February 2022

ANTENATAL, INTRAPARTUM & POSTNATAL CARE

DEFINITIONS

- **Antenatal care (ANC):** Care provided *during pregnancy* by skilled health-care professionals to ensure best health conditions for both mother and baby.
- **Intrapartum care**: Care provided *during childbirth* by skilled health-care professionals to ensure best health conditions for both mother and baby.
- **Postnatal care (PNC):** Care provided *up to six weeks following childbirth* by skilled health-care professionals to ensure best health conditions for both mother and baby.

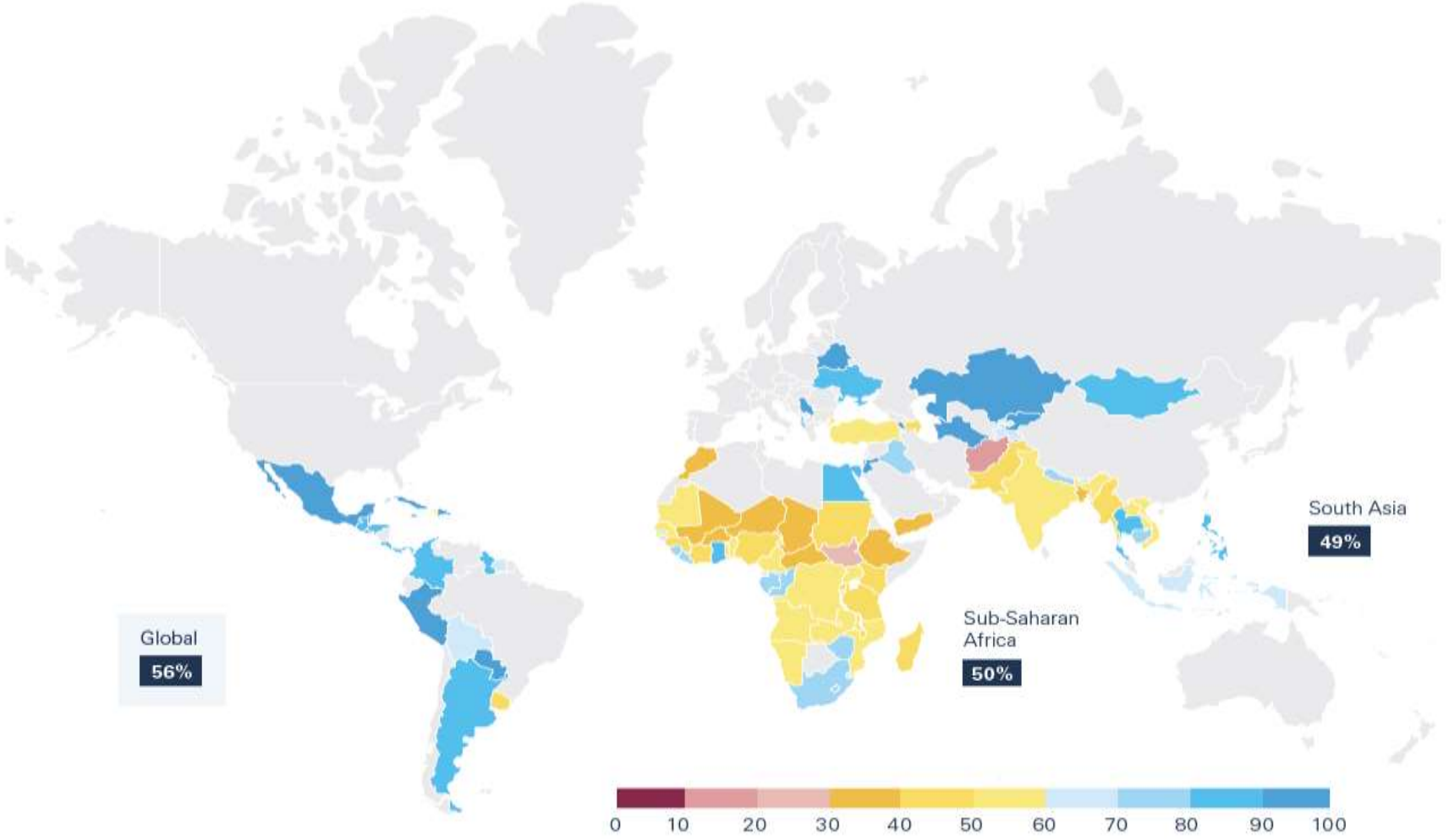
RATIONALE – 1/2

- In many contexts, adolescent pregnancy is common: In 2016, an estimated 21 million girls aged 15-19 in developing countries became pregnant, approximately 12 million of whom gave birth. An estimated 2.5 million girls aged under 16 years in low-resource countries give birth every year. Drivers are context specific; they include child marriage, poverty, lack of opportunity & values related to womanhood & motherhood.
- Adverse maternal health outcomes among adolescents have major health & social consequences: Pregnancy & childbirth complications are the leading cause of death among girls aged 15-19 years globally. In addition, adolescent mothers face higher risks of maternal morbidity. Early child bearing can increase risks for newborns as well as for young mothers.

RATIONALE – 1/2

- ANC, IPC & PNC are effective: The health benefits of these interventions for mother and baby are clear. There are not ascertainable harms or burdens.
- Access to & provision of good quality services needs attention: Adolescents face barriers to accessing & using skilled care before, during & after pregnancy. Certain groups of adolescents e.g. very young adolescents, unmarried adolescents, & those who are displaced because of war, civil strife or other emergencies face special barriers.

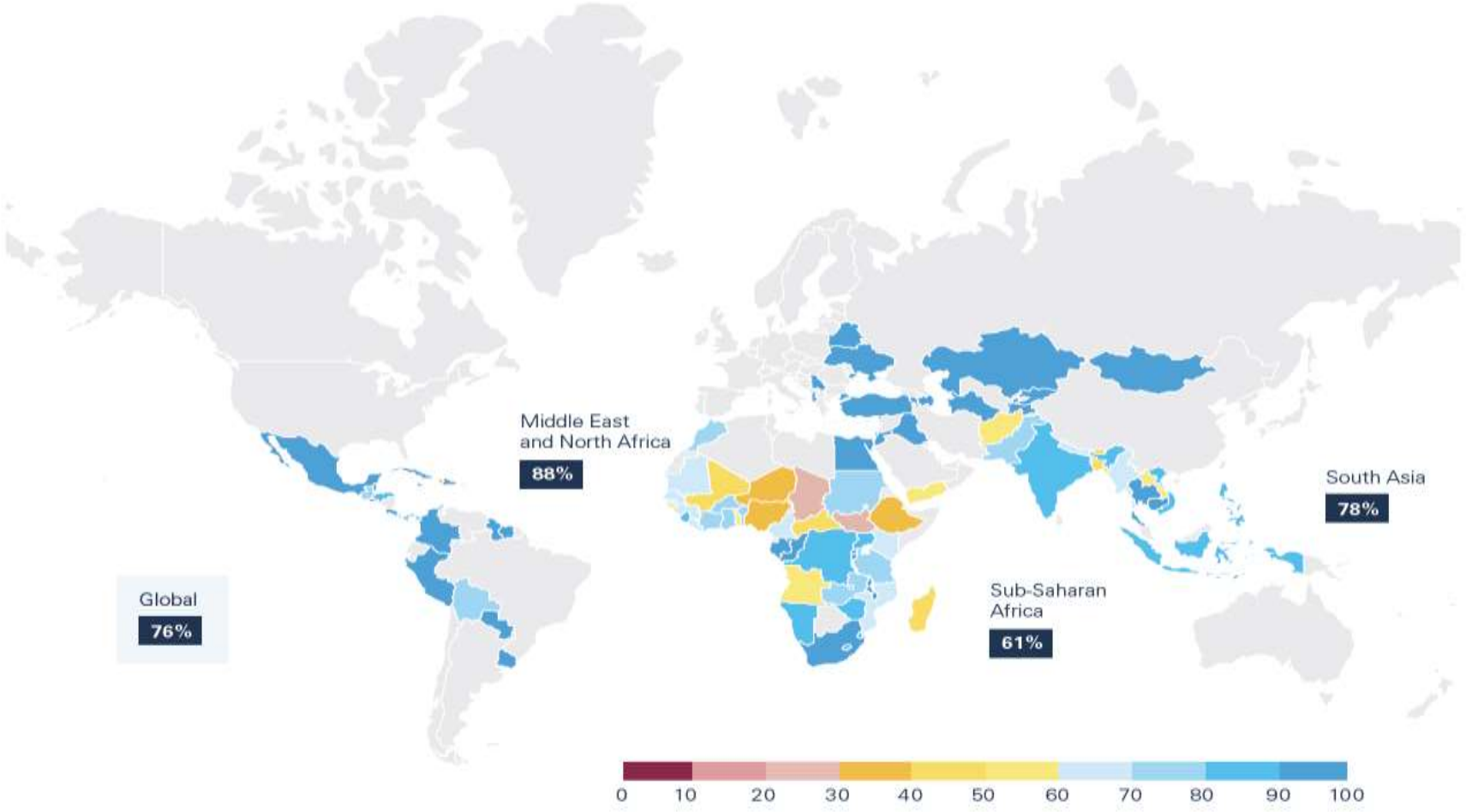
Percentage of adolescent girls aged 15–19 years attended by a service provider at least four times during pregnancy (ANC 4), 2013–2018



Source: UNICEF's SOWC 2019 - data analyzed by International Center for Equity in Health, Federal University of Pelotas, Brazil, based on DHS, MICS and other national surveys, 2019.

Note: *Data refer to the most recent year available during the period specified in the chart title. Regional estimates represent data from countries representing at least 50 per cent of the regional population. Data coverage was insufficient to calculate regional estimates for East Asia and the Pacific, Europe and Central Asia, Middle East and North Africa, Latin America and the Caribbean and North America. The boundaries shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

Percentage of births among adolescent mothers aged 15–19 years attended by skilled heath personnel (typically a doctor, nurse or midwife), by country, 2013–2018



Source: Joint UNICEF/ WHO SBA database, based on DHS, MICS and other national surveys as well as national administrative data, 2019.

Note: *Data refer to the most recent year available during the period specified in the chart title. Regional estimates represent data from countries representing at least 50 per cent of the regional population. Data coverage was insufficient to calculate regional estimates for East Asia and the Pacific, Europe and Central Asia, Latin America and the Caribbean, and North America. The boundaries shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

HUMAN RIGHTS OBLIGATIONS

- States are obliged under human rights law to provide ANC, IPC & PNC.
- Upholding adolescents' rights in this area is linked to state obligations to ensure universal access to a comprehensive package of SRH interventions before, during & after pregnancy to all women & girls.
- Maternal health care should be free, confidential, adolescent-responsive and non-discriminatory; third-party authorization requirements should be removed.

KEY CONCEPTS TO CONSIDER

- Pregnant adolescents, especially unmarried ones, often face barriers to accessing maternal health services including ANC, IPC & PNC: Ensure availability of & access to ANC, IPC & PNC, including emergency obstetric care.
- ANC, IPC & PNC services are often not responsive to the needs of adolescents: It is critical for health workers to receive pre- & in-service training, & ongoing support to ensure they have the competencies & attitudes to provide high quality care, based on the rights of all people to health, confidentiality & non-discrimination.

WHO GUIDELINES

- ***WHO guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries (2011).***
- ***WHO recommendations on antenatal care for a positive pregnancy experience (2016) – with an update on micronutrient supplementation (date to be added).***
- ***Use of multiple micronutrient powders for point-of-use fortification of foods consumed by pregnant women (2016).***
- ***Optimal serum and red blood cell folate concentrations in women of reproductive age for prevention of neural tube effects (2015).***
- ***Guidelines for the identification and management of substance use and substance use disorders in pregnancy (2014).***
- ***WHO recommendations for prevention and treatment of pre-eclampsia and eclampsia (2011) - with updates in 2018 and 2020)***
- ***WHO recommendations for induction of labour (2011 – with updates on induction of labour at our beyond term, 2018.***
- ***WHO recommendations for augmentation of labour (2014).***
- ***WHO recommendations for intrapartum care for a positive childbirth experience (2018).***
- ***WHO recommendations for prevention and treatment of maternal peripartum infections (2015).***
- ***WHO recommendations for the prevention and treatment of postpartum haemorrhage (2012) – with updates in 2018 and 2020.***
- ***WHO recommendations on tranexamic acid for the treatment of postpartum haemorrhage (2017).***
- ***Daily iron supplementation in postpartum women: guideline (2016).***
- ***Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting (2012).***
- ***WHO recommendations on health promotion interventions for maternal and newborn health (2015).***
- ***Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting (2012). WHO recommendations on health promotion interventions for maternal and newborn health (2015).***

COMPLEMENTARY GUIDELINES TO WHO's GUIDELINES

- Pregnancy, childbirth, postpartum and newborn care: a guide for essential practice, 3rd edn. (WHO, 2015).
- Managing complications in pregnancy and childbirth: a guide for midwives and doctors, 2nd edn, (WHO, 2017).
- Companion of choice during labour and childbirth for improved quality of care: evidence-to-action brief (WHO, 2016) – updated version dated 2020.
- Prevention and elimination of disrespect and abuse during childbirth (WHO, 2014).
- Obstetric fistula: guiding principles for clinical management and programme development (WHO, 2006).
- WHO recommendation on duration of bladder catheterization after surgical repair of simple obstetric urinary fistula (WHO, 2020)
- Not on pause: Responding to the sexual and reproductive health needs of adolescents in the context of the COVID-19 crisis (UNFPA, 2020)
- ASRH Tool Kit for Humanitarian Settings (Inter-agency working group, 2020)

4 PROVISION OF ANTENATAL, INTRAPARTUM AND POSTNATAL CARE

RECOMMENDED ACTION – Maintain and modify

SPECIFIC MEASURES FOR DELIVERY OF SERVICES

- → Inform adolescents where and how to access maternal care through mass media and digital media where adolescents have access to them.
- → Consider using telemedicine for counselling and screening, including for risk factors known to be increased in the context of COVID-19 and to which adolescents may be particularly vulnerable (e.g. mental health conditions and gender-based violence) and the occurrence of danger signs.
- → Where comprehensive facility-based services are disrupted, (i) prioritize antenatal care contacts for pregnant adolescents, (ii) ensure that birth preparedness and complication readiness plans are adapted at each contact to consider changes to services and (iii) prioritize postnatal care contacts during the first week after childbirth.
- → Put in place targeted outreach strategies where coverage and care-seeking among pregnant adolescents have declined.

For further recommendations see UNFPA Technical Brief package on facility-based maternity service delivery and phone-based antenatal and postnatal care during the COVID-19 pandemic.


The pregnancy is progressing well. Everything is in order. Now I would like to discuss with you about planning and preparing for the birth
Thank you for raising this. We are worried about this because of the night curfews

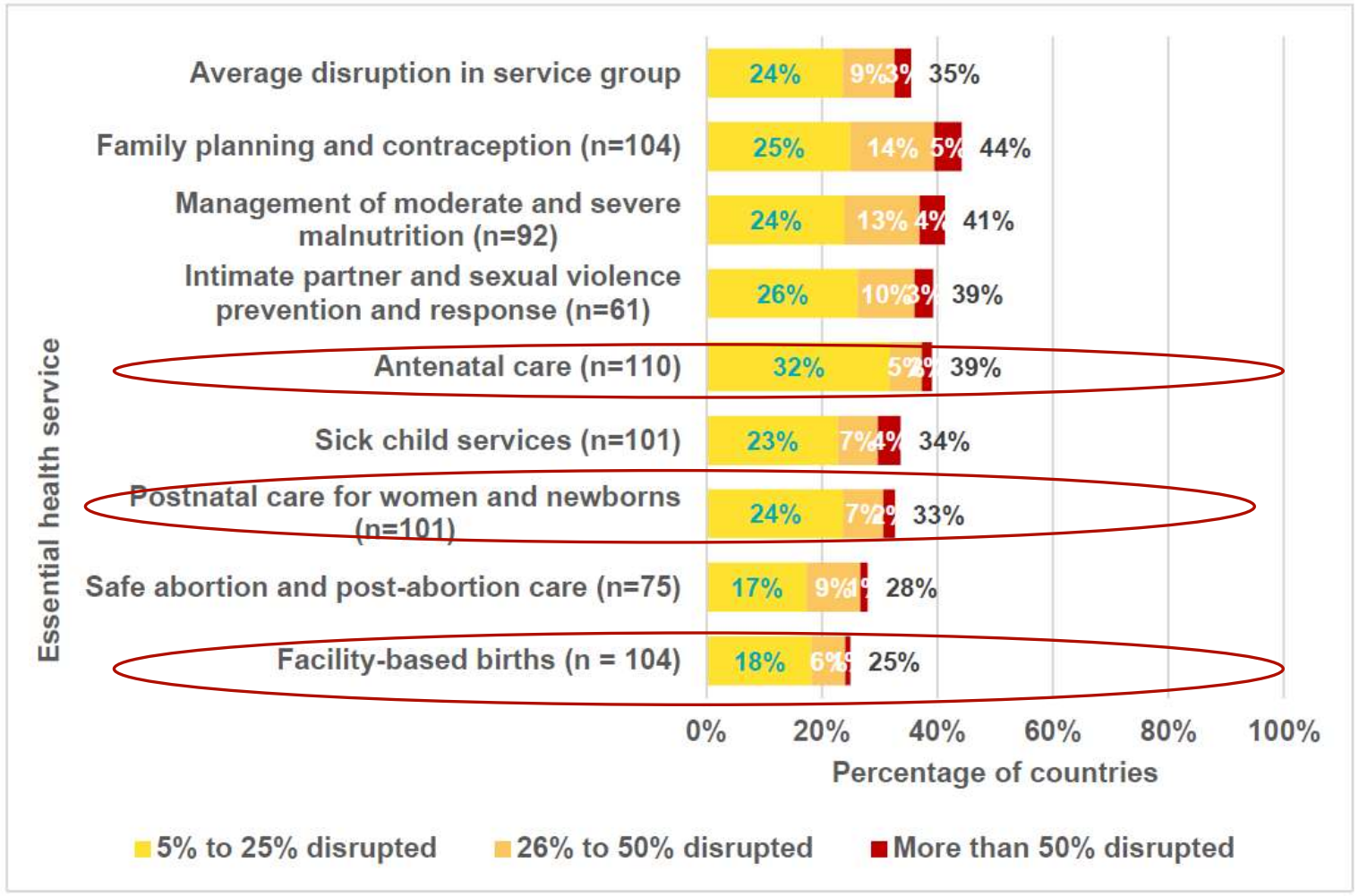
Effect of COVID-19 on maternal health services

- **Lancet systematic review and meta-analysis assessed the effects of COVID-19 on maternal, fetal, and neonatal outcomes of the pandemic. The review found the following:**
- Significant increase in stillbirth (pooled OR 1·28 [95% CI 1·07–1·54] during vs before the pandemic
- Significant increase in maternal death (1·37 [1·22–1·53)] during vs before the pandemic
- Postnatal depression scores were higher indicating poorer mental health, during versus before the pandemic
- Surgically managed ectopic pregnancies were increased during the pandemic (OR 5·81 [2·16–15·6]

Source: Chmielewska B, Barratt I, Townsend R, Kalafat E, Meulen J van der, Gurol-Urganci I, et al. Effects of the COVID-19 pandemic on maternal and perinatal outcomes: a systematic review and meta-analysis. Lancet Glob Health. 2021 Jun 1;9(6):e759–72.

Effect of COVID-19 on services

Figure 9: Percentage of countries reporting disruptions in reproductive, maternal, newborn, child and adolescent health and nutrition services



Source:
World Health Organization. Second round of the national pulse survey on continuity of essential health services during the COVID-19 pandemic: interim report, 22 April 2021. World Health Organization; 2021.

Maternal health in humanitarian contexts

- Two-thirds of preventable maternal deaths and 45% of newborn deaths take place in countries affected by recent conflict, natural disaster, or both. Emergent humanitarian settings and situations of conflict, post-conflict, and disaster significantly hinder the progress of maternal and newborn mortality reduction.
- In such situations, the breakdown of health systems can cause a dramatic rise in deaths due to complications that would be easily treatable under stable conditions.
- Most maternal and neonatal deaths in humanitarian settings occur around the time of labor, delivery, and the immediate postpartum period and the "day of birth" is the most dangerous with more than 40% of maternal and newborn deaths and stillbirths occurring in the first 24 hours after birth.

Source: Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings 2018.

ANTENATAL, INTRAPARTUM, POSTNATAL CARE

A REGIONAL PERSPECTIVE

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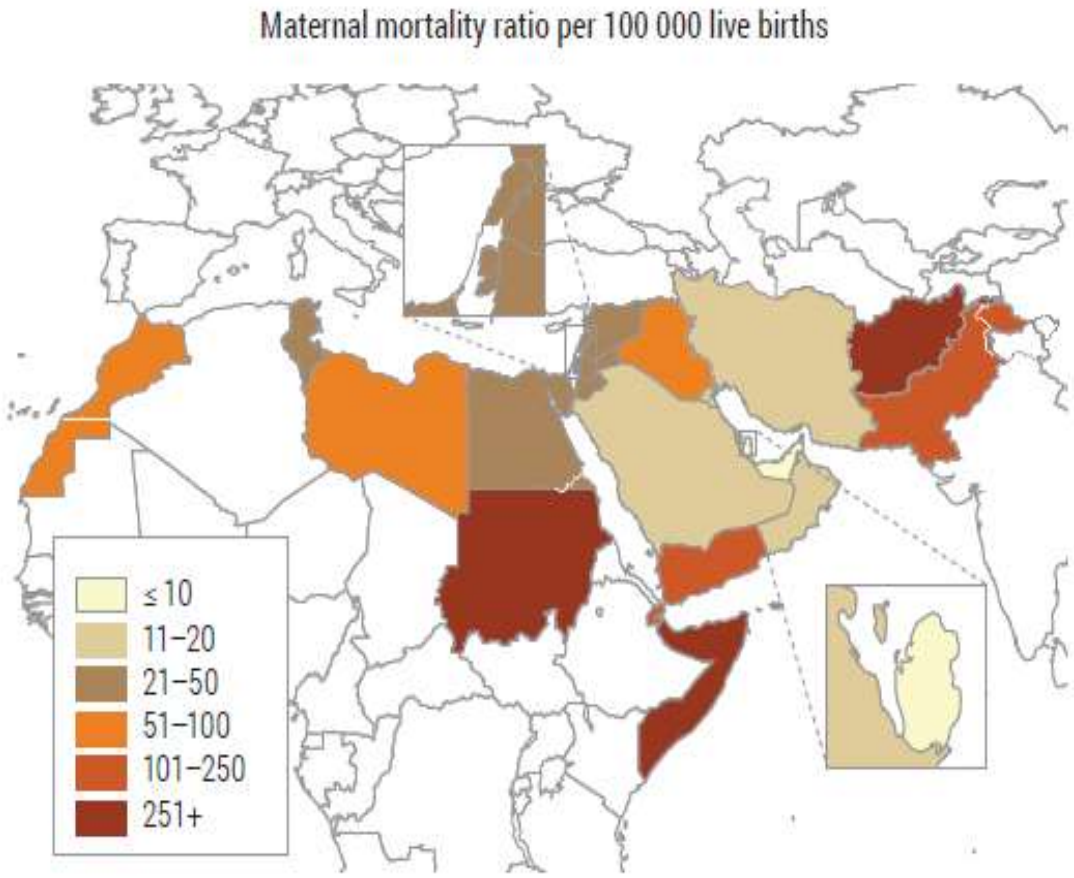
Maternal Mortality Ratio/ 100,000 live births

- **EMR** has the second highest MMR globally
- **Somalia** has the highest MMR (829/100,000 LB)
- **Afghanistan** is next (638/100,000 LB)



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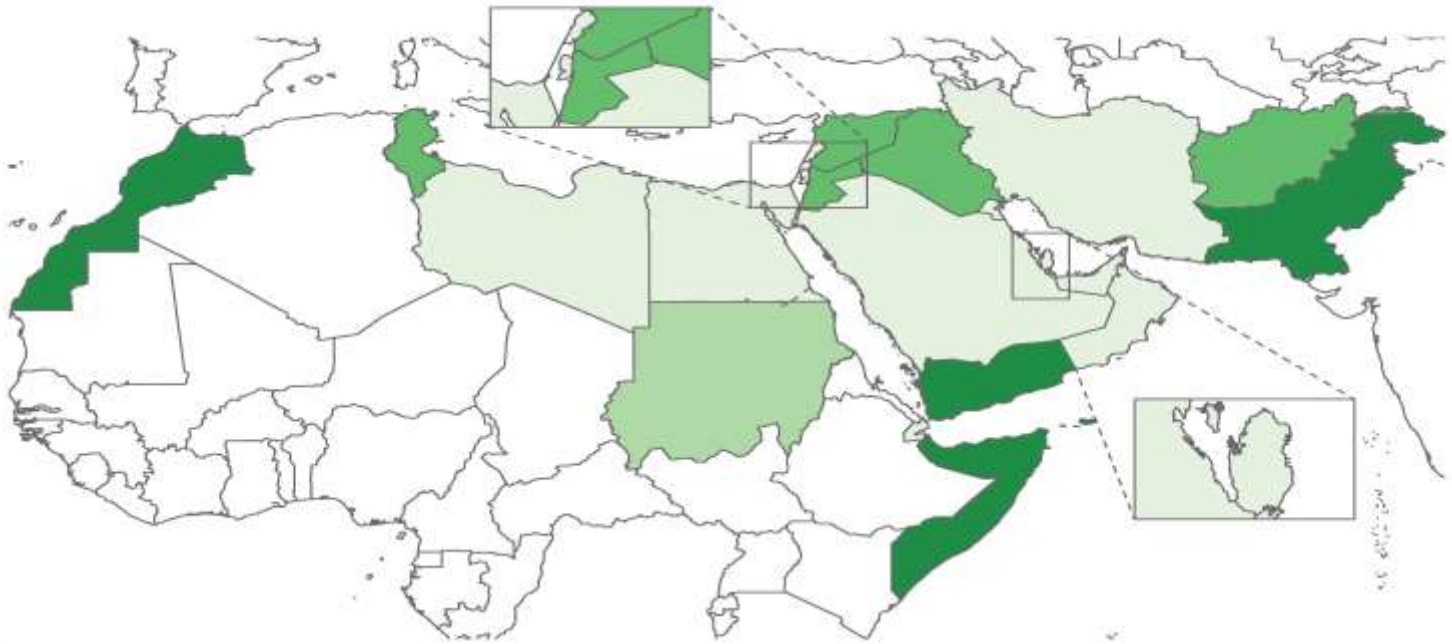
Maternal conditions as leading cause of mortality among female adolescent 15-19 years [1]



Countries with maternal conditions as number one cause of death

Countries with maternal conditions as number two cause of death

Countries with maternal conditions as number three cause of death

Countries where maternal conditions are not among the top 5 causes of death

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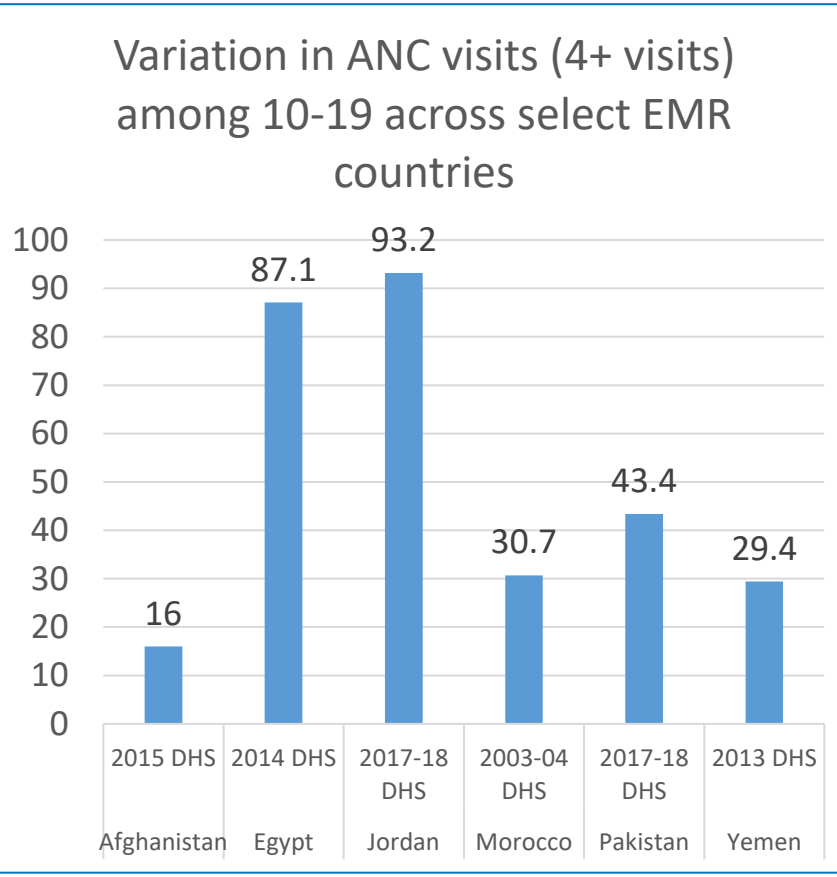
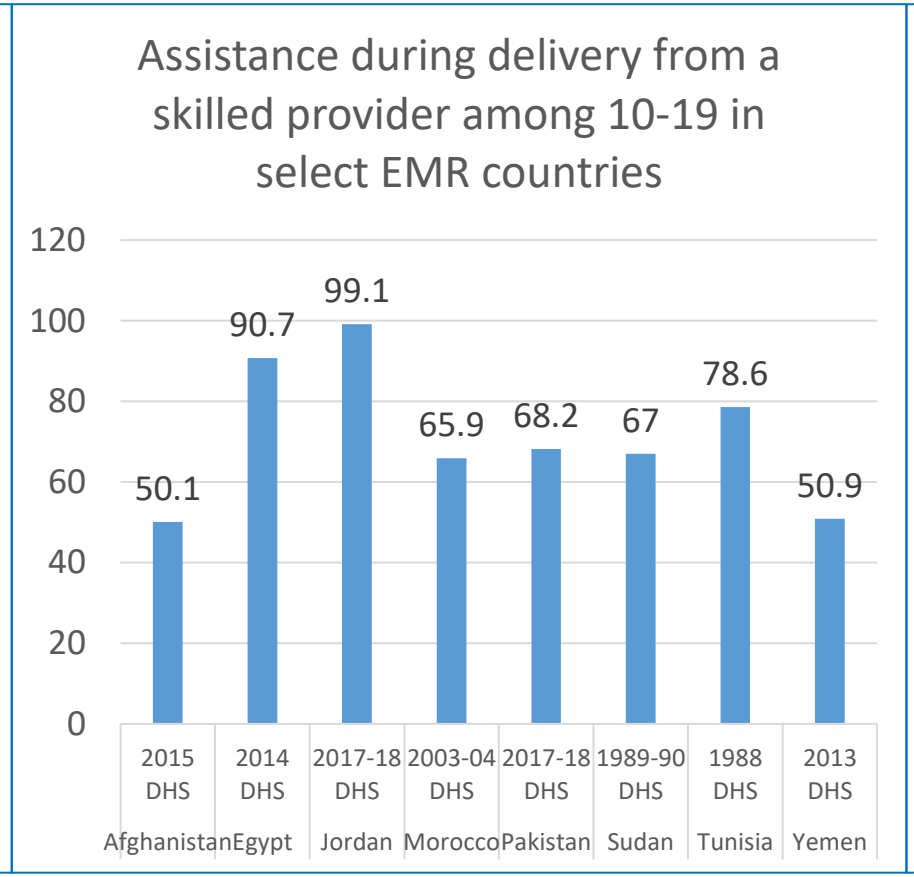
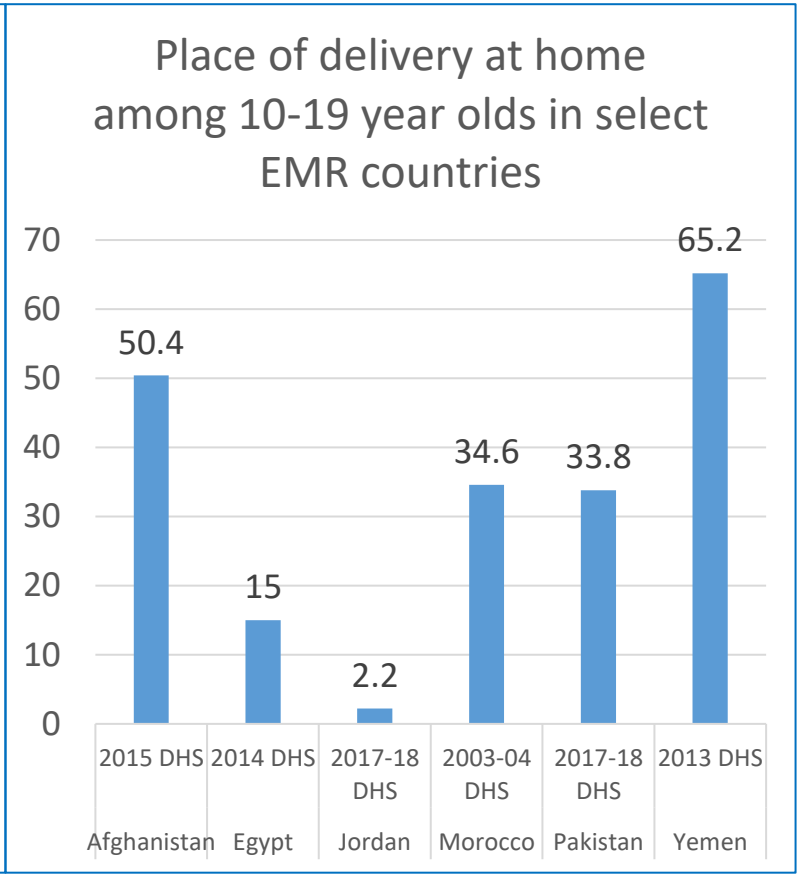
Maternal health indicators in EMR countries







Source: STATCompiler

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Regional- Key indicators

- **Legal and policy support for maternal health services**

I. 15/16 surveyed countries have **national policies on antenatal and postnatal care for mother and newborn**.[1]
II. 15/16 countries have the **policy regarding the right of every women to access skilled birth attendance.**[2]
III. Somalia is the only country that does not have policy for the provision of these health services.

Determinants of maternity care in the region: the case of Afghanistan

- ***Current status and determinants of maternal healthcare utilization in Afghanistan: Analysis from Afghanistan Demographic and Health Survey 2015 :***
- Aimed to assess current status of the utilization of maternal healthcare in Afghanistan and factors associated with it

Sociodemographic Characteristics	Total		ANC*		SBA**		CS***	
	Number	%	Number	%	Number	%	Number	%
Women's age (years)	**19,642**	**100.0**	**3494**	**17.8**	**10,530**	**53.6**	**665**	**3.4**
15–19	856	4.4	155	18.1	464	54.2	35	4.0
21–24	4962	25.3	914	18.4	2861	57.7	128	2.6
25–29	5609	28.6	968	17.3	2982	53.2	203	3.6
30–34	3466	17.6	602	17.4	1774	51.2	94	2.7
35–39	2975	15.1	550	18.6	1619	54.4	133	4.5
40–44	1149	5.8	193	16.9	537	46.7	45	3.9
45–49	625	3.2	112	17.8	293	46.9	27	4.4

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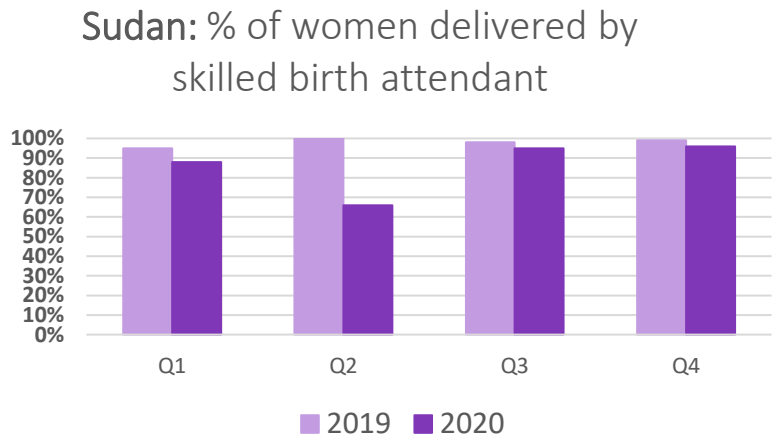
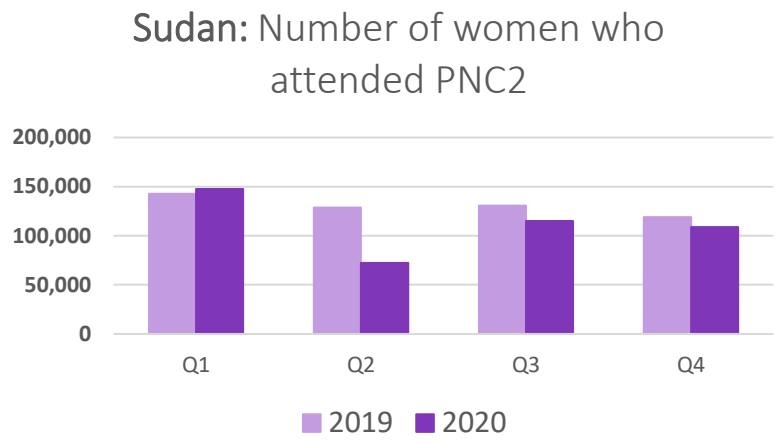
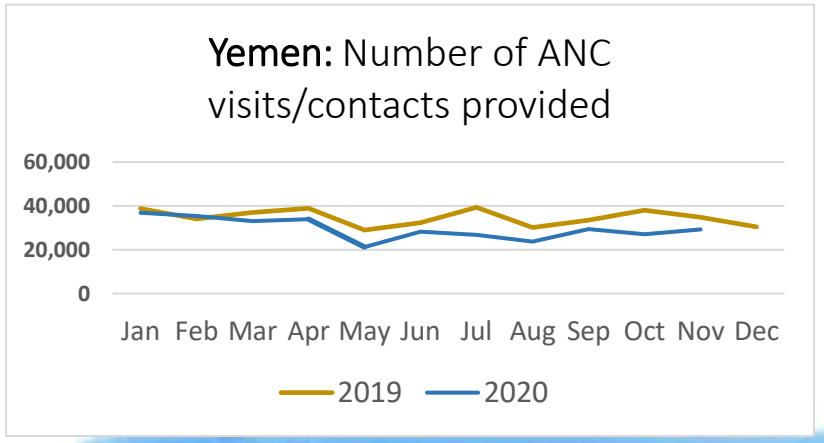
Education (of girl and husband), wealth, access to transportation, urbanity and autonomy (defined as ability to decide alone or jointly with their husbands about how to spend the husband's earnings) powerful factors

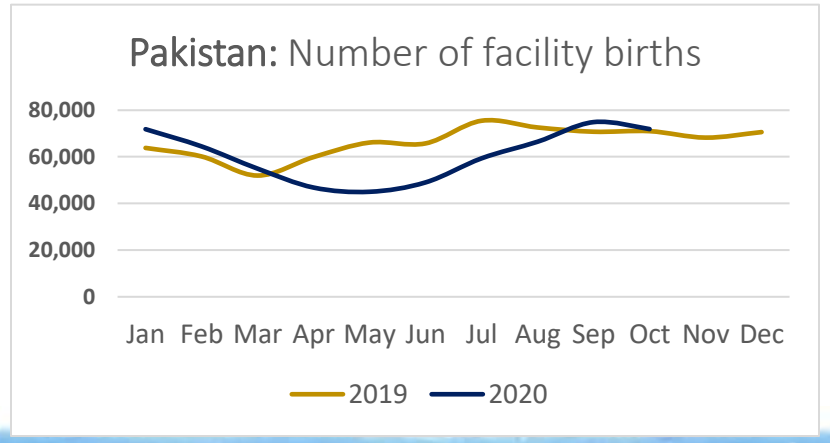
- Compared to women with no formal education, women with the highest educational level were almost 4 times more likely to receive ANC, 13 times more likely to deliver with a skilled birth attendant and more than 2 times more likely to deliver by CS
- Compared to the poorest women, the richest were 3 times more likely to receive more ANC, 11 times more likely to deliver with a skilled birth attendant, and two times more likely to deliver by CS.
- Women with decision-making authority on how to spend their husband's earnings were two times more likely to have four or more ANC visits, 1.3 times more likely to deliver by an SBA and 1,4 times to deliver through CS than women with no such autonomy.

Effect of COVID-19 on coverage of maternal health services in selected countries in EMR









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Maternal health in humanitarian contexts: the case of Syria

- ***Responding to health needs of women, children and adolescents within Syria during conflict: intervention coverage, challenges and adaptations (Akik et al)***
- Aimed to assess intervention coverage indicators and implementation challenges inside Syria during conflict.

- **Lack of prioritization of adolescent-health services**
- **Insecurity:** Movement was limited due to insecurity and attacks on health facilities which prevented care seeking
- **Shortage of specialized healthcare providers:** Task-shifting, done by training "general practitioners, surgeons, nurses and midwives to fill the gap in specialized healthcare workers (mainly obstetricians/gynaecologists)"
- **Procurement restrictions**
- **Problems with MISP and other life-saving interventions:** While MISP was prioritized, it was resisted by Syrians at first because there was a pattern of by-passing primary services that existed before the war. Specialist visits were instead the first point of contact.

> *"[There were] several restricted items, […] mainly the ketamine, which had direct influence on reproductive health. This is an anesthetic, […] and it's preferred in surgeries and maybe caesarean sections, so with high rates of C-sections that we had in the South, […] mostly if [ketamine is] available, it's from the local black market with very questionable quality."* (R01).

Regional initiative 1:
Advocacy campaign in Pakistan

In Feb 2012 CARE (Leading humanitarian and development organization) Pakistan started the project titled:

"Advocating for improved maternal newborn health (MNH) and sexual reproductive health (SRH) policy and practice for adolescent girls and young mothers (AIMS)"

The 14 months project was Implemented in partnership with Rahnuma-Family Planning Association of Pakistan (FPAP).

- **Aim**
  - To increase awareness regarding the specific reproductive and sexual health needs of adolescent girls and young mothers.
  - To advocate for their inclusion in provincial health policies in four provinces of Pakistan.

- **Outcomes**
  - A robust advocacy strategy was designed.
  - Advocacy campaign was planned for Federal and provincial levels.
  - Various key stakeholders of MNH & SRH were willing to accept their responsibilities for ensuring a supportive environment for youth.

Regional initiative 2:
Improving maternal and neonatal health in Sudan
Oct 2011 - Dec 2012 [1,2]

A community-based intervention project implemented in Kassala Town and Rural Kassala localities, covering the catchment communities of 19 PHCUs.

- **Objectives**

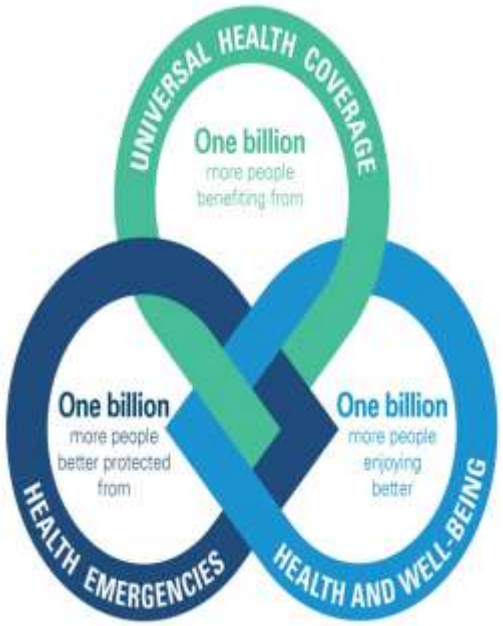
Strengthening Primary Health Care and Community Mobilization to contribute to improved health and wellbeing of mothers, newborns and their families.

- **Outcomes**

- Enhanced the capacity of the PHUs with training of staff and providing supplies.
- The introduction of the referral fund to cover the cost of the antenatal and other maternity care services.
- Community mobilization through establishment of networks and channels to reach discrete audiences at their residential areas through women as an “agent” of change.
- Continuity of supply of family planning methods.

Regional opportunities

Regional alignment with Global Initiatives/Guidance



- **Global strategy for women, children, and adolescents** [1]

It is an opportunity for the countries to integrate ASRH interventions to achieve the global target of reducing MMR to less than 70/100,000 LB (SDG 3.1). The plan is to strengthen the healthcare delivery system, improve skills of health workers on early detection and management of complications in pregnancy and delivery.[2]

- **Adolescent Health in All Policies (AHiAP)** [3]

It is a strategy to consider the implications of decisions on adolescent health, avoid harmful effects and seek synergies. It facilitates the formulation of adolescent-responsive public policies in sectors other than health.

- **Vision 2023 Health for All by All** [4]

Universal health coverage: inclusion of ASRH evidence-based interventions in the regional priority benefit package. [5]