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Insights on skilled attendance at birth in Malawi- The findings of a structured document and literature review

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ABSTRACT

Increasing the number of women who access skilled attendance at birth is the goal of many developing countries including Malawi. The Skilled Attendance for Everyone (SAFE) international research programme coordinated by the Dugald Baird Centre for research on Women's Health at the University of Aberdeen, developed a Strategy Development Tool (SDT).
The tool comprised five modules: Problem identification, Situation analysis (Document and Literature review and Interpretive guidelines), Needs assessment, Monitoring system and Synthesis. The Document and Literature review component of the tool was piloted in Malawi in collaboration with the Ministry of Health & Population. The findings revealed that Malawi has a critical shortage of Skilled Attendance which encompasses both the Skilled Attendant and an enabling environment. While health sector educational programmes appear to be strong, the country has lost significant numbers of health personnel, especially Midwives through resignation, death and retirement. Only 55% of women access health facilities and of these, 56% are assisted by Skilled Attendants at birth. Cultural factors, staff negative attitudes and long distances among other factors, hinder access and utilization of the available Skilled Attendance at birth.

INTRODUCTION

Countries with high levels of maternal mortality are aiming to meet an international development target of at least 60% of all births assisted by a skilled attendant by 2015. This is considered'to be an important indicator of progress towards international goals for maternal mortality reduction (United Nations, 1999). Currently, only 56% of Malawian women access skilled attendants. This is according to the Malawi Demographic and Health Survey (MDHS) 2000.

SAFE (Skilled Attendance for Everyone) is an international research programme co-ordinated by the Dugald Baird Centre for research on Women's Health at the University of Aberdeen. SAFE is in the process of developing a Strategy Development Tool (SDT) which will facilitate the collection of information for the purpose of developing effective, affordable and equitable strategies to increase skilled attendance at delivery. The rationale for developing this tool is that while health policy should be based on evidence, it is often difficult for policy makers to amass the information they require. The SAFE SDT has therefore been designed to make it possible for a team of researchers to uncover sufficient relevant information on skilled attendance for this purpose within a matter of four months. The SDT consists ofthe following modules:

Problem identification
Situation analysis
- Document and literature review
- Interpretive guidelines
Needs assessment
Monitoring system
Synthesis

A summary of preliminary findings related to this process of developing the SDT has been described elsewhere (Int. J O & G... .submitted) .

In the year 2001, in collaboration with the Dugald Baird Centre, the Ministry of Health and Population (MOHP), Malawi, carried out a pilot study of the "Document and literature review" component of the situation analysis module. We now report the findings of this study.

METHODOLOGY

It has to be noted that two similar terms have been used in the introduction - skilled attendant and skilled attendance. The World Health Organization has defined a skilled attendant as a doctor or person with midwifery skills who can diagnose and manage obstetric complications as well as normal deliveries (WHO 1993). SAFE however, recognised that unless a skilled attendant is supported by a minimum level of suppliesand equipment, the care provided might be little better than could be provided by an unskilled attendant. A wider definition of skilled attendance (Graham, Bell and Bullough 2001) was therefore developed and adopted. This encompasses all the following:

Health professionals
with midwifery skills to promote utilization,
conduct normal deliveries and provide first aid
with skills to provide Comprehensive Obstetric Care
the enabling environment of health policy and systems, drugs, equipment, supplies and transportation
knowledge and skills related to referral from one level of skilled attendance to another
the demand for skilled care by the community as evidenced by utilization

This is the definition that was utilized in the present study.

Document and literature review

This module of the SDT provides a structured approa~h to the identification, collection, analysis and interpretation of available information. This involved the researcher in brief consultation period with local safe motherhood experts and other stakeholders to obtain guidance on the historical context and on possible sources of existing data. The literature search was then guided by a comprehensive list of indicators and sub-indicators of

skilled attendance. With a few exceptions, the data search was restricted to the last five years.

A set of guidelines then provided help in assessing the relevance and applicability of the information collected, and the rural-urban distribution of skilled attendance. The analysis ended by drawing conclusions on the need for primary data collection.

FINDINGS

At the time that this study was being conducted, records from health regulatory bodies indicated that there were 3,387 Nurse Midwives and 190 Doctors licensed to practice in the country. There are also a sizable number of Clinical Officers and Medical Assistants with variuos levels of midwifery skills. Problems of retention of staff has seriously undermined the availability of skilled attendants. By 1999, the health sector had lost more than 30 percent of its employees mainly due to resignations, deaths and retirement. The majority of resignations were those of Midwives who opted to go overseas in search of better pay and working conditions (World Bank/MOHP 2000).

There are plans to increase staffing levels as shown in Table 1.

Table 1: Current Vs Prposed number of health for health centres and district/rural hospitals

PERSONNEL TYPE	HEALTH CENTRES		DISTRICT/RURAL HOSPITALS	
	Current Number	Needed Number	Current Number	Needed Number
Doctors	0	0	158	200
Nurses	574	3,000	719	2,333
Medical Assistants	236	-----	159	------
Other Staff	175	1,000	227	1,467

Source: WB/MOHP Public Expenditure Review (2000)

Midwifery and Medical students' curricula are designed to equip them with adequate skills to provide Essential and Comprehensive Obstetric Care respectively. Additionally, inser-vice education in Life Saving Skills (LSS) is an ongoing activity. Evaluation of the effectiveness of LSS training has shown an increase in knowledge levels but not skills and attitudes (Maclean 2000).

Accessibility and Utilization

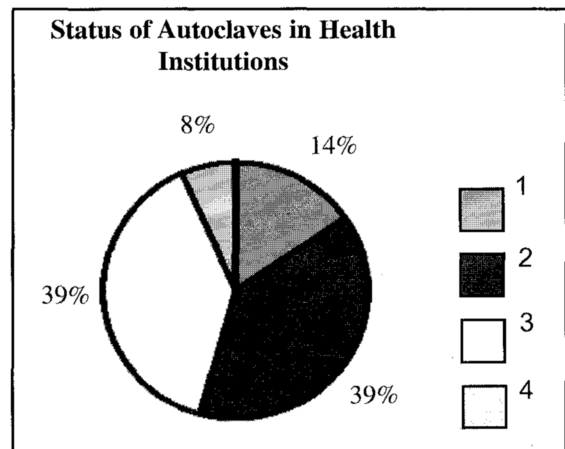
There are a number of health facilities in the country managed by MOHP, Christian Health Association of Malawi, District Assemblies and private practitioners. These facilities are available in both urban and rural areas. However, access is not always easy more especially in rural settings. Women have been known to walk 10-15 kilometres to a health facility (UNICEF 2001). Some women have waited up to 12 hours for transportation such as ambulances during referral. Rampant poverty and deterrent cultural beliefs and practices have also affected access to health facilities. An example of these practices is the requirement for primigravid women to deliver at home.

The Ministry of Health through the Central Medical Stores and the Reproductive Health Unit, supplies equipment and other material resources (Rashidi 2001). The Safe Motherhood Project also supplements government efforts by supplying ambulances, drugs and equipment to all project districts in the South of Malawi. The Johns Hopkins Program for International Education in Gynaecology and Obstetrics has also supplied equipment for infection prevention in many health faCilities. Many facilities have some form of communication system to enable referral. But radio-communication systems do not always work.

However, there is evidence that there is misuse of ambulances by drivers who use them for personal errands. Pilferage of drugs and equipment has also been reported (W orld Bank/MOHP 2000).

Kawonga & Kamwendo (2000) report that available equipment is not always in good working condition. For example, they found that only 39% of autoclaves were in working order in more that seven health institutions studied (see Fig. 1)

Fig. 1



1. Autoclaves in working order
2. Condition of Autoclaves unknown
3. Autoclaves not working
4. Autoclaves not available

Information Gaps

Secondary data analysis revealed information gaps in relation to skilled attendantss' own views on bad attitudes; the proportion of women who experience self-delivery even within health institutions; how many of the installed radio communication systems are within working and availability and status of equipment such as vacuum extractors.

The extent to which running water and electricity are available, especially in rural health facilities and the reasons why in-service education programs are dysfunctional, are also not known.

DISCUSSION

The available data suggest that skilled attendance is largely unavailable to 45% of childbearing women in Malawi. The proportion of women who have access to skilled attendance is therefore less than desired. Some ofthe reasons for the discrepancy between the number of women attending antenatal care and those delivering at health facilities are known and need to be addressed. Mechanisms for retention of staff and development of a professional culture of self-discipline are crucial to the provision of quality care.

Because of problematic control of resources, which make up an enabling environment, the majority of those women who access skilled attendants receive sub-standard care. Supportive supervision and consistent implementation of in-service education programs would ensure maintenance of resources and skills in prac-

titioners whose pre-service training appears to be fairly strong. Long distances to health facilities, cultural beliefs and practices hinder utilization of skilled attendance. These need to be addressed through community mobilization, so
that women are deterred from seeking unacceptable alternative services during labour and delivery.
Investigations into staff attitudes would be helpful, especially as regards the perceptions of Midwives and Doctors. Deliberate self evaluation could result into more meaningful reformation and better attitudes.

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