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Editorial: **Skilled attendance at childbirth: let us go beyond the rhetorics**

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Almost two decades into the Safe Motherhood Initiative, maternal mortality ratios of 500+ per 100 000 live births still being the rule rather than the exception in sub-Saharan Africa are no reason to celebrate (AbouZahr & Wardlaw 2003). Lukewarm political commitment, inadequate resource prioritization, competition between international agencies, major technical difficulties to accurately measure maternal mortality and a focus on interventions with doubtful effectiveness, such as antenatal screening and training of traditional birth attendants, contributed to this sad state of affairs (AbouZahr 2001).

The Safe Motherhood Technical Consultation in 1997 in Colombo stated that 'having a health worker with midwifery skills present at childbirth, backed up by transport in case of emergency referral, is perhaps the most critical intervention for making motherhood safe' (Starrs 1998). Skilled attendance at childbirth is now the ruling paradigm, and its adoption as a Millennium Development (MDG) subtarget is a clear demonstration of the trust it inspires at the level of international policy-making.

The rationale for promoting the presence of a skilled attendant at every delivery is rooted in three observations. First, the early identification and timely and appropriate management of obstetric complications is crucial to save women's lives. Given that an estimated two-thirds of maternal deaths occur around the time of delivery and that antenatal screening has a very low predictive value for the identification of obstetric complications (Hall *et al.* 1980; Rooney 1992; De Brouwere *et al.* 1998), it seems likely that the presence of a skilled attendant at every delivery could keep mothers alive. Secondly, historical evidence shows that wherever maternal mortality was significantly reduced, both in developed and developing countries, the majority of deliveries are attended by skilled personnel (Högberg *et al.* 1986; Loudon 1992; Van Lerberghe & De Brouwere 2001; Pathmanathan *et al.* 2003). Finally, the obvious ineffectiveness of training traditional birth attendants (TBAs) has shifted attention to training professional providers (Bergström & Goodburn 2001). Although TBAs are accessible and culturally well accepted, they do not have life-saving skills even after training.

Although hard evidence of the skilled attendance strategy's effectiveness and cost-effectiveness is lacking, it looks conceptually sound. Its building blocks, i.e. the skilled attendant and the enabling environment, are explicitly recognized. This is an important step forward, underscoring the complexity of the strategies required and the need to look beyond single magic bullets. However, field realities and studies point to two issues, so far largely overlooked, which need to be tackled.

The first concerns skills. The minimum and additional skills as defined by the Safe Motherhood Inter-Agency Group, emphasize almost exclusively technical skills. Of course these are as essential as drugs, supplies and equipment. However, an increasing number of socio-anthropological and operational studies show that the interpersonal skills and attitude of these professionals are equally important (Jewkes *et al.* 1998; Andaleeb 2001; d'Oliveira *et al.* 2002; Jaffré & Olivier de Sardan 2003).

The second issue is how to make this strategy work in low-resource settings. The MDG subtarget of 90% skilled attendance worldwide by 2015 is unlikely to be achieved in the short term. AbouZahr and Wardlaw's (2001) analysis shows levels of around 37% for sub-Saharan Africa with no overall increase during the period 1989–1999. Even if the skilled workforce did function better, were more evenly distributed and working to full potential, their number would be insufficient to meet the needs of all pregnant women, urban and rural.

In Mali in 2002 for example, 265 midwives were posted in Bamako or in regional hospitals, while only 164 were working at peripheral level. Unsurprisingly, only 24% of births were attended by a skilled professional. To meet the MDG subtarget, more than 5000 midwives would need to be trained. The capacity of midwifery schools in Mali being around 70 graduates per year, this would take several decades. Increasing capacity is not easy in such a poor country: building and staffing of midwifery schools demands long-term investment, and, as in Mali the salaries

of the health workers at peripheral level are covered by the population, posting midwives to communities incurs considerable cost to the women and their families.

We urgently need to find intermediate solutions to these problems. One option is to invest in upgrading and certifying the skills of auxiliary staff. Auxiliary health workers and nurses represent an important proportion of the health workforce at peripheral level. They could play a considerable role in the reduction of maternal and perinatal mortality and morbidity provided their competencies are upgraded to appropriately manage major obstetric complications. Unless the two major challenges of health staff attitude and of availability of adequately skilled providers are addressed, skilled attendance will not move beyond rhetorics.

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