

UN Process Indicators: key to measuring maternal mortality reduction

by Janet Meyers, Samantha Lobis and Henia Dakkak

Is enough being done to provide displaced women with emergency obstetric care (EmOC)?

Every year more than half a million women die from complications of pregnancy and childbirth. Many more suffer severe disabilities. WHO estimates that 15% of all pregnant women will develop direct obstetric complications such as haemorrhage, obstructed or prolonged labour, pre-eclampsia or eclampsia, sepsis, ruptured uterus, ectopic pregnancy and complications of abortion. If left untreated, they will lead to death or severe disability. Maternal mortality and morbidity can only be reduced by ensuring women with obstetric complications receive good-quality medical treatment without delay. The desperate circumstances of refugee and IDP women fleeing conflict place them at exceptional risk of pregnancy-related death, illness and disability.

The target of reducing maternal mortality by 75% by 2015 is a key UN Millennium Development Goal. Because obstetric complications cannot be predicted or prevented, all pregnant women need access to good quality EmOC. Key 'signal functions' have been identified as necessary to the provision of basic and comprehensive EmOC. Basic EmOC services must be able to provide the

following signal functions: parenteral (given intravenously or by injection) antibiotics, parenteral oxytocic drugs, parenteral anti-convulsants (for pre-eclampsia and eclampsia), manual removal of placenta, removal of retained products and assisted vaginal delivery. Comprehensive EmOC includes all these plus: ability to perform surgery (Caesarian section) and blood transfusion.

Conflict-affected populations have access to EmOC through the Minimum Initial Service Package (MISP) for RH services.¹ However, the MISP was designed and developed to prevent excess neonatal and maternal morbidity and mortality in the early phases of complex emergencies. Since most conflict-affected populations remain in camps for extended periods of time, efforts to establish permanent access to

EmOC need to be made. Therefore, to reduce maternal mortality and morbidity among this population of women, it is imperative to assess the local health system and plan EmOC programmes accordingly.

UN Process Indicators

In 1997 UNICEF, WHO and UNFPA issued a set of indicators called 'UN Process Indicators' to monitor the availability, utilisation and quality of EmOC.² To standardise the use of the UN Process Indicators, they were published with a set of guidelines in the document 'Guidelines for Monitoring the Availability and Use of Obstetric Services',³ commonly referred to as the 'UN Guidelines'.

Based on a specific package of medical services that must be available at health facilities in order to save women with complications, the UN Process Indicators offer a systematic approach to assessing health care systems and for planning sustainable maternal health interventions. While a variety of tools,

Pregnancy ward at Kakuma camp, Kenya



The Six UN Process Indicators and Recommended Levels		
UN Process Indicator	Definition	Recommended Level
1. Amount of EmOC services available	Number of facilities that provide EmOC	Minimum: 1 Comprehensive EmOC facility for every 500,000 people Minimum: 4 Basic EmOC facilities per 500,000
2. Geographical distribution of EmOC facilities	Facilities providing EmOC well-distributed at sub-national level	Minimum: 100% of sub-national areas have the minimum acceptable numbers of basic and comprehensive EmOC facilities
3. Proportion of all births in EmOC facilities	Proportion of all births in the population that take place in EmOC facilities	Minimum: 15%
4. Met need for EmOC services	Proportion of women with obstetric complications treated in EmOC facilities	100% (Estimated as 15% of expected births)
5. Caesarean sections as a percentage of all births	Caesarean deliveries as a proportion of all births in the population	Minimum 5% Maximum 15%
6. Case fatality rate	Proportion of women with obstetric complications admitted to a facility who die	Maximum 1%

service packages and policies have been developed by UN agencies and NGOs to standardise and monitor humanitarian health services and include maternal health, most do not adequately or systematically address women's access to EmOC. This is why the UN Process Indicators would be invaluable to the humanitarian community.

The UN Process Indicators answer the following questions:

- Are enough facilities providing EmOC?
- Are they well distributed within a geographic area?
- Are enough women using these facilities?
- Are women with obstetric complications using these facilities?
- Are enough critical services being provided?
- Is the quality of the services adequate?

Manuals and guidelines under the spotlight

RHRC has reviewed five published manuals and guidelines used by humanitarian organisations to ascertain the need for and utility of the UN

Process Indicators in conflict settings. The documents reviewed were:

- Sphere Project, *The Sphere Project: Humanitarian Charter and Minimum Standards in Disaster Response*, 2000.⁴
- Inter-Agency Working Group on Reproductive Health in Refugee Situations (IAWG), *Reproductive Health in Refugee Situations: an Inter-Agency Field Manual*, Geneva: UNHCR, 1999.⁵
- Médecins Sans Frontières (MSF), *Refugee Health: An approach to emergency situations*, 1997.⁶
- World Health Organisation, *Reproductive Health during Conflict and Displacement: A Guide for Programme Managers*, Geneva: WHO, Department of Reproductive Health and Research, 2000.⁷
- UNHCR, *Guidelines on the Protection of Refugee Women*, 1991.⁸

Four questions were used to guide the review:

- 1) Does the document include EmOC?
- 2) Does it clearly identify which EmOC services need to be in place?
- 3) Does it incorporate the UN Process Indicators into the assessment,

monitoring or evaluation plans?

- 4) Does it list the UN Guidelines as a resource?

Our key findings were:

- The newly revised **Sphere Project** manual includes a section on EmOC and clearly defines basic EmOC services to be provided at the health centre and comprehensive EmOC services needed at the referral hospital level. However, the UN Process Indicators are not included and the UN Guidelines are not listed in the resources.
- While the **IAWG** manual includes the importance of good quality EmOC to reduce maternal mortality, discusses process indicators in general and refers to the UN Guidelines, it does not include the UN Process Indicators specifically.
- The **MSF** manual includes the need for EmOC, the importance of working with existing health systems and the direct link between obstetric complications and maternal morbidity and mortality. It does not include specific EmOC services and skills required, reference to UN Process Indicators or necessary variables, or reference to the UN Guidelines.
- The guide developed by **WHO** includes the importance of EmOC, quality of care, and human rights and list some EmOC services and types of skilled practitioners needed. While it has a general list of process indicators it does not include all the necessary EmOC services or skills required nor make specific reference to the UN Process Indicators or UN Guidelines.
- **UNHCR** guidelines include the need for accessible women's health services but do not include EmOC specifically.

Recommendations

There have been great improvements in defining indicators for monitoring and evaluating EmOC initiatives in humanitarian programmes. However, there is a continued need to standardise monitoring and evaluation of maternal mortality reduction programmes in a way that is understood universally. Guidelines developed by UNICEF, WHO and UNFPA⁹ should be

distributed to all agencies working with war-affected populations. Improved coordination between the field and national-level partners in the collection of the UN Process Indicators would greatly improve the quality of the data and improve monitoring of maternal mortality reduction programmes.

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To respond to the needs of populations affected by conflict, the Reproductive Health Response in Conflict (RHRC) Consortium, with funding from Columbia University's Averting Maternal Death and Disability (AMDD) Project, is supporting 11 EmOC projects in the countries of Bosnia-Herzegovina, Kenya, Liberia, Pakistan, Sierra Leone, southern Sudan, Thailand, Tanzania and Uganda. Because facilities are frequently damaged or destroyed during conflict, initial activities included facility construction or renovation plus provision of equipment, supplies and medicines. Additional activities are staff training and community outreach.

1. MISP is a set of priority activities designed to: prevent excess neonatal and maternal morbidity and mortality; reduce HIV transmission; prevent and manage the consequences of sexual violence; and plan for comprehensive reproductive health services. For more information, see: www.ippf.org/resource/refugeehealth/manual/2.htm#Objectives

2. A Paxton, D Maine & N Hijab, *Using the UN Process Indicators of Emergency Obstetric Services*, AMDD Workbook, May 2003.

3. See: www.eldis.org/static/DOC12421.htm

4. See: www.sphereproject.org

5. See: www.unfpa.org/emergencies/manual

6. Médecins sans Frontières, *Refugee health: an approach to emergency situations*, New York City: MacMillan Education Ltd. 1997.

7. See: www.who.int/reproductive-health/publications/RHR_00_13_RH_conflict_and_displacement/RH_conflict_introduction.en.html

8. See: www.womenscommission.org/pdf/unhcr.pdf

9. The 'Guidelines for Monitoring the Availability and Use of Obstetric Services' are available in hard copy by contacting UNFPA and WHO or online at:

- www.unicef.org/health/guidelinesformonitoringavailabilityofemoc.pdf
- www.unfpa.org/upload/lib_pub_file/188_file-name_emoc-guidelines.doc
- www.who.int/reproductive-health/publications/unicef/