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CHAPTER - 7

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WHY PROMOTE SAFE MOTHERHOOD IN EMERGENCIES?



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PAKISTAN: A healthworker checks a woman's blood pressure in a health center tent in one of the camps for families affected by the South Asia earthquake.

During an emergency it is easy for pregnant women to become exhausted, malnourished and anaemic because of stress, lack of food and water, a hurried evacuation, or the need to travel long distances to reach safety or humanitarian assistance. Transportation routes may be cut off, distribution networks dissolved and health facilities destroyed. Maternal

support services that are normally available to the affected community may have been destroyed or operating at reduced capacity; and existing supplies may fall far short of demand when large numbers of people move into a new location.²

These circumstances put women at a higher risk of death or disability from complications during pregnancy and/or delivery. In close partnership with health providers, you can support the protection of infants and pregnant women in emergency situations through safe motherhood promotion, social mobilisation,

Identify key audiences for each of the prioritised behaviours:

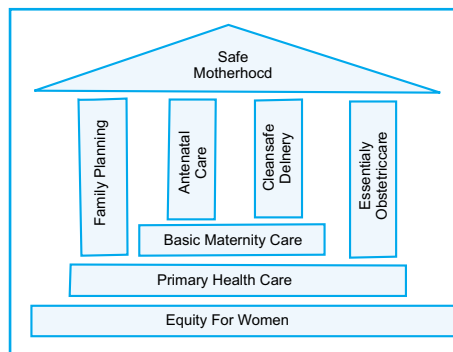
- Pregnant and post-partum women.
- Family decision makers (this may vary depending on culture, situation, and household composition).
- Community opinion leaders (religious, women group leaders, locally elected leaders, others).
- Birth attendants (professional or traditional).
- Community health providers involved in maternity care.
- Health facility based health professionals (private and government).

Source: Saving Mother's Lives!

and advocacy with local governments, health providers and humanitarian agencies.³

The pillars of safe motherhood, as illustrated below, highlight the strategic safe motherhood interventions that you can promote in your communication initiative. During the initial emergency response it would be wise to focus on a few risk-reducing behaviours that are discussed in the *Getting the message right* section.

The “four pillars” of safe motherhood⁴



PRINCIPLES OF SAFE MOTHERHOOD PROMOTION

Safe motherhood promotion in emergencies should focus on a limited number of practices that are proven to decrease infant and mother deaths. Your communication effort should result in women having the power to have healthy pregnancies, safe deliveries and positive birth outcomes. Consider the following principles when planning your communication initiative to support safe motherhood goals:

1. **Prioritise behaviours, emphasising the ones with the most potential to reduce death and disability.**

To reduce death and disability in mothers and infants the priority safe motherhood practices are seeking antenatal care within the first three months; a safe and clean delivery; and receiving immediate post-natal support.

2. **Involve the decision makers in a mother’s life.**

In many South Asian cultures, a mother-in-law, husband or other family decision maker influences the antenatal and postnatal practices of new and expectant mothers. Identify and involve the family decision makers and include them as key participants in participatory assessment, community mobilisation and support efforts as well as in monitoring activities. However, be aware that

the household composition may have changed as a consequence of the disaster. Some expectant women and mothers may be alone, or new heads of the household. You will need to know this too!

3. **Disseminate positive safe motherhood messages.**
Messages should show how safe motherhood practices benefits mother, baby and family.
4. **Your communication support should be aligned with and in support of the national maternal health plan/policy.**
Don't reinvent the wheel; build on the country's existing health policies and find ways to fill in the gaps.

DOING THE GROUNDWORK

Before any emergency strikes, communicators should form alliances and work in coordination with key partners in safe motherhood promotion. These allies could be the community health workers, birth attendants (professional and traditional), nurses, doctors (private and government), district

Continued access to family planning in emergencies

Family planning is especially important when health services have been damaged or destroyed by war or natural disaster. Experience has shown that in emergencies women, girls and adolescents are sometimes raped; forced into having sex in exchange for food and other needed items; and otherwise sexually abused.

We should be mindful of the weakened/absent law enforcement in emergency situations and ensure that emergency contraceptives are available; and that women who have been using family planning services pre-disaster continue to have access to these services.

Communication actions should ensure that women, men, and adolescents know when, where and how-to access family planning services and supplies; know the importance of seeking medical care and counselling if raped or sexually abused; and know where to go for these services.

Be sure that your family planning/safe motherhood actions are in line with the affected community's national reproductive plan, and that your messages are in sync with other concerned agencies.

Source: Adapted from Family Planning²

health officers, faith-based leaders and others. If you establish these partnerships your groundwork will become a process of filling in the gaps - combining pre-existing knowledge about the affected community with new information received from rapid assessments. By information and feedback gathering - both pre-and-post emergency - you will be able to influence relevant behavioural results, safe motherhood communication actions, messages and materials.

Keep in mind that during emergencies it may be harder for an affected community to part from social and cultural beliefs, practices and traditions that vary from the positive behaviours you are presenting. Understanding such barriers will be critical in planning your communication initiative.

Some tools to do the groundwork

Key informant interviews

There is sufficient evidence that in many countries in South Asia, a woman's beliefs, practices and attitudes toward pregnancy are influenced by family decision makers such as husbands, mothers-in-law, and community and family elders. These decision makers are often the ones who decide whether a woman needs antenatal or post-natal care, should breastfeed, or go to a health facility for an obstetric emergency. In emergency situations, this tradition will depend on factors such as the extent of community disruption, displacement, mortality and morbidity rates. You can use key informants – affected pregnant women, adolescent girls, health workers, men and family decision makers – to provide insight on the decision making processes that form the beliefs, attitudes and practices on pregnancy, delivery and other safe motherhood-related issues. **Please see Tool 5 in Part III of the toolkit.**

Focus group discussions

In stabilised situations mothers have many obstacles to making sure that they have a safe pregnancy and delivery. In an emergency, ensuring safe motherhood becomes even more difficult. Some women may not know how to have a healthy pregnancy; rumours can spread about health services or providers; or the affected community does not support a woman's choice to adopt safe motherhood practices. Through focus group discussions identify the cultural traditions, practices and beliefs that are disincentives to positive change in the cultural

context of the country and the emergency. The added value of focus groups is that participants not only provide information for your communication initiative but can also carry lessons learned back to the affected community. **Please see also Tool 9 in Part III of the toolkit.**

By using these tools in different stages of an emergency, you can determine whether the priorities that centre on safe motherhood issues change at different phases of an emergency.

GETTING THE MESSAGE RIGHT

In emergencies, new mothers and pregnant women will receive messages on hygiene, breastfeeding, child protection and measles vaccination.

Prevent message clutter and focus on messages on the two main risk-decreasing strategies.

These strategies are:

1. Creating demand and support for antenatal and post natal care.
2. Knowing how to have a clean and safe delivery.

Promote the above strategies with clear, concise and easily understood messages. Choosing the right mix will depend on which key behaviours you have prioritised as the most critical ones to save the lives of infants and new and expectant mothers in the emergency. Your choice of messages will also depend on who your main audiences are – for example, pre-and-post partum women, community health

Pointers on using counsellors in a safe motherhood BCC programme^{5, 6}

A component of safe motherhood promotion can include training health workers and peer educators to counsel and communicate the benefits and importance of safe motherhood practices to the affected women, their families and community.

Counselling is beneficial in that it can be used to reinforce safe motherhood messages disseminated via IEC materials and the mass media. It can also help bridge cultural, ethnic, and social gaps between healthcare providers, TBAs and affected women.

Counselling should only be used if you have the resources and capacity to do so. This can be challenging in an emergency situation, because there is often a poor client-counsellor ratio. However, if you have the resources and capacity, consider that the affected women and families should receive:

Information - To learn about the benefits and availability of the services and access to services regardless of gender, creed, colour, marital status or location.

workers, village elders and/or relief workers. Involve women and other key audience members in developing the messages. This will go a long way in ensuring that the messages are effective, clear and understood by all of the intended target audiences. Safe motherhood messages might include:⁷

1. It is important for all family members to be informed about and able to recognise the warning signs of problems during pregnancy and childbirth.
2. Make a birth plan and know where to get immediate skilled help if problems during pregnancy or delivery arise.
3. A skilled birth attendant, such as a doctor, nurse, or trained midwife, should check the woman at least four times during every pregnancy and assist at birth.
4. All pregnant women need particularly nutritious meals and more rest than usual throughout the pregnancy.
5. Smoking, alcohol, drugs, poisons and pollutants are especially harmful to pregnant women and young children.
6. Physical abuse of women and children is a serious public health problem. Abuse during pregnancy is dangerous both to the woman and the foetus.
7. Every woman has the right to health care, especially during pregnancy and childbirth. Health care providers should be technically competent and treat women with respect.

Choice To understand and be able to apply all pertinent information and make an informed choice, freely ask questions, and receive answers in an honest, clear and comprehensive manner.

Safety A safe and effective service.

Privacy To have a private environment during counselling or services.

Confidentiality To be assured that any personal information will remain confidential.

Dignity To be treated with courtesy, consideration and attentiveness.

Comfort To feel comfortable when receiving services.

Continuity To receive services and supplies for as long as needed.

Opinion To express views on the services offered.

COMMUNICATION ACTIONS FOR SAFE MOTHERHOOD

UNICEF's emergency response is guided by the Core Commitments for Children in Emergencies (CCC) that provide the overarching organisational framework in a humanitarian response (see Chapter 3). The table below outlines the CCC in the areas of Health and Nutrition related to safe motherhood. Included are suggested behaviour change communication (BCC) and social mobilisation activities that have been effective in improving women's health during pregnancy and delivery in an emergency situation. Remember to involve relevant members of the affected community and your partners in planning your communication and social mobilisation actions, as well as to carefully monitor and evaluate the programme.

TABLE: Extract from UNICEF's CCC in health and nutrition and corresponding suggested BCC and social mobilisation support.

BEYOND THE INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
<ol style="list-style-type: none"> 1. Support the establishment of essential health-care services, by providing outreach services and home-based management of childhood illnesses and emergency obstetric care services, and treatment for malaria, diarrhoea and pneumonia. 	<ul style="list-style-type: none"> ■ Ensure that affected women, family decision makers, birth attendants, and traditional healers know the warning signs during pregnancy and danger signs in a delivery that mean that they must get help immediately. They must receive information on when and where to seek antenatal care and emergency obstetric care – i.e. through group discussions, women's shelters, maternity caregivers, health workers, counselling and IEC materials.

BEYOND THE INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	<ul style="list-style-type: none"> ■ Ensure that health workers and other service providers know and understand the importance of seeking professional emergency obstetric care and are able to communicate this to women. ■ Involve government agencies and professional health associations in training support service providers, in giving advice and support to women on preparing a birth plan and planning for potential obstetric emergencies. ■ Mobilise the community to support pregnant women in obstetric emergencies by designing a community-based birthing plan and increasing knowledge on danger signs during delivery through talks with women's groups, mass media, IEC materials, audiovisual presentations, flip charts, etc. ■ Advocate and mobilise support with the local government, camp management, private sector and humanitarian agencies to increase knowledge on the need for reliable emergency obstetric care for all affected women, providing reliable transportation systems, and training of birth attendants.
<p>2. Provide tetanus toxoid with auto-disable syringes and other critical inputs such as cold-chain equipment, training and behavioural change expertise, and financial support for advocacy and operational costs for immunization of pregnant women and women of childbearing age.</p>	<ul style="list-style-type: none"> ■ Ensure that all affected women and family decision makers know the benefits of tetanus toxoid shots to both mother and baby; when, and where to get the vaccination – i.e. one-one-counselling/talks, health worker visits, women's representatives, midwives, and IEC materials.

BEYOND THE INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	<ul style="list-style-type: none"> ■ Train birth attendants, health workers, counsellors and service providers on how to communicate the importance of tetanus toxoid vaccinations to affected mothers and family decision makers. ■ Advocate and mobilise support with local authorities, camp management and other relevant stakeholders to provide tetanus toxoid vaccinations to all affected women (especially those of reproductive age). ■ Involve public figures in advocating the benefits of tetanus toxoid vaccination to affected women and communities.

Communication to support safe motherhood initiatives in emergencies has to be timely, appropriate and based on the nationally identified priorities and national maternal health policies. Remember to build on existing activities and partnerships!

BEYOND THE INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
<p>3. Support the establishment of essential health-care services, by providing outreach services and home-based management of childhood illnesses and emergency obstetric care services, and treatment for malaria, diarrhoea and pneumonia.</p>	<ul style="list-style-type: none"> ■ Ensure that affected women, family decision makers, birth attendants, and traditional healers know the warning signs during pregnancy, and danger signs in a delivery that mean get help immediately; and that they know when and where to seek antenatal care and emergency obstetric care – i.e. group discussions, community based radio, women’s shelters, maternity caregivers, health workers, counselling and IEC materials.

BEYOND THE INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	<ul style="list-style-type: none"> ■ Ensure that health workers and other service providers know and understand the importance of seeking professional emergency obstetric care and are able to communicate this to women. ■ Involve government agencies and professional health associations to train and support service providers in giving advice and support to women on preparing a birth plan and planning for potential obstetric emergencies. ■ Mobilise the community to support pregnant women in obstetric emergencies by designing a community-based birthing plan and increasing knowledge on danger signs during delivery through talks with women's groups, mass media, IEC materials, audiovisual presentations, flip charts, etc. ■ Advocate and mobilise support with the local government, camp management, private sector and humanitarian agencies to increase knowledge on the need for reliable emergency obstetric care for all affected women, reliable transportation systems, and training of birth attendants.
<p>4. Provide health and nutrition education, including messages on the importance of breastfeeding and safe motherhood practices.</p>	<ul style="list-style-type: none"> ■ Ensure that affected women and family decision makers know the components of maternal nutrition – a pregnant woman needs the best foods available to the family; should avoid food restrictions; needs iodised salt, vitamin A and iron supplements. Understands that a woman should exclusively breastfeed for the first 6 months (unless in exceptional cases in which the infant

BEYOND THE INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	<p>should be cup fed an adequate amount of appropriate BMS); receive antenatal/postnatal care; seek and use clean delivery kits (where available); have an attended birth; and get immediate care for warning signs during pregnancy or delivery – i.e. counselling, health workers, audiovisual presentations, women’s representatives, birth attendants/midwives, and IEC materials.</p>
	<ul style="list-style-type: none"> ■ Ensure that health workers, birth attendants and maternity caregivers, women’s representatives, counsellors and other relevant stakeholders know and can communicate to affected mothers and family decision makers the factors of maternal nutrition; exclusively breastfeeding for the first 6 months (unless in exceptional cases); receiving antenatal/postnatal care (including tetanus injections); and immediately seeking help for emergency obstetric situations. ■ Mobilise the community to support pregnant women and new mothers by facilitating mother-to-mother support networks, women’s group, community-based birthing plans, referral systems, etc.



AFGHANISTAN: Woman receives vaccination in a clinic.

MONITORING MILESTONES

The result of a safe motherhood programme in an emergency situation is to reduce maternal and neonatal mortality and morbidity through timely and appropriate safe motherhood interventions.⁸

This is usually the overall objective your communication initiative should seek to support. It is critical to monitor whether your communication support to the safe motherhood programme is on track. On which indicators you need to monitor your communication efforts depends on which specific behavioural results you seek to achieve from the affected groups. The following are, however, some common core indicators listed to give you an idea. **Tools 12 and 13 in Part III lists possible sources of information to help you measure the indicators.**

- Health workers, midwives, women's representatives, counsellors and other relevant stakeholders are trained on maternal nutrition and breastfeeding facts and communicate the importance of antenatal and postnatal care visits, clean and attended delivery, the warning signs during pregnancy and danger signs during pregnancy.
- Affected women and their families know the benefits of and practice healthy eating, taking vitamin A supplements and iron; receiving tetanus shots; having a clean and attended delivery; seeking antenatal and postnatal care.
- Affected women and their families know the warning signs during pregnancy; when and where to get immediate help, and seek medical help when complications occur.



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SRI LANKA: Deputy Principal Mohammad Hanifa Abdul Rahman teaches social studies to Grade 8 boys in a temporary classroom at Al-Arham Vidyalaya School in the Addalaichenai area in the eastern district of Ampara. The school, whose students are from a Muslim fishing community, has been relocated to a temporary structure on rented land. The original school, located less than 40 metres from the sea, was completely destroyed by the tsunami. Two of its 350 students were killed during the disaster and 80 percent of the children's homes were damaged or destroyed. Many of the students have been traumatized and are afraid to return to the original school site. UNICEF has provided the materials for a temporary school building as well as 12 school-in-a-box kits.

- The affected community demonstrates support to pregnant women via mother-to-mother support networks, women's group, community-based birthing plans and referral systems, etc.
- Local governments and humanitarian agencies have allocated the resources needed for adequate care and affordable quality services; have established the necessary transportation systems, supplied essential drugs, clean delivery kits – and have formed necessary partnerships to supply these.

SPECIAL CONSIDERATIONS: SAFE MOTHERHOOD AND HIV

In an emergency situation, the effects of poverty, powerlessness and social instability are intensified and the social norms regulating behaviour are often weakened. Women – including those who are pregnant – and children are at an increased risk of violence, and can be forced to have sex for them to gain access to basic needs such as food, water or security. These are all factors which make affected women and children more vulnerable to HIV infection.⁹

In South Asia, where HIV prevalence is still considered to be generally low, communication initiatives must take into account whether HIV and AIDS prevention, treatment and support should be part of the communication strategy to support the larger goals of safe motherhood. When you plan and prepare a behaviour and social change component for a safe motherhood response in an emergency situation, which includes an HIV/AIDS communication component, consider the following factors:

- What were pre-emergency HIV incidence and prevalence figures?
- What is the general knowledge level among the affected population regarding HIV and AIDS?
- Were comprehensive PMTCT services available prior to the emergency? Are they available post emergency in the affected area (this includes determining if anti-retroviral prophylaxis and treatment are available for mothers and their newborns prior to the emergency)? If yes, the rapid assessment which is conducted in the initial phase of an emergency will have to establish if there was an interruption of anti-retroviral therapy caused by the emergency.

- Are voluntary and confidential HIV counselling services available in ANC services?
- Are trained HIV counsellors available?
- Does the country have a national HIV and infant feeding policy? If not, we should seek guidance from global policies.¹⁰

RESOURCE BANK

Further reading

1. *Advances in Maternal and Child Health, Vol.3*, Oxford University Press, Oxford, 1983.
2. Berer, M. and Sandari Ravindran, T.K., *Safe Motherhood Initiatives: Critical issues*, London, Blackwell Science, 2000.
3. De Brouwere, V., et al., 'Safe Motherhood Strategies: A review of the evidence', *Studies in Health Services Organizations and Policy, Vol. 17*, 2001.
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6. United Nations High Commissioner for Refugees, *Guidelines on Refugee Women*, UNHCR, Geneva.
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8. World Health Organization, *Managing Complications in Pregnancy and Childbirth: A guide for midwives and doctors*, WHO, Geneva, 2003.
9. World Health Organization and Reproductive Health Outlook, *Developing Health Promotion and Education Initiatives in Reproductive Health: A framework for action planning*, WHO/RHR, Geneva, 1998.

Web sites

1. Global Reproductive Health Forum
<http://www.hsph.harvard.edu/Organizations/healthnet/>
2. Reproductive Health Outlook
<http://www.rho.org/index.html>
<http://www.rho.org/html/menrh.htm>
3. Saving Women's Lives Initiative
<http://www.savingwomenslives.org>

4. The Safe Motherhood Initiative
<http://www.safemotherhood.org>
5. United Nations Children's Fund
<http://www.unicef.org/health/index.html>
6. United Nations High Commissioner for Refugees
<http://www.unhcr.ch>
7. United Nations Population Fund
<http://www.unfpa.org/emergencies/index.htm>
<http://www.unfpa.org/icpd>
8. US Center for Disease Control and Prevention (CDC)
<http://www.cdc.gov/nccdphp/drh/>
http://www.cdc.gov/nccdphp/drh/mrh_mens.htm
9. White Ribbon Alliance for Safe Motherhood
<http://www.whiteribbonalliance.org>
10. World Health Organization
http://www.who.int/topics/reproductive_health/en/

Footnotes

- ¹ White Ribbon Alliance, *Saving Mother's Lives, What Works: A field guide for implementing best practices in safe motherhood*, India, 2002.
- ² Adapted from 'Family Planning', retrieved from <http://www.unfpa.org/emergencies/planning.htm> on 9 October 2005.
- ³ World Health Organization, *Health in Emergencies*, WHO, Geneva, 2001, p. 6.
- ⁴ World Health Organization, *Mother-baby Package: Implementing safe motherhood in countries*, Maternal Health and Safe Motherhood Programme Division of Family and Health, WHO, Geneva, 1996, p. 11.
- ⁵ JHPIEGO, Behavior Change Interventions for Safe Motherhood: Common problems, unique solutions, JHPIEGO, Baltimore, 2004, p. 3.
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- ⁷ Messages taken from United Nations Children's Fund, *Facts for Life*, UNICEF, New York, 2002, pp. 10 -11.
- ⁸ United Nations Children's Fund, *Technical Notes: Special considerations for programming in unstable situations*, UNICEF, New York, 2003, p.91.
- ⁹ Inter-Agency Standing Committee, *Guidelines for HIV/AIDS Interventions in Emergency Settings*, IASC, Geneva, p.7.
- ¹⁰ UNICEF, UNAIDS, UNFPA, WHO, *HIV and Infant Feeding, Guidelines for decision makers*, Geneva, 2003.