

## Review of Literature

### **Traditional birth attendant training for improving health behaviours and pregnancy outcomes**

*Sibley LM, Sipe TA, Brown CM, Diallo MM, McNatt K, Habarta N.*

*Cochrane Database of Systematic Reviews* 2007, Issue 3. Art. No.: CD005460. DOI: 10.1002/14651858.CD005460.pub2.

In the developing world, many women give birth at home assisted by family members or traditional birth attendants (TBAs). TBAs lack formal training and governments and other organizations have conducted training programs to improve their skills. There is disagreement that these training programs are effective. This review included four studies and examined the effect of TBA training on TBA behaviour and on pregnancy outcomes. We conclude that the potential of TBA training to decrease newborn death is promising, when combined with improved health services. The number of studies, however, is insufficient to provide the necessary evidence for TBA training effectiveness.

### **Practical lessons from global safe motherhood initiatives: time for a new focus on implementation**

*Lynn P Freedman, Wendy J Graham, Ellen Brazier, Jeffrey M Smith, Tim Ensor, Vincent Fauveau, Ellen Themmen, Sheena Currie, Koki Agarwal*

***Lancet* 2007; 370:1383–91**

Three key elements that are crucial for reduction of maternal mortality—family planning, skilled care for all deliveries, and access to emergency obstetric care for all women with life-threatening complications. ( Note: There is no emphasis on institutional delivery among these three key elements)

Maternal health programmes that are well implemented strengthen the broader health system with collateral benefits for many other health disorders.

Understanding context entails an appreciation of the relation between supply and demand within the district level health system—ie, the continuum from home or community, up through health posts and health centres, to the first referral level facility.

## **Detours and shortcuts on the road to maternal mortality reduction**

*Deborah Maine*

*Lancet 2007; 370: 1380–82*

Although in many settings there is a substantial overlap between births attended by a skilled provider and institutional deliveries, there are many places where this is not the case. By focusing on institutional deliveries, programmes could meet their targets, but miss the goal of reducing deaths and long-term disability for women.

Private, for-profit clinics and hospitals are usually concentrated in urban or periurban areas. Will the support for private services (through vouchers or other means) increase care for underserved populations? Will such initiatives overcome financial and cultural barriers, and increase equity? Do private facilities actually provide good-quality care? Finally, we need to question whether strengthening private-sector care will be less expensive than strengthening government health services.

### **What can a meta-analysis tell us about traditional birth attendant training and pregnancy outcomes?**

*Lynn Sibley, MS, Ph.D., CNMa,\*, Theresa Ann Sipe, MN, MPH, Ph.D., CNMb  
Midwifery (2004) 20, 51–60*

TBA training was associated with significant increases in attributes such as TBA 'knowledge' (90%), 'attitude' (74%), 'behaviour' (63%) and 'advice' (90%) over the untrained TBA baseline.

TBA training was also associated with small but significant decreases in peri-neonatal mortality (8%) and birth asphyxia mortality (11%).

in some countries, skilled birth attendance is a distant reality and TBAs are the only obstetric care provider available. Recognising the challenge, the technical working group on skilled attendance at birth thus recommended that 'Where TBAs account for a significant proportion of births, safe motherhood programs should include activities aimed at 'integrating' them into the system' (Starrs, 1998, p. 31).

In what context and in what content does it make sense to train TBAs? Where home birth is the norm and mortality levels are high, and given the timing and causes of maternal and perineonatal death (Li et al., 1996, Save the Children, 2001), we suggest that, in addition to birth preparedness and referral, it makes sense to equip TBAs with skills for prevention, recognition and initial management of selected maternal and neonatal complications (skills that are of proven efficacy in the hands of skilled attendants) and that can be safely performed by TBAs in the home setting (e.g., safe clean delivery, external bimanual compression for uterine atony, resuscitation for birth asphyxia). Yet it only makes sense to train TBAs in these skills in situations where TBAs attend the majority of births in the area (this should be documented), are influential in health care and referral decision-making; and can be supported, supervised and backed by adequate

emergency obstetric care services. A case can also be made to train TBAs in high mortality situations where services do not, or will not, exist for some time.

### **An Intervention Involving Traditional Birth Attendants and Perinatal and Maternal Mortality in Pakistan**

*Abdul Hakeem Jokhio, M.B., B.S., Ph.D., Heather R. Winter, M.D., M.R.C.O.G., and Kar Keung Cheng, M.B., B.S., Ph.D.*

*N Engl J Med. 2005 May 19;352(20):2091-9*

There was a significant reduction in perinatal mortality of about 30 percent in the intervention group of this large, cluster-randomized, controlled trial. The estimated percent reduction in maternal mortality was similar but was not statistically significant despite the large size of the trial. The large decrease in puerperal sepsis is consistent with the recorded high use of safe-delivery kits by traditional birth attendants. It is likely that much of the reduction in perinatal mortality was mediated through reduced sepsis, but it was not possible to obtain definitive information.

The training of traditional birth attendants included teaching them to recognize serious complications of pregnancy and delivery, and obstructed labor was more frequently recorded for women in the intervention group. Referral to public health services was also encouraged, and correspondingly, a higher proportion of women in the intervention group than in the control group were referred to an emergency obstetrical care facility.

### **Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster-randomised controlled trial.**

*Manandhar DS, Osrin D, Shrestha BP, Mesko N, Morrison J, Tambahangphe KM, Tamang S, Thapa S, Shrestha D, Thapa B, Shrestha JR, Wade A, Borghi J, Standing H, Manandhar M, Costello AM; Members of the MIRA Makwanpur trial team.*

*Lancet. 2004 Sep 11-17;364(9438):970-9*

From 2001 to 2003, the neonatal mortality rate was 26.2 per 1000 (76 deaths per 2899 livebirths) in intervention clusters compared with 36.9 per 1000 (119 deaths per 3226 livebirths) in controls (adjusted odds ratio 0.70 [95% CI 0.53–0.94]). Stillbirth rates were similar in both groups. The maternal mortality ratio was 69 per 100000 (two deaths per 2899 livebirths) in intervention clusters compared with 341 per 100000 (11 deaths per 3226 livebirths) in control clusters (0.22 [0.05–0.90]). Women in intervention clusters were more likely to have antenatal care, institutional delivery, trained birth attendance, and hygienic care than were controls.

Birth outcomes in a poor rural population improved greatly through a low cost, potentially sustainable and scalable, participatory intervention with women's groups.