With three quarters of all maternal deaths occurring during childbirth or the immediate post-partum period, having skilled health personnel attend deliveries is pivotal to reducing maternal mortality.

together account for two thirds of births not attended by skilled health workers. India is currently seeking to address the problem by encouraging facility-based care with financial incentives\(^\text{13}\) (see Panel on Integrating maternal and newborn health care in India, page 84).

Worldwide, births in urban areas are twice as likely to be attended by skilled health personnel as those in rural areas. In West and Central Africa, where the disparity is greatest, they are two and a half times as likely. Disparities along economic lines are also notable; for the developing world as a whole, deliveries of women from the poorest households are around half as likely to be attended by skilled health workers as those from the richest households.\(^\text{14}\) (For a fuller discussion of disparities in access to maternity services, see Panel on page 38, Towards greater equity in health for mothers and newborns.)

WHO has made several recommendations for reducing post-partum bleeding or haemorrhage, a leading cause of maternal death. The most common causes of post-partum bleeding are failure of the uterus to contract sufficiently, tears of the genital tract and retention of the placental tissue. The most widely accepted method of intervention is active management of the third stage of labour, which follows the completed delivery of the newborn child and lasts until the completed delivery of the placenta. Active management involves administering a uterotonic to facilitate contractions for delivery of the placenta and delayed clamping, cutting and traction of the umbilical cord.

WHO recommends active management by skilled attendants for all mothers but does not recommend the package for unskilled attendants. The agency has called for further research on optimal times for cord clamping and what drugs, if any, non-skilled attendants should administer.

**Figure 3.4**

**Delivery care coverage**

![Graph showing delivery care coverage by region and type of care](image)

- **West/Central Africa**
  - Institutional deliveries: 46%
  - Skilled attendant at birth: 49%
- **Eastern/Southern Africa**
  - Institutional deliveries: 33%
  - Skilled attendant at birth: 40%
- **South Asia**
  - Institutional deliveries: 35%
  - Skilled attendant at birth: 41%
- **Middle East/North Africa**
  - Institutional deliveries: 71%
  - Skilled attendant at birth: 81%
- **East Asia/Pacific**
  - Institutional deliveries: 73%
  - Skilled attendant at birth: 87%
- **Latin America/Caribbean**
  - Institutional deliveries: 86%
  - Skilled attendant at birth: 85%
- **CEE/CIS**
  - Institutional deliveries: 89%
  - Skilled attendant at birth: 94%
- **World**
  - Institutional deliveries: 54%
  - Skilled attendant at birth: 62%
- **Sub-Saharan Africa**
  - Institutional deliveries: 40%
  - Skilled attendant at birth: 45%
- **Developing countries**
  - Institutional deliveries: 54%
  - Skilled attendant at birth: 61%
- **Least developed countries**
  - Institutional deliveries: 32%
  - Skilled attendant at birth: 39%

* Sub-Saharan Africa comprises the regions of Eastern/Southern Africa and West/Central Africa.

** Institutional deliveries refers to the proportion of women aged 15–49 years who gave birth in the two years preceding the survey and delivered in a health facility.

*** Skilled attendant at birth refers to the percentage of births attended by skilled health personnel (doctors, nurses and midwives).

Source: Demographic and Health Surveys, Multiple Indicator Cluster Surveys, World Health Organization and UNICEF.