation and systematisation of experiences through the establishment of committees to study maternal and newborn deaths.

The Results

To date all the institutions that make up Mexico's National Health System are participating in the Mother and Baby Friendly Initiative. Over ninety percent of the hospitals had been accredited in 1998 (657 out of 721).

Lessons Learned

By using the Mother and Baby Friendly Hospital Initiative combined with the reproductive health focus adopted at various international UN Conferences, it was possible to broaden the scope of activities in the context of the improvement of quality of care provided in hospitals

What lies ahead

The objective for 1999 is to consolidate this strategy, and incorporate the first level facilities through the establishment of Mother and Baby Friendly health centres so that in the future, this strategy can operate with the participation of the civil society organised in Mother and Baby Friendly communities.

SUCCESSFUL EXPERIENCES OF THE MOTHER-BABY FRIENDLY HOSPITAL INITIATIVE IN THE SOCIAL SECURITY FACILITIES IN MEXICO

*A presentation by Jorge Arturo Cardona Perez
General Director of Reproductive and Mother and Child Health, IMSS, Mexico*

The Mexican social security system is composed of a number of institutions including the IMSS (Instituto Mexicano del Seguro Social), the Social Security Institute for the workers of the State, Mexican Petroleum, the National Navy, and the National Army. These institutions provide care for nearly two-thirds of the Mexican population, covering approximately one out of three Mexican children.

The Mexican Social Security Institute (IMSS)

The IMSS considers reproductive health a global concept, and bases its work on an ethical and humanist background with a focus on quality of care. IMSS is the only institution in Mexico to have certified all its hospitals as Baby-Friendly Hospitals.

Adapting the Baby-Friendly Hospital Initiative enabled IMSS to integrate reproductive health concerns into its primary health care referral facilities. Some 1,500 Family-Friendly Health facilities representing nearly 85% of care provided by IMSS were thus certified. These facilities provide integrated care to the mother/father/baby, incorporating the principles of reproductive health.

The IMSS set the following objectives for improving maternal health: reducing maternal and perinatal mortality; facilitating the prevalence and use of contraception. Other issues are also addressed: menopause, gender equity, violence, breast and cervical cancer, and infertility. To date, 1,700 heads of clinical departments have been trained.

The Integrated Reproductive Health System: The Mother-Baby Friendly Hospital Initiative

The Baby-Friendly Hospital Initiative was consistent with the standards of quality espoused by the IMSS. The certification of the Mother-Baby Friendly Hospitals was started in 1993, revised in 1995, and, by 1997, 187 hospitals affiliated with the social security system had been certified.

Results

Although it is too early to measure qualitative improvements, some statistics are already apparent. There is a decrease in the number of cases of respiratory and other acute infections. Another indicator of the implementation of the initiative could be the quantity of milk substitutes prepared by the IMSS. The number of bottles prepared fell from 16 million in 1993 to 6 million in 1997 indicating how successful efforts to promote breastfeeding were. Not only was breastfeeding a health benefit for babies and their mothers, it also allowed the institutions to use the financial savings to fund training programmes for the staff involved in the initiative.

The Family-Friendly Health Units

At the primary health care level, the goal is to provide integrated reproductive health services. This entails underpinning reproductive health initiatives with information, education, and communication (IEC) activities in a family-focussed framework, and inspiring the population to take charge of their own medication pertaining to reproductive health, as well as providing preventive medical care.

The Process

- Ten criteria of quality and 204 standards were defined and developed in pilot projects and tested over a period of five years.
- Documents and strategies were disseminated to participating facilities.
- Self-assessment exercises were carried out by the participating facilities.
- Operational changes were initiated in the units based on the self-assessment results.
- A certification process was performed by outside observers.

Lessons Learned

- It is necessary to break down doctors' resistance to working with interdisciplinary tools.
- Modifying the Baby-Friendly Hospital Initiative to include mothers made it possible to broaden the scope of services to include reproductive health.
- It is possible to adapt the Baby-Friendly Hospital Initiative to primary care facilities.
- Certification was not an imposed process, but rather the outcome of a process of self-assessment.

Conclusion

The evolution of the certification process of IMSS is a good example of a health care system that takes advantage of the new role of governments. IMSS promotes an integrated basic health care model, balancing the freedom of the provider to organise services to meet local needs with the certification process based on objective and transparent evaluations of technical standards as well as the users' level of satisfaction.

The IMSS is committed to quality care and an integrated health care system focused on rural as well as on urban poor, and on the health needs of adults, children, and adolescents. The first national survey on reproductive health was carried out, and the results were published in April 1999.

THE COMMITTEE FOR A SAFE MOTHERHOOD IN MEXICO

A presentation by Maria del Carmen Elu and Elsa Santos, Safe Motherhood Committee, Mexico

The Mexican Committee for Safe Motherhood was created in 1993 as a direct result of the first National Conference on the Safe Motherhood Initiative in 1987. Two subsequent National Conferences on Safe Motherhood have taken place in Mexico.

Organisation

The Mexican Committee for Safe Motherhood is composed of 25 member organisations including a number of public and academic institutions, women's organisations, international development agencies, and eight Safe Motherhood state committees. The Committee which meets bimonthly to discuss its workplan and develop strategies embodies a high degree of commitment to improve the health of mothers and women.

The Committee has a Technical Administrative Secretariat which monitors the implementation of decisions, co-ordinates activities, manages fundraising, publishes and distributes educational material, provides technical and financial assistance, and represents the Committee at the Inter-institutional Group of Reproductive Health when necessary.

Activities

- **Advocacy:** The Committee has compiled and disseminated information, conducted sensitising campaigns, and created initiatives aimed at improving women's health. The Committee published 22 reports summing up the results of its activities including a bi-annual bulletin advocating the Safe Motherhood Initiative. A cassette called "Where It Hurts Most" to combat violence inside the family, particularly against pregnant women, has been produced. Events have been held to provide information and to advise participating men and women on reproductive health issues including a festival for pregnant women that provided information and advice about risk factors.
- The Committee **fosters dialogues between various public health authorities and civil society.** The Committee has organised 11 conferences on Safe Motherhood at state and municipal levels to devise strategies and enlist authorities' commitment to reducing maternal morbidity/mortality. It has sponsored 50 workshops on a number of issues : family planning (postpartum and post-abortion), gender and reproductive health, domestic violence against pregnant women, cancer of the uterus, quality of health care, and caesarean sections.
- The Committee is **researching investigative projects and innovative strategies:** Health outposts for pregnant women have been set up in places that women frequent on a regular basis, like market places, schools, etc. In these health outposts, three simple indicators allow the identification of women with risk factors and these women are advised to attend prenatal consultations.

- Political action: The Committee **advocates integrating a gender perspective** -- including sexual and reproductive rights -- into policies, programmes and health services, based on the recommendations of International Conferences such as the United Nations Cairo and Beijing Conferences.

Conclusion

For the past five years, the Committee has developed and expanded a movement aimed at achieving safe motherhood. As a result, Mexican women enjoy improved chances for a safe pregnancy thanks to an increased freedom of choice, decreasing levels of violence and improved quality of health care.

The women-friendly health services approach is used to develop new tools to fight maternal mortality, especially among the most vulnerable segment of the population. Some of the promising developments of this approach include: enhanced self-esteem, affirmation of women's rights to make informed choices, establishment of a more balanced relationship between providers and users of health services, prevention of violence, promoting women's empowerment and men's participation in reproductive health decisions. Finally, it is vital to involve women themselves in conceptualising as well as developing strategies to achieve women-friendly health services.

THE WOMEN AND MATERNAL HEALTH PROJECT IN BANGLADESH

A presentation by Yasmin Ali Haque, UNICEF Bangladesh

Background

Three women die every hour in Bangladesh from complications of pregnancy and child birth. Like many developing countries, Bangladesh has a high maternal mortality ratio (MMR), 850 per 100,000 live births, largely due to a lack of access to health services. About 90% of births occur at home without the presence of a skilled attendant, and only 5% women with obstetrical complications are treated in a health facility. These statistics highlight the fact that Bangladeshi women are among the highest risk categories in the world for dying due to complications of pregnancy and childbirth. The barriers of access to health care are both geographical and cultural, with violence against women accounting for 14% of maternal deaths.

The Interventions

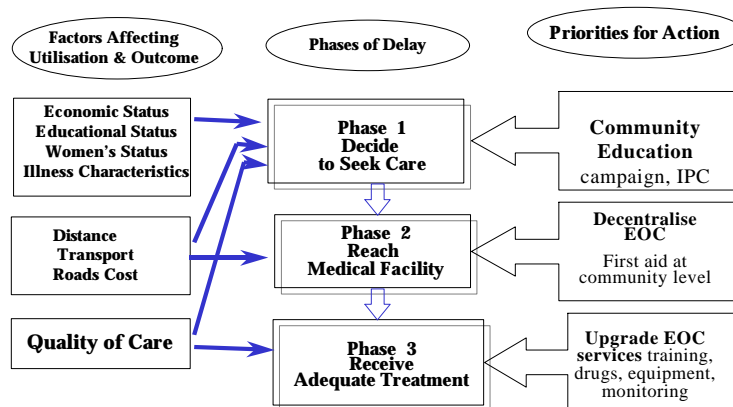
The Government of Bangladesh, in partnership with UNICEF and the Obstetrical and Gynaecological Society of Bangladesh (OGSB), has launched the *Essential Obstetric Care Project* and the *Women-Friendly Hospital Initiative*.

The objective of these projects is to improve the status of women in society as well as women's health by:

- Establishing and ensuring access to a critical package of services in households, outreach centres, and larger facilities;
- Ensuring efficient and effective delivery of health services; and
- Effecting behaviour changes in maternal health care practices among providers and consumers alike.

Promoting Community Participation in Preventing Maternal Deaths

Framework for action



The "Three Delay Model" has been used to define the interventions needed and as a basis for building awareness among individuals and families. Social mobilisation, through empowerment of women, is key to reducing maternal mortality. The stakeholders in this effort include health professionals, lawyers, women's activists, donors, health administrators, and development partners. In addition, the highest level of the Government has expressed **political commitment** with the Prime Minister having declared May 28th a national day of observance of Safe Motherhood. He has also spoken out condemning violence against women.

Strengthening Essential Obstetric Care

The **Essential Obstetric Care Project** (EOC) has been working to improve access to health care facilities for women with obstetrical complications since 1994. EOC has been instituted in 11 districts covering a total population of 19 million. Comprehensive EOC services¹ were established at the higher district level hospitals and at selected intermediate level Thana Health Complexes. The Thana Health Complex provides basic obstetric services, while Obstetric First Aid Units have been set up in local Family Welfare Centres to help stabilise women with complications while referring them to other more comprehensive facilities.

The referral system for complications was revamped and a mechanism for continuing medical education was established. The project required upgrading facilities, decentralising management, training staff, supplying drugs and equipment, record-keeping, and monitoring progress.

Upgrading the EOC provided the opportunity to include components for addressing violence, which is one of the most important causes of maternal death in Bangladesh.

The Woman-Friendly Hospital Initiative (WFHI)

The Woman-Friendly Hospital Initiative was launched in 15 facilities on May 28, 1998 on the national Safe Motherhood Day. The goal was to create the conditions necessary for women to be treated with respect, to reduce maternal mortality, fight against violence, and eliminate discrimination against women. The WFHI attempts to ensure respect of standards for:

- Quality of care: Respect for the dignity of women must be fostered and communities and hospitals must cooperate to actively uphold women's rights to quality health care;
- The Mother-Baby package: Emergency Obstetric Care, prenatal care, neonatal care, and measures to ensure successful breastfeeding;
- The strategy to end violence against women: Each level must have four staff members trained in the area, records must be maintained, and a referral service must be organised;
- Gender equity in health services and allocation of resources.

¹ Comprehensive EOC encompasses basic EOC (management of obstetric complications that can be safely provided at health centers), plus surgical obstetrics (caesarian sections, repair of tears, laparotomy, etc) , anesthesia and blood transfusions.

Communication and Social Mobilisation

The third component of the project consisted of strategies for communication and social mobilisation aimed at raising awareness and encouraging participation of communities, individuals, and families, including husbands and mothers-in-law. They are critical as they are the decision-makers when it comes to seeking help for birth-related complications.

The Three Delay Model was employed to raise awareness about:

1. How and when to make decisions to seek care in case of emergency;
2. How to reach medical facilities;
3. How to receive adequate care.

The Results

The intermediate results of this work are encouraging: a 60% increase in the number of referrals at health facilities, a 32% increase in the number of institutional births, and 34% more emergency caesarean sections. Moreover, the reputation of the health services improved as more people used them.

Lessons Learned

It is critical to address issues of accessibility, the attitude of providers towards women, and decision-making powers in the household. The programme was able to address the difficult and unspoken issue of violence against women. Violence isolates women, prevents them from seeking adequate and timely care, and thus increases the number of maternity-related deaths. Addressing the problem of violence against women by promoting a change of attitude will consequently help reduce maternal mortality.

The involvement of the professional community through the Obstetrical and Gynaecological Society of Bangladesh was of great importance to the success of the project.

Using process indicators and focussing the interventions has been helpful in boosting the performance of the health system.

What Lies Ahead

- Utilisation of EOC services, particularly in district hospitals, must be boosted in order to substantially reduce maternal mortality;
- Posting doctors to facilities improves the effective functioning of those facilities;
- Communication strategies to effect behavioural changes and development must focus on real societal advances for women.

NATIONAL MOTHER AND CHILD HEALTH INSURANCE IN BOLIVIA

*A presentation by Jorge Mariscal, Health Officer, UNICEF Bolivia
Jaime Telleria, Director of the Women and Child Department, Ministry of Health, Bolivia and
Jorge Jara, Representative, UNICEF Bolivia*

Country Profile

Bolivia has one of the highest maternal mortality rates in Latin America. An estimated 1,000 Bolivian women die every year of causes related to childbirth leaving behind over 3,000 orphans. The 1994 National Demographic and Health Survey (DHS) showed that, although the maternal mortality rate was stable, there were huge discrepancies within the country between urban and rural areas.

In Bolivia, health care services are provided by the public system, by NGOs and, to a lesser extent, by the private sector. The 1994 DHS revealed a major under-utilisation of health services (only 45% of beds in the public health system were occupied). Cost and cultural barriers were identified as the causes of this under utilisation. Patients were required to pay for their own medical fees, anaesthetics, antibiotics, and materials. Patients also felt mistreated, discriminated against on the basis of their economic status, and felt that their cultural differences were not respected.

The Proposal

In an attempt to resolve these problems, the Government established the **National Mother and Child Health Insurance** in 1996. UNICEF played a major role in helping the Government plan the insurance scheme by assisting in the establishment of administrative and monitoring mechanisms, and the strengthening of the relations between the central and municipal governments and the health system.

The insurance scheme provides universal and free access to the network of public assistance and social security for women of child-bearing age and children under five years of age. This health insurance for women covers: four prenatal visits, hospital delivery, treatment for complications that arise from pregnancy and delivery, including caesarean section, and one postpartum consultation. For children, services include treatment of diarrhoeal diseases and acute respiratory infections. The ultimate goal is to assure every citizen the right to access essential health services by splitting funding between the Government and the 311 municipalities participating in the scheme. The Government pays the salaries of health personnel and the municipalities cover the variable costs of medicine and medical and surgical supplies.

The key elements that facilitated the implementation of the National Health Insurance are:

- Public policy applied at national scale;
- Universal and free access to a range of essential services;
- Decentralised operations at the municipal level;
- Funding from national resources: specific, sustainable and decentralised at municipal level; and
- Civil society nominated committees from grassroots organisations to oversee the services.

In order to make this programme sustainable, a number of activities have been used including advocacy, technical assistance, negotiations with municipalities, social education, and training of health staff.

The Results

In 1998, two years after the launching of the Insurance Scheme (June 1, 1996), the Harvard School of Public Health and the Partnership for Health Reform carried out an external evaluation, and issued the principal findings:

| Services provided | Percentage of increase |
|------------------------------------|------------------------|
| Prenatal check-up (new) | 30.2% |
| Prenatal check-up (total) | 41.3% |
| Childbirth within services (total) | 44.4% |

Interviews with new users, 70% of whom belong to a low socio-economic group, showed that this group was not familiar with modern health services. More than 85% of the new users expressed their satisfaction with the assistance received, fewer complained about mistreatment from the health staff. Instead, doctors and nurses in an overwhelming majority now take the time to explain to patients what they are doing and they provide careful assistance to the users. Since the cost factor was eliminated, users look for the best care they can find and this has led to some over-utilisation of referral facilities.

Lessons Learned

1. Increased financing, when combined with measures to strengthen the accountability of providers, will improve the quality of care.
2. The few female municipal council members played an essential role in advocating for the scheme while many doubted it was possible to sustain an insurance scheme, proving that the involvement of individuals, especially women, can make the difference within an organisation.
3. The legal implementation of a binding clause in the contract between a municipality and the Health Insurance Scheme, ensured commitment at local level.

What Lies Ahead

- The National Mother and Child Health Insurance will also cover other services such as treating complications of abortions, an important cause of mortality, sexually transmitted diseases, family planning services, transportation for emergencies, simplification of administrative procedures, and, last but not least, a cross-sectoral special emphasis on reproductive health.

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- Although removing financial barriers is important, it is recognised that it is not enough and that the quality of care must be systematically improved. The Basic Health Insurance will involve users to help ensure that the implementation of the Child and Mother Friendly Health Services will maintain the standards of quality and be culturally acceptable.
 - An effort will be made to improve IEC on issues related to women and health, foster empowerment of women and the family and all the actors that play a role in the improvement of health care in Bolivia.
 - All the municipalities have now agreed to participate in the Insurance Scheme, which theoretically covers all Bolivian women and children.

THE PATH TO WOMAN FRIENDLY HEALTH SERVICE IN JAMAICA

A presentation by Affete McCaw-Binns, University of West Indies

Country Profile

Jamaica has a population of 2.5 million. The maternal mortality ratio (MMR) of the country presently stands at 120/100,000 live births and 86% of live births take place in health institutions. In 1986-1987, the Jamaica Perinatal Survey² was conducted in order to identify the reasons for poor maternal outcome and unsatisfactory infant health. The major causes of maternal health problems detected were eclampsia and pre-eclampsia.³ The survey also showed that the referral system was not functioning satisfactorily and vital registration of perinatal and maternal deaths was found to be inadequate.⁴ Policy initiatives and interventions grew out of these studies to respond to the deficiencies identified.

The Interventions

1. Improvement in infrastructure

In order to improve the standard of care provided in health institutions, it was considered necessary to improve physical infrastructure to:

- Better supervise mothers in labour;
- Reduce the number of unattended deliveries;
- Reduce low-risk cases at third-care levels;
- Create a baby-friendly environment, while recognising the need for privacy and dignity of the mother at delivery;
- Increase capacity at EOC facilities.

2. Reorganisation of health schemes

At the same time, health care services were reorganised, including:

- Improving training of staff to better identify high-risk women and inform mothers of signs of risk;
- Updating, revising or developing treatment protocols;
- Standardising record keeping, and improving registration of perinatal deaths.

² Ashley D, McCaw-Binns A, Golding J et al. Perinatal mortality survey in Jamaica: aims and methodology. Paesiatric and Perinatal Epidemiology 1994; 8, Suppl. 1, 6-16

³ Ashley D, Greenwood R, McCaw-Binns A, Thomas P, Golding J. Medical conditions present during pregnancy and risk of perinatal death in Jamaica. Paediatric and Perinatal Epidemiology 1994; 8, Suppl. 1, 66-85

⁴ McCaw-Binns A, Fox K, Foster-Williams K, Ashley D, Irons B. registration of births, stillbirths and infant deaths in Jamaica. Int J Epidemiology 1996; 25(4): 807-813

3. Pilot project that addresses eclampsia

A pilot project was organised to fight the devastation caused by eclampsia which included:

- Staff training to improve diagnosis and treatment;
- Increasing access to referral, in order to ensure prompt treatment;
- Empowering women to recognise and appropriately respond to signs and symptoms of severe pre-eclampsia, and other obstetric complications;
- Intensified hospital management of women with severe symptoms: if control of blood pressure was not possible, early delivery preferably by induction of labour, was advocated.

A multinational effort is underway to test an audit process to evaluate regularly the management of major life-threatening obstetric emergencies. The Jamaican Ministry of Health and the University of West Indies are co-operating with the Dugald Baird Centre (University of Aberdeen) and investigators from Ghana to establish criteria and teach them to health teams, and conduct regular reviews to bolster new practices.

The Results

There has been a 65% reduction in prenatal eclampsia in the pilot area.

A review of the years 1993-95 showed a 28% decline in maternal mortality in public hospitals compared with 1981-83. There is no major difference now in the mortality risk between women who live in parishes with only basic obstetric care and those who have access to tertiary or comprehensive care, except for management of haemorrhage, where outcomes are better in tertiary care.

Nine in 28 hospitals have been certified Baby-Friendly. The maternal components in this initiative include delivery of good-quality prenatal care, early detection and referral of high-risk women, health education, family planning services, and monitoring for breast and cervical cancers.

What Remains to Be Done

1. Access to primary care for working women must be expanded by offering evening services in select areas.
2. Family planning must focus on management of adolescent fertility in an effort to delay the initiation of sexual activity and first pregnancies in order to ensure that all pregnancies are wanted.
3. Continue to detect high-risk conditions in prenatal care, establish referral obstetric care where not available.
4. Field test and implement the use of the partogram.
5. Improve the quality of care and continue the certification process of Mother/Baby-Friendly Hospitals.
6. Improve the management of haemorrhage at basic and comprehensive facilities.
7. Services must seek to ensure satisfaction of mothers. A satisfied mother makes optimum use of facilities offered.

IMPLEMENTING THE MOTHER-BABY PACKAGE IN UGANDA

A presentation by Prof. E.M. Kaijuka, Ministry of Health, and Dr. Olive Sentumbwe, WHO

Country Profile

Uganda has a population of approximately 20 million, the majority of which lives in rural settings. The population is among the fastest growing in Africa with an average of 6.8 children per woman. The maternal mortality ratio (MMR) of 510/100,000 live births is caused, among other factors, by poverty, ignorance of danger signs, a poorly developed public transport system and communication that hinder referrals as well as by the generally poor quality of health services. Only 38% of deliveries take place in institutions attended by professionals.

Among other major relevant problems faced by Uganda is:

- A high incidence of STD/HIV-AIDS. Some 1.5 million Ugandans are infected with the HIV/AIDS virus, with 350,000 suffering the full-blown disease;
- A low contraceptive prevalence rate of 15%;
- A high teenage pregnancy rate of 43% making adolescents an especially vulnerable group;
- Malaria is endemic, but there is also an especially severe strain that is associated with HIV/AIDS.

The Safe Motherhood Action Plan

Uganda assessed its maternal and prenatal health care needs following the Nairobi Conference in 1987. The Mother-Baby Package Project was undertaken to implement a Safe Motherhood Programme. Mobilisation was the key thrust of the initiative whose main goals were to involve key players in Ugandan society, e.g. the First Lady who is the patron of the Safe Motherhood Programme. People at all levels of civil society were asked to participate in a sensitising campaign.

The Safe Motherhood action plan aims at improving health care quality through:

- Training of staff;
- Provision of adequate supplies;
- Access to maternal care;
- Family planning services;
- Strengthening management of health care services and information systems.

The Safe Motherhood action plan strives to redress social inequities that erode the status of women.

The Mother-Baby Package

By 1994, the country focussed on the implementation of the Mother-Baby Package, which comprised integrated family planning services for mothers and adolescents, prenatal and delivery care, care of the newborn, and breastfeeding. A policy review identified the need to legalise the midwife profession in order to make them more effective and listed additional responsibilities. It has also required the Nursing Council to review the Nursing Bill and the Midwifery Handbook.

Contents

Information/Education/Communication: Adolescents are vulnerable because they lack access to a range of health care services. It was therefore decided to target this group wherever they may be, in or out of school, in the streets, and even in war zones, to provide them with vital information on reproductive health, to teach them safe sexual behaviour, and to provide treatment for sexually transmitted diseases when necessary.

Improving maternal health care: A number of interventions were implemented to improve health care provided to mothers and to reduce MMR, including screening for HIV/AIDS and STDs, management of health care for women suffering from HIV/AIDS, treating complications arising from pregnancies, and immunisation against tetanus.

Implementation

Trained midwives were identified to be among the key actors for the implementation of the Mother-Baby Package. They had been providing a range of services without any legal framework authorising them to do so. Procedures were therefore reviewed and midwives authorised to set up IV lines, carry out manual vacuum aspiration (as rural women have no access to abortion care services) and administer certain drugs like antibiotics and valium. The revision of the Nursing Bill and the Midwifery Handbook remains to be completed.

USAID, UNFPA, UNICEF, DFID, WHO, GTZ, and CARE donated equipment to help improve health care, especially emergency obstetric care. UNFPA was also involved in a plan to improve transport and infrastructure that were identified as vital to effective health care.

Results

The communication campaign targeting adolescents has been successful in slowly decreasing the prevalence of HIV among youth. A decline from 37% to 12% in the rates of pregnant women infected with HIV has also been detected.

Lessons Learned

- Community participation is the key to success;
- Communities should be empowered to participate effectively in the development of maternal health care programmes;
- Communities must be involved in identifying relevant and effective transport and communication initiatives;
- Women and their families must learn about risk factors connected to pregnancy and know how to get appropriate care when needed;

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- It is difficult to achieve safe motherhood unless men are fully involved and participate in the delivery of maternal health services because women are unable to use the services provided for them without the aid and involvement of men;
 - Service providers need to change their work ethics, i.e. attitudes and practices towards their clients, adopting a "more friendly face" and showing empathy;
 - Technical and financial resources must be co-ordinated among ministries and different levels of government to ensure a successful implementation process.

What Lies Ahead

The following priority areas are being addressed:

- Advocacy, community mobilisation, and sensitisation regarding the issues;
- Equipping health units;
- Transport and communication improvements.

USING MATERNAL AUDITS TO IMPROVE QUALITY OF MATERNAL HEALTH CARE IN SRI LANKA

A presentation by Hiranthi De Silva, Acting Director, Maternal & Child Health Family Health Bureau, Sri Lanka

Country Profile

Sri Lanka has a population of 18.3 million, a population growth rate of 1.1%, and a maternal mortality ratio (MMR) of 60/100,000 live births. The contraceptive prevalence rate is 66.1%, and 96% of deliveries are tended by trained assistants. These positive figures are the result of a long tradition of developing public health care, and the population therefore enjoys a good level of health.

Maternal mortality is quite low considering the general level of development of the country, but there is still room for improvement. Some 250 women still die each year due to complications of pregnancy including haemorrhage, high blood pressure, and anaemia. Some 60% of pregnant women are anaemic and, consequently, 18% of all babies are born with low birth weight. Determining the causes of death of a mother may help to improve the quality of women's health care.

The Health Care System

Health care is readily available: 50% of outpatients are treated in the private sector, while other patients use the free health care services provided by the public sector.

The Public Health Midwife (PHM) provides the basic care at the primary level and serves as the main link between the various levels of the community health care system. The Medical Officer for Health heads the health units which cover the divisional secretary areas, and s/he is assisted by a number of health workers including the PHM. A District Health Administrator (DHA) is responsible at the district level, and each province has a Minister of Health. Patients can seek care in any medical institution of their choice.

The **Safe Motherhood Programme** was set up in 1988. The holistic and human-centred Reproductive Health concept was introduced following the UN Population and Development Conference in Cairo (ICPD) in 1994. Services providing care for women and children were integrated with family planning services that were being provided by the same health units.

Reporting Maternal Death

The routine reporting of maternal death had been in place for several decades. The head of the institution where the death occurred had to file a report, which was then sent to the Family Health Bureau and to the District Health Administrator. The Medical Officer for Health was responsible for the investigation if the death had occurred outside a health institution.

The Present Procedure

An element of urgency was injected into the process in 1985 mandating that a death be reported to the Family Health Bureau (FHB) and District Health Administrator (DHA) immediately by telephone or by telegram, and in the case of institutional death, a letter must follow. The Medical Officer for Health of the area is then notified by the DHA. In case of a death happening outside a health facility, the Medical Officer for Health has to report the death to the FHB and the DHA right away. After reporting, an investigation is to be carried out within three days for an institutional death and seven days for a death outside of an institution.

Since 1985, reviews are organised annually at central level: representatives of the Ministry of Health, the supervising staff, the Medical Officer for Health, and Heads of Institutions are invited to analyse the circumstances of each woman's death. The discussions are conducted fairly and openly to enable the pinpointing of shortcomings that might have led to the death of a mother. Corrective actions must follow. Since 1998, the reviews are held at the provincial and district levels. The meetings also provide a good opportunity to assess various needs, including training, equipment, and development. The discussions also effect changes in attitudes.

Problems

- Underreporting by medical staff has been identified as a major obstacle to the success of the programme. The underreporting is due either to unintentional omission or to a misclassification of cause of death including early pregnancies and/or abortion;
- Understaffing of services also remains a serious obstacle;
- Lack of co-ordination and follow-up action is also a problem.

The Strategies for the Future

Ensuring accurate reporting of maternal deaths seems to be critical to decreasing the annual rate of maternal deaths. Some strategies have been devised to improve the review of maternal deaths, including the introduction of a pregnancy box on Death Certificates, better training of staff, introducing a confidentiality element in services that would ease the procedure for the Heads of Institutions. UNICEF is also involved in researching the trends and present procedures in maternal death reviews as this seems to be a powerful tool to improve the quality of care given to women.

INCREASING USE AND IMPROVING QUALITY OF MATERNAL AND CHILD HEALTH SERVICES IN TUNISIA

A tool for evaluation and micro-planning

A presentation by Moncef Sidhom, Director of Basic Health Care, Ministry of Health, Tunisia

Country Profile

Tunisia has a population of 9.3 million, and a GDP of \$2,100 per capita. The maternal mortality ratio (MMR) is 69/100,000 live births. The rate of utilisation of health services is high and most health care facilities are considered to be functioning well and easily accessible with more than 90% of the population living within 4 km. from a health facility. Nevertheless, all partners in the health sector, including health professionals, users and authorities, agree that it is necessary to improve the level of quality of the health care services.

Although 84% of pregnant women have at least one prenatal consultation, only 64% of them are monitored during the first trimester of pregnancy. Only 17% of pregnant women have four consultations during pregnancy which is considered the minimum adequate level of monitoring. The following problems were identified:

- Inadequately trained staff;
- Long waiting hours at centres for users;
- Difficult working conditions for staff;
- High cost yet insufficient contact between health care staff and patients;
- Users are not involved in determining the care they need.

The Evaluation Tool

As one of several tools used to define the quality of care, the Ministry of Health adapted a tool which was the result of *South/South* Cupertino devised after a case study mission in Mali and Senegal and used in several African countries.

The essence of the tool is a community-based monitoring curve used in Mali and Senegal that was adapted to the Tunisian reality. It was first used only as an evaluation tool and later developed and modified in order to be used for follow-up actions and micro-programming activities from one year to another.

The Monitoring Curve (Example of Prenatal Consultation)

Three indicators are concerned with service *coverage*, and three with *quality*. The six indicators, namely, the number of people covered, availability, degree of use, early or first trimester monitoring of pregnancies, adequate number of visits for monitoring pregnancies, and quality of care (itself defined by 7 indicators), are set out in a fixed order, as the first one has implications for the next one

and so forth. Any spike in the curve indicates a problem or a bottleneck, and hence allows health centre authorities to identify clearly where they must intervene to supervise, train, and provide equipment. The comparison is used for benchmarking, for setting standards, and focussing supervision where necessary.

Six steps are necessary:

1. Computing performance indices;
2. Drawing the performance curve;
3. Studying the curve, visualising problems and bottlenecks;
4. Analysing causes, and identifying corrective measures;
5. Following up the last micro-plan;
6. Setting up the micro-plan of actions to be taken.

The tool is successful both with the authorities to identify where action is needed and with teams who feel motivated to improve based on the results of quantitative indicators.

Moreover, the tool is useful because it is versatile and can be used for any population group: children below 1 year of age (EPI), women who have just given birth (FP) covered by any health programme, chronically ill people, and for those suffering from diabetes and hypertension.

The tool can also be used at all levels of the health chain. At the health district or regional centre, it allows for identifying problems and devising solutions. At the regional level, it allows for comparison of performances in order to create a plan for supervision.

Lessons Learned

It is possible, with some adjustment, to use the tool that was created mainly for monitoring, for other purposes. This tool was improved and adapted to the particular situation of Tunisia. What was conceived as a tool to develop follow-up action became a tool for evaluation and micro-planning.

Such a tool can also be used to set up a dialogue between representatives of a given community, authorities that want to raise the quality of care at national level, and health personnel who work at regional or local level.

IMPROVING QUALITY OF CARE IN GEORGIA

A presentation by Ketil Nemsadze, MD, Professor at State Medical University, Georgia

Country Profile

A small nation with a population of 5.4 million, Georgia gained independence in 1991 after the breakup of the USSR, and is still a country in transition struggling to establish its own identity based on its own history.

Mothers are well respected in Georgia, but Georgian culture does not allow women the freedom to choose what they need and want. The situation is slowly changing as the country evolves into a more open society.

Ensuring Quality of Care for Women is a Way to Promote their Status in Society

"Quality of care is universal, but must be adapted to local standards," says Dr. Nemsadze about the health care situation for women in Georgia. "Indicators must be established and used to monitor quality."

Universal standards of quality of professional health care were defined as follows:

- Availability of family planning services;
- At least four prenatal visits along with educating the mother;
- A referral system for high-risk women;
- Methods to suppress painful procedures;
- Use of modern technology;
- Minimal use of medications;
- Neonatal health care.

Universal ethical standards in quality of health care should be the following:

- Acting in the best interest of the woman socially, financially, and culturally;
- Risk assessment and management;
- Respect for users and their rights to obtain information; obtaining consent and ensuring confidentiality;
- Social justice in allocating funds to making services accessible to all.

Communities should be involved in the evaluation of services, and health professionals should receive state and community support. Dr. Nemsadze identified the above as being a big problem in Georgia, but also stressed that the situation is progressing well, though a lot has yet to be achieved.

IMPLEMENTING THE TEN STEPS PROGRAMME FOR A SAFE DELIVERY IN PERU

*A presentation by Olga Frisancho, Ministry of Health, Peru, and
Mario Tavera, UNICEF Peru*

Country Profile

Peru has a population of 23.8 million, and 5% of its budget goes to health care services. A 1996 study showed that the maternal mortality ratio (MMR) stands at 261 per 100,000 live births, and that it has been stable for several decades. About 51% of women deliver at home, and 60% of these receive four prenatal check-ups by professional health care personnel. The survey also showed that health services are not of high quality and lack a people-centred approach, and that access to health services in rural areas is inadequate. The system does not respect the users' cultural values, and there are considerable financial barriers to using the available services.

The Ten Steps for a Safe Delivery Project

The Peruvian Ministry of Health, UNICEF, USAID and Project Health 2000 collaborated to implement a project designed on the basis of the 1996 assessment. It was undertaken within the time frame 1997-2000, to:

- Improve the administration of the health services;
- Improve access and co-ordination of services provided;
- Improve the capacity of the services to resolve health problems;
- Develop the systems of referral and follow-up;
- Monitor maternal and perinatal mortality.

USAID also developed the Project Health 2000 to improve the quality of service and attention paid to clients in maternity wards.

To ensure a safe delivery, health facilities should follow these ten steps:

1. Establish a written policy of safe delivery;
2. Train and sensitise all personnel;
3. Provide thoughtful quality care to the pregnant woman;
4. Give priority care to obstetrical emergencies, post-abortion complications, haemorrhagic shock, septic shock and eclampsia;
5. Establish an operational blood bank;
6. Have surgical facilities;
7. Have the necessary equipment for reviving newborns and for caring for premature and low weight newborns, including a "kangaroo pouch";
8. Have a telephone or radio and adequate transport;
9. Organise and operate a Maternal and Perinatal Surveillance Committee;
10. Establish community support groups to identify those at high risk and help in monitoring maternal mortality.

The Implementation Process

1. A national facilitating committee co-ordinated by an obstetrician was set up.
2. Institutions were inspired to participate through a national awareness workshop that culminated with participants committing their institution to implement the initiative and receiving training modules.
3. The Safe Motherhood multi-disciplinary team was then formed to inspire the staff.
4. The material was adapted to the particular environment of the institution.
5. The sensitivity and training workshops were conducted to encourage participation in identifying problems in order to ensure feasible solutions.
6. Appropriate technologies were developed to identify potential blood donors in the community and to train staff in the use of the partograph.
7. Workshops were replicated to brief all staff and to produce a programme work plan.
8. A management workshop was organised to garner the full commitment of the institution's authorities and to draw up a schedule for change.
9. The process was then monitored.
10. The accreditation procedure started with a monitoring and supervision module, external evaluation module, including interviews with users and staff, and observation visits.
11. Indicators pertaining to the process and results were surveyed and facilities with 80% compliance were granted accreditation.

What Has Been Done So Far

Advocacy activities at the national, regional and local levels have been conducted to garner the commitment to the implementation of the Initiative. Thirty-one maternity centres have been evaluated using the criteria of the Ten Steps developed concerning content and training materials and modules. Indicators were established and three maternity wards in Lima were tested as part of a pilot project.

| Hospital | M.Auxiliadora | | San Bartolome | | C.Heredia | |
|--|---------------|--------|---------------|--------|-----------|--------|
| | 1995 | 1997 | 1995 | 1997 | 1995 | 1997 |
| Performance of 10 steps (data 96 and 98) | 67.3 % | 89.2 % | 76.1 % | 81.2 % | 75.3 % | 77.8 % |
| Maternal mortality | 249.5 | 170 | 56 | 48 | 188 | 313 |
| Prenatal control | 6.4% | 60.6% | 12% | 8% | 19.8% | 25.4% |
| Apgar < 6 at 1 min. | 8.17% | 5.98 % | 8.1% | 7% | 4.9% | 1.5% |

The Lessons Learned

- The process is more complex than originally thought, and it was found to be an ongoing process.
- Calling it “Ten Steps for Safe Motherhood” instead of “Mother Friendly Services” gives the programme a more integrated focus on both pregnancy and delivery.
- User participation, not only individual, but also community-based, is essential.
- Low salaries can negatively impact staff motivation.

What Lies Ahead

- The project is expected to cover 90 maternity centres by the Year 2000.
- The process should be expanded with the implementation of a continuous quality improvement programme.
- A strong nutritional component during pregnancy must be integrated into the programme.
- Adapting to local conditions is essential. There is also a need for integrating cultural respect into the content of the package from the beginning.
- If it is well received at lower levels, there is a desire for more infrastructure and equipment at the national level.
- There is a need for political support at all levels.
- Because of the high proportion of deliveries that take place outside of hospitals, the initiative must include other referring services such as Health Centres.
- The Government has decided to implement the Ten Steps for Safe Motherhood programme into the National Health Insurance Scheme in the 21 poorest regions of the country.

IMPROVING THE QUALITY OF MATERNAL AND PERINATAL HEALTH IN BRAZIL

A presentation by Tania Lagos, National Co-ordinator of the Programme of Woman's Health, Ministry of Health, Brazil, and Caroline Sui, UNICEF Brazil

Background

Brazil is the fourth largest country in the world with a population close to 156 million. Brazil consists of 27 states and 5,600 municipalities that are serviced by more than 3,400 hospitals. An overwhelming 91.5% of deliveries are institutional, higher in urban areas according to the 1996 Demographic and Health Survey. Caesarean deliveries represent 36.4% of all births, and the maternal mortality ratio was 99 per 100,000 live births in 1996.

The major problems in maternal health care in Brazil are principally related to lack of access to **quality health care services**. Late referrals for complications as well as financial considerations for doctors and institutions account for a high **proportion of caesarean births**. The aim of the project is therefore to reorient health care providers, to raise awareness among women, and to mobilise communities on the importance of striving for natural births.

Safe Motherhood

The Safe Motherhood Initiative in Brazil is a partnership between several government institutions at the state, regional and national levels, UNICEF, PAHO/WHO, UNFPA, the Brazilian Federation of the Gynaecology and Obstetrics Society, and universities.

The objectives of the initiative are:

- To reduce maternal and perinatal morbidity/mortality rates by improving the quality of health care services;
- To sensitise professionals to take an integrated approach to women's health issues, including reproductive health and children's care, incorporating new routines and making assistance and services more caring and sensitive.

The Implementation Process

The first phase of the project was establishing the criteria for evaluating hospitals and health care establishments using the **Eight Steps to Safe Motherhood** programme.

1. Access to information on reproductive health, family planning, and women's rights;
2. Assistance during pregnancy, childbirth, and after birth;
3. Incentives for a normal and caring birth;
4. Establishing written routines to ensure standardisation of assistance;
5. Training health care personnel in implementation of routine procedures;
6. Establishing adequate facilities for maternal and perinatal care;
7. Introducing the use of filing and information systems;
8. Periodic evaluations of maternal and perinatal health indicators.

Five hundred hospitals were asked to participate in three regional workshops that were organised to disseminate information on and train professionals in Safe Motherhood evaluation. Evaluation tools were designed for each of the steps in the process. These tools were developed to enable observation, revision of routines and guidelines, interview with personnel and patients, and to devise follow-up procedures that should be carried out by hospital top management.

Workshops were organised in the participating states to disseminate information about childbirth and delivery processes and their implications under the eight Steps to Safe Motherhood Programme. Some hospitals were assessed according to whether they complied with the processes, providing opportunities for discussion and problem-solving when they were found not in compliance which helped to stimulate the hospital teams to implement plans for improvement of maternal care.

Special Initiatives to Promote Natural Births

A campaign promoting natural births was launched in order to reduce the high rates of caesarean sections, to improve the quality of the assistance, and to update medical skills of health professionals. The campaign emphasised the importance of natural childbirth and raised the awareness of women, and communities in general, on the importance of mobilising for action. The Government introduced an incentive for promoting natural birth by capping reimbursements for caesarean sections at each institution at 40% of all live births.

Doctors and institutions that are financially affected by these changes in government policy have filed lawsuits claiming that caesarean sections are in the best interests of the women, even though unequal access to caesarean section in lower socio-economic groups is apparent. The overuse of epidural anaesthesia during normal delivery has, for the same reasons, been included in the list of paid services. In an attempt to reduce unnecessary interventions, assisted deliveries by skilled health personnel in health facilities have become eligible for remuneration from the State.

Results and Lessons Learned

Overall, an increased awareness of the need to improve the quality of care of women and children was detected. Standards of quality are being developed through accreditation. So far, three hospitals have been accredited and another 150 hospitals are in the process of accreditation.

A multifaceted approach to women's health, the Safe Motherhood Initiative is a complex and lengthy process and appears to face more obstacles than the Baby-Friendly Initiative. Social, economic, and regional differences must be taken into consideration when developing criteria for the Initiative. Most local health establishments are small and face difficulties when trying to meet the criteria established for achieving Safe Motherhood accreditation. It turns out that evaluation tools are most suitable for bigger hospitals with more than 1,000 births per year which cope with more complexity in their daily work. They cannot be used effectively in smaller hospitals and health service establishments.

It is important to systematise and disseminate information about successful experiences in order to stimulate other health services to incorporate initiatives aimed at improving the quality of care. Networks among various groups of health professionals must be developed and maintained at the local level in order to capitalise on information and experience.

In order to create a health care system with a human face, the users must be encouraged to be involved in this process and their needs and opinions must be solicited when developing quality criteria. This should be done in strategic alliances with civil society organisations such as women's NGOs, research institutions and universities, state institutions, and federal representatives.

What Lies Ahead

It is necessary to enlarge the scope of maternal health care beyond the hospital level and integrate it into a more holistic approach to women's health. Empowering the users, i.e. women, by offering alternative health care services at the community level should lead to a strengthening of the demands of this group.

More mechanisms should be created to ensure higher remuneration of accredited Safe Motherhood or Women-Friendly Health Services. Increasing advocacy activities for women's rights and health issues, with special emphasis on childbirth, should be at the top of the priority list of health service establishments. Municipal health managers and local leaders should be more involved in the processes described above.

THE COPE EXPERIENCE IN IMPROVING WOMEN-FRIENDLY SERVICES

A presentation by Amy Pollack, AVSC International

AVSC International has 50 years of experience in implementing quality assurance programmes in clinical settings, including providing procedures in operating rooms and service delivery sites where preventing infection is chief among other indicators of quality. AVSC's expertise is especially applicable to the area of maternal health because it deals with issues of training and management in settings where turnover is continuous, overcapacity and emergencies are common, and management of infection prevention is ongoing and challenging.

More resources, therefore, need to be invested to assure quality than in many of the other clinic and hospital-based services that are not on 24 hour call. Where resources are scarce and women's social status is relatively low, the quality of maternity services and the state of the maternity ward reflect this low status, and is often a descriptive indicator of women's plight in that area.

From AVSC's inception, **informed choice and medical monitoring** have been the backbone of the quality assurance approaches we have used to ensure quality in service delivery. Since the late 1980s, AVSC added other components to its quality assurance package:

- Facilitative supervision;
- Problem-solving and improvement at the site, dubbed The Client-Oriented Provider-Efficient approach (COPE);
- Whole-site training including Inreach;
- Annual assessment tool (QIQ).

AVSC's quality improvement approaches are based on the rights of clients and the needs of staff (adapted from The International Planned Parenthood Federation (IPPF) framework) to promote safe services and good client-provider interaction. The various components complement and strengthen each other.

The Client-Oriented, Provider-Efficient (COPE) Process

The usual procedure for solving problems in health services is to have an outside expert on quality assess the service, make recommendations, have the recommendations implemented, follow up, and monitor change. However, this method does not guarantee a lasting change because the health care staff and providers are not involved in the process.

COPE is different. It relies on self-assessment rather than external inspection or policing. It is a process of continuous quality improvement through site-level problem-solving and involves all levels of staff at the service delivery site.

Using COPE implies that the supervisor has adopted a **facilitative** approach to **supervision**. **Facilitative supervisors** are committed to quality improvement and rely on coaching, mentoring and two-way communication. They build a health team that focuses on the client who also is a major actor in the implementation of change.

COPE is a process and a set of tools. Staff use 10 self-assessment guides based on the client's rights and staff's needs framework to assess the services they provide. The trigger questions in the guides are educational and help reinforce standards. Different levels of staff form small groups who work on a couple of guides each. With the use of the guides, they identify problems and subsequently analyse the problems and develop solutions. Together, they develop an action plan, which should be openly discussed at the site for everyone to see. The action plan states the problems and their causes, solutions to the problems and areas of responsibility, and sets the timeframe for solving the problems.

The client interview is also important because clients may reveal problems that had remained undetected by staff members. Other tools that may reveal problems include the client-flow analysis and the medical records review. All the problems identified are incorporated in the site's action-plan.

Using the COPE process and tools, health staff learn to identify problems and develop solutions. The process relies on self-assessment, as opposed to external inspection, and encourages staff involvement. This leads to staff ownership and commitment to the solutions developed.

Originally, COPE was designed to assess the quality of family planning services, but now the tools have been revised to reflect broader reproductive health services. For example, a more specialised version of COPE was developed for maternal care. Another specialised version has been developed for child health services with input from UNICEF, USAID/REDSO, and WHO.

Results and Lessons Learned

- Programmes that have used COPE frequently report that they have solved persistent problems with local resources. For example, in East Africa, one hospital mobilised each of the villages in the district to pave the pathways between wards and the operating theatre--each village paved one path. One regional hospital repaired 230 beds with local resources, instead of waiting for a supply of bedsprings from the Ministry of Health. One urban clinic developed a way for emergency patients to get to the nearest hospital. Another site managed to have its water supply re-established after three years with no running water through persistent follow-up with the authorities.
- If change does not have local ownership, it cannot be durable, and the quality of care will not improve on a long-term basis. Nobody can impose it from outside.
- Staff feel gratified and motivated when the problem has been identified locally, solved locally, and when conditions have improved without external help.
- COPE empowers people. They start solving small problems and end up solving more difficult ones through a chain reaction of problem-solving.
- Decentralisation is taking place in most countries, which means that there is a need for problem solving at the local level, to contribute to national policy changes. This is where COPE is very useful.
- Other advantages of COPE are that it uses the wisdom of the experts; it is simple, effective, adaptable, and transferable; it provides a forum for discussion for staff and their supervisors, often for the first time; and it helps staff focus on clients.

THE QUALITY ASSURANCE APPROACH TO IMPROVE ESSENTIAL OBSTETRIC CARE: AN EXPERIENCE IN LATIN AMERICA

*A presentation by Barbara Kerstiens, University Research Centre
Centre for Human Services (URC-CHS)*

Quality design is a systematic process in which the needs, expectations, and desires of the different clients are determined and subsequently matched with concrete service features that maximise the satisfaction of these needs with available resources.

Quality Design is used to prevent problems, when there is no current process, or when it is not well defined. This is quite different from quality improvement which refers to problem-solving in existing processes.

USAID/Quality Assurance Project (QAP) uses quality design as part of an intervention strategy to improve Essential Obstetric Care through increased stakeholder and client involvement and mobilisation.

USAID/QAP presently has 17 teams working in three countries (four in Bolivia, five in Ecuador and eight in Honduras). The design team includes people from different backgrounds including health personnel, traditional or trained birth attendants, midwives and doctors, women and their families, and community representatives.

The Methodology of the Quality Redesign Project

The methodology consists of 10 steps:

1. Select the process/system to be redesigned.
2. Define the vision for the mission of the new system/process.
3. Create a simplified flowchart of the new system/process.
4. Identify customers, both external and internal, of the selected process.
5. List customer needs and expectations. Prioritise them.
6. Link needs with each activity in the simplified flowchart.
7. Identify key features in the new design that respond to priority needs. Link key elements/features with activities.
8. Design the new system/process. Description or Flowchart.
9. Test for robustness, i.e. reliability and manufacturability.
10. Plan implementation and required resources.

The needs and expectations of the different people involved are defined through questionnaires, brainstorming, focus groups, and interviews. For example, when a woman needs emergency obstetric treatment, the following must be available: transportation to a referral centre, health staff at the facility 24 hours a day, and necessary supplies and equipment. Some steps can be fairly simple, and some may require more time. Solutions are also reached through group work.

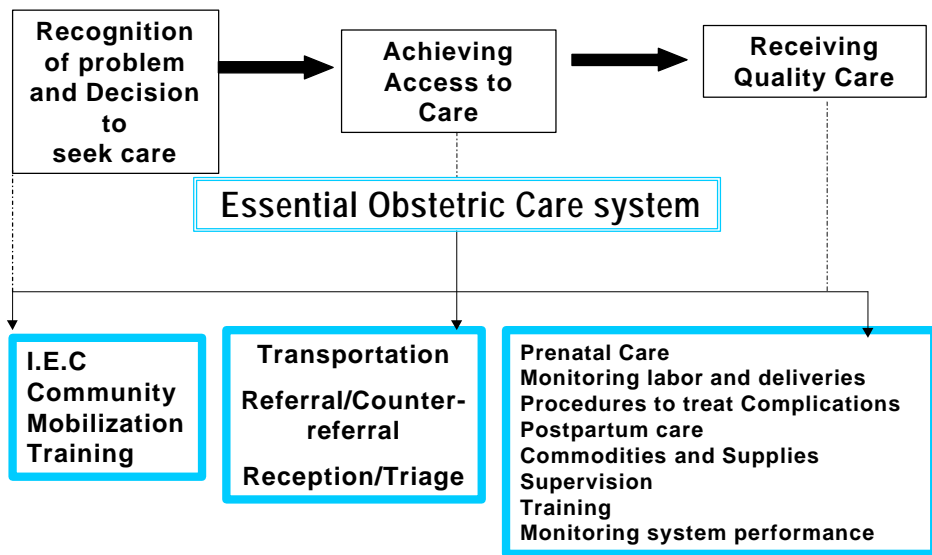
Basically, a redesign project takes six months from beginning to end. The team meets once a week for about three hours without any expense being involved as team members are not paid, except for the reimbursement of the travel expenses of some participants.

The Results

Six months after the start-up of the activities, the five design teams working in Ecuador have reached implementation stage for the components they selected. Reception/triage in two hospitals has been improved; all emergencies are now treated in the same area of the hospital; and referral/follow-up forms have been developed for all facilities. Husbands can now attend prenatal visits. Transportation has become less of a problem, as there is an agreement between several facilities, and ambulances are shared. Confusion has been reduced, as there is now only one reception area for obstetric emergencies in the district hospital instead of two. Information, education, and communication messages are based on local needs within the community involved.

Conclusion

The redesign approach allows patients, their communities and providers to devise design options to improve quality of EOC services using their respective needs as a starting point.



MOTHERCARE'S APPROACH TO BUILDING QUALITY INTO SERVICES THROUGH TRAINING AND CONTINUING EDUCATION SYSTEMS

A presentation by Marge Koblinsky, MotherCare

Background

The MotherCare project was implemented in South Kalimantan (Indonesian part of Borneo). The area is divided into three districts and has a population of 1 million inhabitants. The area is laced with rivers, and travel often has to be done by boats. Eighty-seven per cent of births are home deliveries, only 8% are institutional; in rural areas, only 52% of women benefit from the assistance of a trained birth attendant during delivery.

Problem

The maternal mortality ratio (MMR) is at 540/100 000 live births, higher than the rest of Indonesia. At the end of the 1980s, the Indonesian Government decided to provide one midwife for each village following the examples of Sri Lanka and Malaysia, who had thus managed to reduce maternal mortality. But the “bidan di desa”, or midwives at the village level deployed in South Kalimantan, were very young (about 25 years old). Their training was minimal -- eight years of schooling, three years in a nursing school, and one year in midwifery before they were sent to the area.

Before the project had started, the Government had deployed 60,000 of these bidan di desa, and they were performing only one delivery per month on average, that is, 7% of deliveries.

Strategy

In 1995, the MotherCare project, together with the Indonesian government, decided to try to reduce MMR and perinatal deaths with a focus on the use of trained assistance for prenatal and postpartum care.

Three factors justified such a strategy:

- Skilled personnel were available. Although the bidan di desa were not highly skilled, they were already there, and the Government sent two obstetricians to the area.
- There had been a number of interventions to improve services; the technical and interpersonal skills of the bidan, midwives at the clinic level, and bidan di desa had been improved with training sessions; and maternal death reviews and record-taking made it possible to follow progress made.
- In this community, a large majority of births were home deliveries, which means that it was necessary to raise the community's awareness about the existing services, danger signs, etc.. The intervention was for health staff to provide information, education, and communication at the community level.

The Training Process

A five step training programme was organised, three steps in collaboration with the Ministry of Health:

1. Barriers at community level and health facility level were **assessed** by gauging health care providers' knowledge, reviewing their functions, as well as the protocols they used.
2. **Guidelines** were developed - an essential step for improving any quality of services. Time consuming but essential, this was done with the help of hospital administrators and providers.
3. **Training:** Sites had to be prepared to ensure that each trainee had enough clinical experience to become competent. Some time is necessary between the different stages of training. The trainers themselves must gain from training and be able to incorporate what they have learned into their own practices. The clinic midwives had a different experience from the newly trained village midwives. The former needed additional training in life saving skills, while the latter needed to enhance their routine skills, i.e. normal birthing and postpartum care, etc.

And two steps with the collaboration of the EB, the Indonesian Midwifery Association:

4. **Continuing education** was offered in an attempt to sustain quality. The senior midwives at the clinic level were trained to visit the midwives at the village level twice a year to supervise them concerning the procedures they must comply with. A summary of all these proceedings was sent to the district level and was discussed at chapter meetings every three months, where continuing education was provided.
5. **Peer review.**

Outcome

An evaluation of the entire programme to focus on the increased use of these midwives, as well as on the quality of work that they perform, was planned for the summer of 1999.

Lessons Learned

- The project used existing human resources, even though they did not seem to have the required level of technical skills to improve quality.
- The partnership between the Government, the Midwifery Association, and MotherCare created solutions adapted to both cultural and economic conditions.

WHO: DEVELOPMENT OF STANDARDS FOR IMPROVING QUALITY IN SOUTH EAST ASIA

A presentation by Jelka Zupan, WHO HQ and Duangvadee Sungkhobol, WHO SEARO

Background

Approximately 40% of the world's maternal deaths, or nearly 250,000, occur in the WHO South East Asian Region each year. The maternal mortality rate is still high in seven out of ten countries in the region where more than half of the deliveries occur at home attended by untrained persons.

It has long been recognised that the cornerstone of quality maternal health care is a person with adequate knowledge and midwifery skills who lives in or close by the community where women live.

WHO has been developing **standards** of quality and has defined **norms** as a scientifically determined requirement in a given health sector. Various efforts have been undertaken by WHO to strengthen national capacities in the area of midwifery education and practice. Following is an example from the WHO SEARO region.

Standards of Midwifery Practice

Since it is not possible to develop standards that would be serviceable in all countries, a prototype of midwifery practice standards was established with active consultation from member states. These were meant to be locally adapted to provide guidance for the critical tasks performed by midwives. They were based on good midwifery practices in countries within and outside the region, the latest research findings, and recommendations from the WHO Safe Motherhood programme.

These standards cover general midwifery practice, prenatal care, delivery care, postpartum care and life-saving midwifery practices. They include performance criteria, i.e. equipment required, supporting systems, pre-requisite skills, audit tools, and action plans to remedy problems.

The standards were then refined during a regional consultation in 1996 and field-tested in selected facilities in Bhutan, Indonesia, Nepal, and Thailand during 1997 and 1998, for maternal health services. Participating trained midwives, auditors, and medical doctors at first referral units were trained to use the standards. After three months, standards were finally assessed.

The Outcomes

All midwifery-trained personnel found that the standards were useful tools for improving the quality of the care they provided. They also felt their competency had increased, and therefore felt more self-confident.

The clients expressed their satisfaction with the care they received. More women were using the centres and the drop-out rates had declined.

The midwifery services were more efficient and cost-effective and referrals improved too.

Finally, in implementing the standards, countries were able to identify skill and knowledge deficits in midwifery-trained personnel as well as deficiencies in supplies, equipment and support system requirements needed to provide quality midwifery care.

There was, however, a lack of essential supplies and equipment for implementing some of the standards in many settings, and it was difficult to implement the standards in hospital settings as some specialists were reluctant to change their practices.

Lessons Learned

- Standards help to improve the work of midwives and other attending health personnel and they help to decrease unnecessary tasks.
- They foster participatory management and supportive supervision.
- The use of the midwifery standards can facilitate quality improvement and better management of midwifery services.

Recommendations

1. Countries should involve all major stakeholders: health planners and managers, midwife practitioners and educators, consumers, professional associations, etc. in drafting and implementing the standards in their countries.
2. It is crucial to try to identify good practice models for implementing the standards in the country. Countries may need to start on a small scale to demonstrate the effectiveness of the standards.
3. There must be an integration of midwifery practice and education. The standards must be reflected in both service training and pre-service education.

UNICEF: LESSONS LEARNED FROM THE BABY-FRIENDLY HOSPITAL INITIATIVE

A presentation by Helen Armstrong, Programme Division, Nutrition Section, UNICEF

The Baby-Friendly Hospital Initiative (BFHI) focuses on the health of both infants and mothers. It facilitates breastfeeding and ensures that women in maternity care have full information and support and can choose how to feed their infants in an atmosphere free of commercial influences. Therefore, any maternity facility that strives to be mother-friendly should also meet the BFHI Global Criteria and be assessed and officially designated Baby-Friendly.

Developing and going to scale with successful BFHI pilot programmes have taught UNICEF a number of useful lessons.

The BFHI is a global programme that was built on grassroots experiences. During the 1970s and 1980s, mother-to-mother breastfeeding support groups had been more successful than many medical systems in increasing the exclusive use and duration of breastfeeding. As a wealth of practical knowledge became more widely understood, scientific evidence documenting the benefits of breastfeeding was also established by developing the Cochrane database and other published material. Recommendations could then be developed both from mothers' broad experience of what made breastfeeding go well, and from research evidence.

Ten Steps to Successful Breastfeeding

The recommendations included "Ten Steps to Successful Breastfeeding" co-published in 1980 by WHO and UNICEF in their joint booklet *Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services*. These steps were then expanded into the Global Criteria for the Baby-Friendly Hospital Initiative (BFHI) in 1991. The Global Criteria were designed to be applicable in all settings, in industrialised as well as in developing nations, since good management techniques of breastfeeding are universal. It took two years to develop a consensus on the ten steps and they have become the basis for accreditation of the BFHI health facilities. They are:

1. Have a written breastfeeding policy that is regularly communicated to all health care staff;
2. Train all staff in skills necessary to implement this policy;
3. Inform all pregnant women about the benefits and management of breastfeeding;
4. Help mothers initiate breastfeeding within half an hour of birth;
5. Show mothers how to breastfeed and how to sustain lactation, even if they should be separated from their infants;
6. Feed newborn infants nothing but breastmilk, unless medically indicated, and under no circumstances provide breastmilk substitutes, feeding bottles, or teats free of charge or at low cost;
7. Practice rooming-in which allows mothers and infants to remain together 24 hours a day;
8. Encourage breastfeeding on demand;
9. Give no artificial teats, or pacifiers, to breastfeeding infants;
10. Help start breastfeeding support groups and refer mothers to them.

Communications campaigns should target first-time mothers. By convincing them to breastfeed, one establishes a pattern that will ensure that they will breastfeed all their babies. It takes courage to change practices that have not been questioned. Multiparous mothers are more difficult to convince.

Implementation

Since the BFHI was launched in 1991, the number of Baby-Friendly Hospitals has grown to over 14,500 in 125 countries, and more are designated every year. Each designated facility represents the hard work of a retrained group of health professionals who transformed routines that had long gone unquestioned.

It took time to inform government authorities, health professionals, breastfeeding organisations and achieve national consensus and commitment among them on modern infant feeding management. Before policies were developed, health professionals and policy-makers needed to be informed and educated to counter misinformation. Any attempt to define national or international criteria too hastily, or with the apparent assistance of commercial interests, tended to prolong negative conditions and practices that continued to undermine women's rights to breastfeed.

National multisectoral committees, as recommended by **the Innocenti Declaration of 1990**, were set up to implement the BFHI. These committees often had to educate themselves regarding the science and the clinical experiences which showed that certain long-standing customs of their health services were now outdated. Once persuaded, the national committees took responsibility for implementation, training, assessment and monitoring, and took charge of awarding the global BFHI designation. With time, they have also carried out reassessments to ensure that standards are maintained.

As part of the BFHI, health staff at all levels were retrained with better skills in counselling mothers. Encouraging mothers to breastfeed without either providing supportive conditions or counselling to reinforce the mother's sense of competence, had previously proven ineffective in increasing breastfeeding rates. WHO and UNICEF produced training materials for 18-hour, 40-hour, and 80-hour courses. A very important lesson learned was to keep the vocabulary and the technical content of all levels of these materials consistent. This ensured a common breastfeeding management.

Assessment

National breastfeeding committees were able to assume the task of verifying implementation of the criteria previously handled by external assessment of facilities by using international questionnaires. National ownership was thus established while universal standards were maintained. A baby-friendly facility, whether in Beijing or Bogota, Libreville or London, will meet the same basic standards.

The assessment process focuses on the experiences of a random sample of mothers. Perhaps the most revolutionary lesson learned from the BFHI is that hospital practice is best judged by learning from individual mothers who tell about their actual experiences. We learned that the young women who had just given birth rather than administrators or senior staff, offer the best information on actual maternity care practices. First-time mothers were especially important, since how they feed their first child will shape what they do with the subsequent infants.

Lessons Learned

An important lesson learned from the BFHI has been that the use of standard training materials is possible when they are grounded in global scientific knowledge and clinical experience. National adaptation of training materials is not necessary and indeed entails the danger of reintroducing old and erroneous information. It was preferable for national programmes to use the training materials as published, perhaps adding a few extra sessions as necessary, but without supplanting the evidence-based material. This improved the effectiveness of training while saving professional time and funds for actual training courses.

Not everything went smoothly, however, in introducing BFHI:

- Health facility managers are overworked and have difficulty undertaking any new programme unless they feel that it will save staff time, money, and lives in the long run. Sharing positive experiences and examples of good practices from a few pioneering Baby-Friendly facilities helped to persuade other managers to take on the commitment.
- Resistance arose within the health system from those groups with vested interests in commercial sector ventures. Vigilance against such influences in the health care system and the national breastfeeding committees are vital to protecting the health and well-being of women and children.
- Resistance can also be expected from professionals who have not been updated on current evidence-based practices. Steps were not taken early enough to win the support of the organisations of health professionals for the BFHI. A lesson learned has been to build consensus among paediatric, obstetric, nutrition and nursing associations, along with the organisations of breastfeeding mothers, from the start.

What Remains to Be Done

It was hoped that Step 10 of the BFHI, fostering maternal support groups in the community, would link hospitals with the communities they serve. In many settings, however, this has not occurred.

Hospitals often provide ongoing support to breastfeeding mothers, but rarely encourage mothers to seek counselling from more experienced mothers in their own communities. Greater emphasis on developing collaborative, trusting relationships between maternity facilities and community mother-to-mother groups would be valuable from the start of any new initiative.

EXPERIENCES FROM UNFPA-SUPPORTED PROJECTS ON SAFE MOTHERHOOD

A presentation by Lindsay Edouard, United Nations Population Fund (UNFPA)

Introduction

An improvement in maternal mortality necessitates a national strategy addressing three main issues: (a) commitment of society to ensuring safe pregnancy and delivery, (b) access to and quality of health care and (c) special needs of girls and women. Whereas the appropriate approaches and technologies are applicable to all parts of the world, the wide geographical discrepancies in maternal mortality reflect differences in the status of women, their economic opportunities, nutrition and access to social and health services.

Reproductive health includes safe motherhood as part of maternal health. A rights-based approach to reproductive health supports improved access by women to quality services. Having supported projects on safe motherhood for several years, UNFPA conducted a thematic evaluation in Bangladesh, Guatemala, the Philippines, Morocco, Niger, Senegal and the United Republic of Tanzania during 1997 and 1998.

The objective was to assess its contribution at the country level and to propose recommendations for future assistance regarding maternal health in the context of reproductive health. As these projects were started when relevant programming guides were becoming available, this evaluation could examine the value of activities at the stages of design, implementation and evaluation for projects and programmes.

Issues

The evaluation placed special emphasis on four aspects of these projects: (a) relevance by analysing the process undertaken for selection of the strategy, (b) efficiency by examining the implementation of activities through a review of the workplan, monitoring system and coordination as well as flexibility regarding modifications due to either inappropriate components in the strategy or unforeseen circumstances, (c) effectiveness by assessing the extent to which the selected strategy achieved the expected results, and (d) impact by reviewing the contribution of the strategy to the reduction in maternal mortality in the country.

Findings

Maternal health was addressed in national policies partly through advocacy from the interregional and regional levels but there was a lack of technical assistance from those levels. Although the projects targeted selected geographical areas, the specific factors causing maternal deaths were often not identified in the local situation before the selection of appropriate interventions for a strategy. Needs assessment usually benefited from the availability of information from related projects.

The strategies generally responded to nationally perceived needs but were neither comprehensive nor effective for addressing maternal mortality at the local level. Although the importance of

emergency obstetric care was recognised as being most effective in the prevention of maternal mortality, programming for this aspect of the strategy proved to be inadequate.

Central monitoring and supervision were carried out regularly to ensure that interventions were being implemented but there was a lack of systematic mechanisms to measure progress and outcome.

Consultations occurred between organisations for project formulation to avoid duplication of activities. However, the implementation of activities occurred in isolation, as the projects were not part of an overall collaborative effort.

Recommendations

A needs assessment, based on the examination of the causes of maternal deaths at the local level, must be an integral component of project formulation to use available information beyond maternal mortality at the national level. Besides causes, information should be collected on the characteristics of the mothers who died, place of death and on the birth attendants.

Strategies should be based on current technical information and incorporate basic premises: (a) every pregnancy faces risks, (b) a skilled attendant should be present at every delivery, and (c) more emphasis is needed on care right after birth in order to prevent and detect complications early.

Whilst the strategies target particular aspects of maternal care, they should also address other components pertaining to the use of these services and integrate them into other reproductive health efforts.

Indicators that are selected to monitor projects should measure progress on strategy implementation through the regular collection of data in all settings. Process indicators are valuable to identify problems and constraints. Selected indicators should be practical and operationally significant besides being based on available data that are reliable.

UNFPA should collaborate closely with other UN agencies, donors, governments, non-governmental organisations and civil society so as to achieve the goals of maternal health as set out in the Programme of Action of the International Conference on Population and Development.

LESSONS FROM THE WORLD BANK'S REVIEW OF SAFE MOTHERHOOD ASSISTANCE

A presentation by Anne Tinker, The World Bank

“Safe Motherhood is a human right... If the system lets a woman die, then the system has failed. Our task and the task of many like us... is to ensure that in the next decade, safe motherhood is not regarded as a fringe issue, but as a central issue.”

(James D. Wolfensohn, President, The World Bank)

Poverty alleviation and promotion of human development are the principles of the World Bank's strategy for economic development. This goal can only be achieved by meeting the basic health needs of the poor and under-served groups. Women represent a disproportionate percentage of the poor. The World Bank, along with other development players, has been instrumental in effecting smaller families, widespread primary schooling, access to health facilities, declining birth rates and infant mortality rates, and increasing the age of marriage -- all of which have contributed to raising the status of women.

The World Bank has recently been reviewing its experiences in Safe Motherhood over the last decade. The review indicates that, through its lending programme, The World Bank has been a leader in promoting and supporting efforts to improve maternal health. The review examined all of the Bank's health and nutrition projects and identified those with a Safe Motherhood component. In the end, they identified 150 such projects in 80 countries that were financed by The World Bank. An in-depth review of projects in nine countries: Bangladesh, India, Brazil, Chad, Indonesia, the Philippines, Yemen and Romania, was conducted.

The World Bank promotes Safe Motherhood through broad health sector assistance, health sector reform, and multisectoral approaches. In Pakistan, for instance, one project incorporates health education, girls' education, gender equality, and poverty alleviation. Several projects in Chad, the Philippines, and Indonesia focus specifically on Safe Motherhood. Overall, the average lending by The World Bank for reproductive health is about US\$ 450 million per year, making it the largest lending agency in the reproductive health sector.

Lessons Learned from this Review

The World Bank projects employ a variety of strategies, including health sector reform, multisectoral approaches, and partnerships with other international agencies, and NGOs. Most projects include maternal and child health as well as family planning activities. Few projects, however, include initiatives to assure safe delivery, including an adequate referral system. Yet, this is the most important intervention to reduce maternal mortality.⁵ The following key lessons emerged from the evaluation:

⁵ Delivery care should include safe management of routine deliveries, safe-birth kits for birth attendants, communication and transport to ensure timely referral, management of emergency complications and essential obstetric functions at first level.

- It is important to focus more on safe delivery. A lot of projects incorporate prenatal care and mother and child health, but there is a real need to increase the number of deliveries assisted by skilled attendants, improve the referral systems, and infrastructures in hospitals.
- A focus on child health issues tends to dominate. Although there is room for improving child health, maternal care programmes must be emphasised, as a great portion of deaths of infants and children under five deaths are associated with poor maternal health, nutrition, and delivery.
- Government commitment is critical for the success of projects.
- It is necessary to adopt a long-term approach since making in-roads in improving maternal health is a long-term goal and it is difficult to achieve measurable results in short time-periods. Ten-year programmes are more suitable to effect improvements in maternal health.
- Institutional constraints need to be addressed more effectively. It is necessary to emphasise multisectoral linkages and partnerships. For example, one project in Bolivia had to incorporate components of road-building as transportation was a major problem. In Bangladesh, a consortium of donors and NGOs working with the Government has made the planning and implementation of the project, and its maternal health component, much more efficient.
- Use of facilities must be increased. In many countries, utilisation of health services is low not only because of poor quality of care, but also because women are unable to leave home. In Bangladesh, an effort is made to reach women at home. This factor must be part of country analysis, project planning and implementation.
- It is necessary to use good indicators as indicators drive programmes. Many World Bank projects aim at reducing maternal mortality ratios, but this cannot reliably be measured, especially in five-year projects. It is, therefore, necessary to establish indicators that truly reflect progress made, such as increased deliveries assisted by skilled attendant.

The New Thrusts

The World Bank believes that it will be important to link safe motherhood with health sector reform and sector-wide lending over the next decade. With the shift from vertical programmes to horizontal programmes, the Bank's focus is on building overall health systems. The Bank also considers that to be sustainable Safe Motherhood programmes must also be linked with poverty alleviation programmes. Evidence suggests that access to safe delivery represents the widest disparity among basic human development indicators between rich and poor countries, and between rich and poor within countries.

ANNEX 4: LIST OF PARTICIPANTS IN THE MEXICO WORKSHOP

Ali Haque, Yasmin UNICEF Dhaka BLS
Complex, 1 Minto Rd. Dhaka
1000 Bangladesh Tel : 880.2.9336.701.20 Fax :
880.2.933.56.412 E-mail:
yasmin@mail.unicef.bangla.net **Bchir,**
Abdallah Fac. Medecine Mnastir
Tunisia
Tel : 216.346.2200
Fax : 216.3460737

Boker, Bárbara
Jefe de Servicio, Hospital Medica Sur
Asociación Nacional De Instructoras
en Psicoprofilaxis perinatal Puente de Piedra
150, Toriello Guerra,
Mexico DF, Mexico Tel : 52 5 424-72-80
Fax : 52 5 528-43-89
E-mail: info@anipp.org.m

Alnwick, David
Chief, Health Section
Programme Division, TA-24A UNICEF3 UN
Plaza, New York
NY 10017, USA Tel : 1 212.824.6369 Fax :
(212.824.6370
E-mail: dalnwick@unicef.org

Ben Abdallah, Kamel
Health Programme Officer UNICEF Tunisia
58 Ave. Tahar Ben Achour-Mutuelleville,
Tunis
Tunisia
E-mail: kbenabdallah@unicef.org

Bongiovanni, Annete Senior Technical
Advisor
USAID/LAC-RSD Room 5.09-120
Washington, D. C. 20523-5900 USA Tel : 1
202-712-0537
Fax : 1 202-216-3262
E-mail: abongiovanni@usaid.gov

Amado y Luarca Fernando
Reproductive Health Consultant, PAHO
525 23rd St, North West
Washington, D.C. 20037, USA Tel: 1 202
974.3727 Fax: 1 202.974.3694 E-mail:
amadofer@paho.org

Berggrav, Marit
NORAD
P.O.Box 8034
Oslo, Norway
Tel: 47 22.314400 Fax: 47 22.3144.02
Butu, Cassandra Public Health Specialist
Institute of Health Mgmt31
Vaselor Romania Tel : 40 1-252.7834 Fax : 40
1-252.3014 E-mail: cassb@hotmail.com

Amstrong, Helen Consultant Breastfeeding
and Care Nutrition Section, Programme
Division
UNICEF3 UN Plaza, New York
NY 10017, USA Tel : 1 212-824-6364 Fax : 1
212-824-6465 E-mail: harmstrong@unicef.org

Bezold, Willy Program Coordinator UNICEF
Mexico

Reforma 645, Lomas de Chapultepec
Mexico D.F., Mexico Tel : 52 5 202 32 33 Fax
: 52 5 202 32 33 E-mail:

wbezold@unicef.org **Cao Romero**

Laura Coordinadora General Grupo de
Partería Ticime Congreso 113 E-403
Tlalpan 14090

Mexico, D.F. Mexico Tel : 52 5 573-76-26

Fax : 52 5 513-17-52

E-mail: ticime@laneta.apc.org

Arreola Ramírez Antonio

Jefe de Area

IMSS Pesado 120, Col. Del Valle

México DF, Mexico Tel : 52 5 536-88-81

Blanco E., Paloma Asesor de la
Coordinación de Atención Médica

IMSS - Solidaridad

Toledo 39, 2o. piso

Mexico DF, Mexico Tel: 52 5 211-00-18 ext

14354 Fax: 52 5 211-28-81

Catalán, Angel

SSA Mexico Dir. De Normatividad **Cauich**

Alarcón, Luz Elena Supervisor Médico,

SSA Insurgentes Sur 1397-7o piso

Insurgentes-Mixcoac, Mexico DF

Mexico

Tel : 52 5 598-98-73

Fax : 52 5 598-63-20

De Bernis, Luc Cooperation Francaise

Senegal, Dakar BP 16.134 Dakar

Fann Senegal Tel : 221-825-6844 Fax : 221-

825-7287 E-mail: debernis@telecomplus.sn

Escandón R. Celia

Coordinadora de Atención Médica

IMSS Solidaridad

Toledo 39, Mexico DF

Mexico

Fax : 52 5 727-28-04

Cervantes Salgado Asunción Eugenia

Sub-Dir de Control de Hospitales Foráneos

Sría. De Marina, Sanidad Naval

Eje 2, Ote 861 Col. Cipreses, Coyoacan,
Mexico DF, Mexico

Tel : 52 5 684-81-88 & 1502

Fax : 52 5 684-81-88 & 6222

De la Peza, Lourdes Asesora en Desarrollo
Organizacional Mgmt. Sciences for

Health Alvaro Obregón Esq. Salinas Casa 19,

Centro Cuernavaca Mexico Tel : 52 73

14.46.73

Fax : 52 73 14.46.73

E-mail: ldelaPeza@compuserve.com

Ferraz, Elenice Consultora OPS/OMS Ave.

Paseo Las Palmas 530, Lomas de

Chapultepec, México MEXICO Tel : 52 5 202-

82-00 Fax : 52 5 520-88-68 E-mail:

eferraz@infoabc.com

Cocora, Liviu

Vice President
College of Physicians, Romania
2400 Sibiu Al Calarasilor No. 1/15
Romania
Tel : 40.69.42.69.06
Fax : 901-210-6725

De Silva, Hiranthi Acting Director- Maternal
& Child Health Department of Health Family
Health Bureau, 231 de Saram Place, Colombo
10

Sri Lanka
Tel : 94 1 696.508
Fax : 94 1 696.508

Fisancho Gil, Olga Elisa Médico
Ginecobstetra Ministerio de Salud Los Cisnes
271, S. Isidro PERU Tel : 51 441-4270 Fax : 51
422-48-89

Collado, Carol Coordinator, Family Health
PAHO
525 23rd St. NW,
Washington, DC 20037 USA
Tel : 1 202.974.3504
Fax : 1 202.974.3496
E-mail: ccollado@paho.org

DiGiacomo do Lago, Tania Special
Counsellor to the Women's Health Minister
Ministerio de la Salud Esplanada dos
Ministerios, bloco G, sala 642, Brasilia,
BRAZIL

Tel : 55 61 315.2515
E-mail: tania.lago@saude.Gov.br

Flores Huerta, Samuel Jefe de la División
en Salud Infantil IMSS Mier y Pesado 120, Col.
Del Valle,
México DF, Mexico Tel : 52 5 536-06-
82 Floresan@netservice.com.mx

Corciova, Mihail Florin

Health Consultant
UNICEF Romania
St. OLARI 23, Bucharest ROMANIA
Tel : 40 1.252.1751
Fax : 40 1-2525.750
Tschaffter@unicef.org

Donnay, France UNFPA 220 East, 42nd Street
New York, NY 10017
Tel : 1 212 297 5332 Fax : 1 212 297 4915
E-mail: donnay@unfpa.org

Galwaduge, Chandani Medical Officer
(Maternal & Child Health) Department of
Health Office of DPDHS, P.O.Box 56,
Jabdtm,
Sri Lanka Tel : 94 08-234-238 Fax : 94 08-224-
336

Cruz Olave, Miryan Consultora Promoción
de la Salud
OPS/OMS
Los Cedros 269, S.I. Lima
Peru
Tel : 511-421-3030
Fax : 511-442-4630
E-mail: mcruz@per.opsoms.org

Edouard, Lindsay Senior Reproductive Health Officer
Technical and Policy Division
United Nations Population Fund (UNFPA)
220 East 42nd Street NY 10017, USA
Tel : 1 212.297.5241 Fax : 1 212.297.5145
E-mail: edouard@unfpa.org

Garbouj, Mounira
Ministry of Health / UNICEF
31, Rue ElKharboum, Tunis, TUNISIA
Tel : 216 1 798.657

Garcés, Ma. de los Angeles
Gineco obstetra - Materno Infantil
Ministerio de Salud
Calle 23 esq. N. Vedado, C. de la Habana,
CUBA
Tel : 537-66-23-36
Fax : 537-55-33-53

Herrera Moro, Alberto
Jefe de Servicio Médico Preventivo
ISSSTE
Av. San Fernando 547, Tlalpan, Mexico DF,
MEXICO
Tel : 52 5 604-14-64
Fax : 52 5 606-66-05

Jolibois Maurice Coordinador de atención preventiva INI
Periferico Sur 101, Mexico DF
MEXICO
Tel : 59 5-56-98 ext.2415

García Pérez Luz María Jefa del Depto de Acciones Sociales
Comisión Nacional de la Mujer
Ixcateopan 337, Col. Sta. Cruz Atoyac,
Mexico DF
MEXICO
Tel : 52 5 605 69-21 ext 124 & 135
Fax : 52 5 605 47 14

E-mail: pronam@iwm.com.mx

Hinojosa Sandoval, Miguel Medico de la Direc. de Promoción Atn. Integral de Salud
Ministerio de Salud, Isla Isabela N42-57
Quito, Ecuador
Tel : 593 2 226 234 Fax : 593 2 522 774
E-mail: hinojosa@uio.satnet.net

Kafuko, Jessica Project Officer
UNICEF P.O.Box 7047
Kampala, Uganda
Tel : 256 41 234 591/2
E-mail: jessica.kafuko@unicef.unan.org

González Ramos Rogelio Coordinador Paramédico SSA
Lazaro Cardenas 16-D,
Naucalpan, Edo.
DF Mexico, Mexico
Tel : 52 5 363 38 82

Hussein, Julia DFID P. O. Box 3 Blanhyre
Malawi
Tel : 265 630019
E-mail: safemotherhood@malawi.net

Kaijuka, Emmanuel Ministry of Health P.O.

Box 8 Entebbe Uganda Tel : 256 41
320537 Fax : 256 41 344059

Gotsadze, Tamar

Project Officer, Health

UNICEF Tbilisi

9 Eristani St, Tbilisi

Georgia

Tel : 995 32 232 388

Fax : 995 3225 1236

E-mail: tgotsadze@unicef.org

Jahangir, S.M. Programme Manager, Support
Services and Coordination - ESP Government
of Bangladesh

Directorate of Family Planning

Azimpur, Dhaka, 1215

Bangladesh

Tel : 880 2 912 5240

Fax : 880 2 911 7115

Kerstiens, Barbara Research Associate

Quality Assurance Project 7200 Wisconsin

Ave. Suite 602

Bethesda, Maryland, USA

Tel : 301 941 8527 Fax : 301 941 8427 E-mail:

bkerstiens@urc-chs.com

Harris, Michelle Ministry of Health, Jamaica 2

Worthington Terrace, Kingston 5, Jamaica Tel

: 876 927 6419

Jara Valencia, Jorge Representante

UNICEF Calle 20 esq. Fuerza Naval, La

Paz Bolivia Tel : 5912 77 0222 E-mail:

jjara@unicef.org

Kigadye, Rosemary UNICEF Unicef Box
4076

Dar es Salaam, Tanzania Tel : 051

150811/5 Fax : 051 151603 E-mail:

rkigadye@unicef.org

Hekker, Margo Programme Officer

UNFPA Hanoi, Vietnam, P.O. Box 618,

Bangkok Thailand Tel : 84 4 8236632

Fax : 84 4 823 2822

E-mail: hekker@unfpa.org.vn

John, Theopista

Programme Officer Rep. & Child Health

Ministry of Health

Unicef Box 9083

Dar-es-Salaam, Tanzania Tel : 051 2976 Fax :

051 152977 **Koblinsky, Marjorie** Director

MotherCare/JSI

1616 N Ft Myer Drive

Arlington, VA 22209 USA Tel : 1 703 528

7474 Fax : 1 703 528 7480 E-mail: marge

koblinsky@jsi.com **Kumar, Satish** UNICEF

Calcutta 3 Sunny Park Calcutta 78 India Tel :

91 33 47523 25 Fax : 91 33 475 03 04

Martínez González Aurora Coordinadora del Programa Hospital Amigo
DGSRI Insurgentes Sur 1397, 7o. piso, Mexico
DFMEXICO Tel : 52 5 680 64 95 52 5
277 04 53

Mugisa Olive, Sentumbwe FHP/WHO
National Coord. Safe Motherhood WHO Box
24578,
UGANDA
Tel : 256 41 344 038/58
Fax : 256 41 344 059
E-mail: olive@who.jmul.com

Ley, Angélica Conmujer Jefatura de
Seguimiento y evaluación Ixcateopan 337,
Mexico Tel : 52 643 80-52 Fax : 52 604 71
49 E-mail: pronam@iwm.com.mx

McCaw-Binns, Affette
Epidemiologist
Univ. of the West Indies
Dept. of Community Health, Mona
Kingston 7, Jamaica Tel : 876 977 6346 Fax :
876 927 2893 E-mail: abinns@cwjamaica.com
Muriedas, Pilar Directora SIPAM-
CPMSR Vista hermosa 95 Bis, Col. Portales
Mexico 03300 Tel : 52 5 639 96 74 E-mail:
sipam@laneta.apc.org

López, Johnny Consultor UNICEF
Bolivia Calle Rosendo Villa
202/Sucre BOLIVIA Tel : 591 5 4891
512.54 Fax : 591 0592/064/54093

Mones, Belkys Asesora en Género,
Población y Desarrollo UNFPA
Presidente Masaryk 62
Polanco, Mexico Tel : 52 5 250 40 41 E-mail:
unfpac5t@mexico.com

Navarro Paredes José Luis Sub-Dir. De
Programa de Atención al menor y adolescente
DIF Congreso 20, Tlalpan, Mexico Mexico
Tel : 52 5 573 13 55 ext. 313

Madero Villegas Jorge Arturo

Jefe de Sección de Ginecobstetricia
Hospital Central Militar SDN
Ejercito Nacional y Periferico, Mexico DF,
Mexico
Tel : 52 5 55713 00
Fax : 52 5 557 36 80

Moreno, Manuel Oficial Salud y Nutrición
UNICEF Paseo de la Reforma 645,
Mexico D.F. 11000, Mexico Tel : 52 5 202 32
33 Fax : 52 5 520-05-27 E-mail:
mmoreno@unicef.org

Navas, Guillermo Consultant Health &
Nutrition UNICEF/TACRO Tr. 38/100-25
(P.3) Bogota, D. C. Colombia Tel : 57 1-635-
7255 E-mail: gnavas@unicef.org

Mariscal, Jorge
UNICEF Bolivia
Inofuentes 716
La Paz, Bolivia Tel : 591 2 77.0222 Fax : 591 2
77.2101 E-mail: marisa@unicef.bo

Morteo García Norma Alicia Jefa del Depto.
Atn. Médico Preventiva Secretaría de
Marina Eje 2 Ote. 861, Col. Cipreses,
Del. Coyoacan, Mexico Tel : 52 5 684 81 88
ext 1502 Fax : 684 81 88 ext. 6222

Nemsadze, Ket P.H. pediatrician State
Medical University Georgia Tel : 995 3294
0009

Olaya Vargas, Marco Antonio Jefe de
Depto ISSSTE
Av. San Fernando 547, Mexico
Mexico
Tel : 52 5 606 62 84

Pollack, Amy
President AVSC International
79 Madison Avenue, New York
NY 10016 USA
Tel : 1 212 5618001
Fax : 1 212 779 9489
E-mail: apollack@avsc.org

Saagi, Neera
Govt. of W. Bengal
E3, 44 Ironside Road, Calcutta, INDIA
Tel : 91 33 221.56.25

Fax : 91 33 221.56.25
E-mail: neera-saggi@hotmail.com

Tel : 1 617 524 7766
E-mail: msanchez@sh.org

Olmos Hernández Angel

Coordinador Médico DIF Nacional
Insurgentes sur 3700-73, Mexico
Mexico
Tel : 52 5 601 22 22 ext 4231
& 4232
Fax : 52 5 601-22 22 ext 4230

Pownall, Catharine

Technical Training Adviser Options - Nepal
Safe Motherhood Project
P.O. Box 106, British Embassy
Kathmandu, Nepal Tel : 977 1 262 110 Fax :
977 1 248989 E-mail:
catharine@smp.wlink.com.np

Salas C. Claudia

Asesor de la Coord. De Atención Médica
IMSS - Solidaridad
Toledo 39-1er Piso, Mexico
Mexico
Tel : 52 5 211 00 18 ext 14306
Fax : 52 5 211 28-81

Ortega Medina Gloria Responsable programa

salud DIF Congreso No. 20, Mexico
Mexico
Tel : 52 5 573 15 40 ext 328
Fax : 52 5 655 50 03

Recio Ortiz Adriana

Coordinador Técnico
SRE
Reforma 145, piso 4, Mexico
Mexico

Sanchez, Maria-Pia

Sr. Programme Officer
MSH
891 Centre St, Boston, Ma., USA
Fax : 1 617 524 1363

Ortiz Mariscal José David

Director Médico para AL y el Caribe IPAS
Nebraska 138-2,
Col. Napoles, Mexico
Tel : 52 346 92 99
Fax : 52 346 92 99
E-mail: ortiz@intercable.net

Riutort, Monica

Director of Partnership
Centre for Research in Women's Health
790 Bay St., 7th Floor, Toronto, Ontario
CANADA
Fax : 1 416 323 0311
Tel : 1 416 323 0085
E-mail: monicari@web.net

Stanton, Cindy

Macro International Measure/Evaluation
Project
11785 Bettsville Drive, Calverton
Maryland 20705 USA
Tel : 1 301 572 0845
Fax : 1 301 572 0999
E-mail: stanton@macroint.com

Peters, Margaret International Confederation of Midwives

The Barley Mow Centre, 10 Barley Mow,
Chiswick, London, W4 4 Ph, UK
Tel : 44 0 181 995 1332
Fax : 44 0 181-995 1332

Rizzo, Romolo Nutrition Consultant

UNICEF Reforma 645, Lomas de
Chapultepec
Mexico City, Mexico
Tel : 52 5 202 32 33
Fax : 52 5 202 32 33
E-mail: rizzo@unicef.org

Santos, Elsa CPMSRC

Cauhtémoc 176,
Tepepan México 16020
Mexico
Tel : 52 5 676 48 52
Fax : 52 5 676 44 39
E-mail: imesmsr@infosel.net.mx

Pick, Susan Directora IMIFAP
Malaaga Nte.
25, México
Tel : 52 5 611 58 76
Fax : 52 5 563 62 39
E-mail: pick@imifap.org.mx

Robles B. Francisco Dir. De promoción y desarrollo social

DIF
Congreso No. 20, Mexico
Mexico
Tel : 52 5 573 15 40

Sibanda Mulder Flora Regional Advisor

Women's Health UNICEF
Abidjan B.P. 443,
Abidjan 04 Ivory Coast
Fax : 225 22 76 05
Tel : 225 20 81 60
E-mail: fsmulder@unicef.org

Sidhom Moncef

Ministere de la Sante
31 Rue Khartoum Tunis, Tunisie
PHC Director Department
Tel: 2161.789.679
Fax: 2121.789.148

Stephenson,

Patricia USAIDG/PHN/NN/NMN
1300 Pennsylvania Ave. NW
Washington, D. C. USA
Tel: 202-712-0989
E-mail: pstephenson@usaid.gov

Tinker, Anne The World Bank
1818 H St NW, Washington, D. C. 20433, USA
Tel: 202-473-3683
E-mail: atinker@worldbank.org

Simpson, Hazel DFID
P.O. Box 3 Blantyre
Malawi Associate Professional Officer
265-673571265-630019
E-mail: safemotherhood@alawi.net

Strachan, Deidere Management Sciences for Health

165 Allandale Rd, Boston, Ma.
USA
Tel: 617-524-7799
E-mail: dstrachan@msh.org

Tolstopiatov, Boris UNICEF

UN House Representative
Tel: 99-532-251-236
Fax: 99-532-232-388
E-mail: btolstopiatov@unicef.org

Siu, Carolina UNICEF

SEN 510 Norte
Blvd. A. 1. Andai,

Brasilia, D. F. Brazil Tel: 061-348-1933 Fax:
061-349-0606 E-mail: csiu@unicef.org.br
Sungkhobol, Duangvadee WHO Reg.
Office New Delhi 1.10.002 India Tel:
91.11.331.8607
Fax: 91.11.331.7804
E-mail: sung@who.ernet.in Sungkhobol@whosea.org

Tuiran Rodolfo CONAPO Angel Urraza
1137, Mexico Secretario General Tel: 559-74-
62

Solis Cervantes Gonzalo INI Sub director de
Salud y BS Blvd. Adolfo Lopez Mateos 151
Mexico, D.F. Tel: 595-56-98

Tavera Salazar, Mario UNICEF Peru Flora
Tristan 458, Lima Oficial de Salud 261.3436 E-
mail: mario@unicef.org.pe

Uhaa, Iyorlumun J. Chief, Health
Programme UNICEF Box 7047, Kampala,
Uganda 256-41-2591146
256-41-234-591
Iuhaa@unicef.org

Starrs, Ann

Vice President
Family Care International 588 Broadway
New York, NY 10012, USA Tel: 212-941-
5300 Fax: 212-941-5563 E-mail:
astarrs@familycareintl.org

Tellería, Jaime Ministerio de Salud Capitán
Ravelo 3er piso, La Paz, Bolivia
Director Nacional de Atención a la Mujer y el
Niño
39.2032
31.4103

V.B. Gupta Ministry of Health & Family
Welfare Deputy Commissioner, Ministry of
Health
New Delhi, India 011.301.97.91011.301.9791

Steele, Cynthia

AVSC
79 Madison Ave. N. Y. 10016
VP Resources

212-56-18052
E-mail: csteele@avsc.org

Tinajero Hernández Joel Petroleos
Mexicanos Marina Nacional 350, Mexico Jefe
de Medicina Preventiva Tel: 254-17-19
E-mail: jtinajer@gsm.pemex.com

Valceanu, Daniela

Inst. Of Health Services Mgmt.
Str. Vaselor 31, Bucharest, Romania
40-1-252-3014
40-1-252-7834
E-mail: danavalceanu@hotmail.com

Vanormelingen, Koen

Senior Adviser Health QA
UNICEF
3 UN Plaza, NY 10017
New York, USA
Tel: 1-212-824-6340
Fax: 1-212-824-6465
E-mail: kvanormelingen@unicef.org

Venu, Rema Program Assistant, Women's
Health UNICEF 3 UN Plaza, NY
10017 USA Tel: 212.824.6311 Fax:
212.824.6465
E-mail: rvenu@unicef.org

Von Schmeling Gan, Gustavo
SSA/DGSR Insurgentes Sur 1397-7o piso,
Mexico
Sub-Dir de Atención al recién nacido
Tel: 598-60-68
Fax: 598-98-73

Yerovi Herbozo, Ivan Oficial Asistente de
Salud y Nutrición UNICEF Av. Republica E7-
142 y Almagro
Entebbe, Uganda
Tel: 593.2.503.370
Fax: 593.2.503.373
E-mail: iyerovi@unicef.telconet.net

Zubieta Beatriz CONAPO Angel Urraza
1137, Mexico (Vino con el Srío. General) Tel:
559-74-62

Zupan, Jelka
Medical Officer
WHO
Geneva, Switzerland
Tel: 41.22.791.4221
Fax: 41.22.791.4189
E-mail: zupanj@who.ch

Villafuerte Santiago
ISSSTE
Av. San Fernando 547, Mexico
Jefe de Departamento
60628-55

Zaramba, Sam Ministry of Health P.O.Box 8,
Entebbe
Uganda
Tel: 256-41-320998
Fax: 256-41-320418