The Skilled Care Initiative

TECHNICAL BRIEF

June 2005

THE ENABLING ENVIRONMENT: ASSESSING QUALITY AND AVAILABILITY OF SKILLED CARE

INTRODUCTION

Although effective maternal health interventions are well-known, the challenge is to scale them up to universal coverage in resource-constrained settings. Family Care International's Skilled Care Initiative (SCI) is a multi-faceted, five-year project designed to increase the coverage and use of skilled care in resource-poor settings. Begun in mid-2000 with funding from the Bill and Melinda Gates Foundation, the project is being implemented in four rural, underserved districts in Burkina Faso, Kenya, and Tanzania, and focusses specifically on skilled care as a strategy for reducing high rates of maternal mortality and morbidity.

"Skilled care" refers not only to the presence of a skilled provider at the time of birth, but to a system-wide approach that ensures that a woman and her infant receive appropriate, high-quality care throughout pregnancy, childbirth, and the immediate postpartum period. The condition of health care facilities—including equipment, supplies, and infrastructure—is a critical determinant of whether health care workers are able to provide this care. A supportive policy and regulatory framework; adequate supplies, equipment, and infrastructure; and an efficient system of communication, transportation, and referral are all necessary components of an enabling environment for skilled care.

SAVING WOMEN'S LIVES: THE SKILLED CARE INITIATIVE (SCI)

The Skilled Care Initiative aims to ensure that all women have access to high-quality, skilled care so that pregnancy-related problems can be detected and treated before they become fatal. The Initiative is working in selected districts in Burkina Faso, Kenya, and Tanzania to:

- **strengthen** government commitment and policies to increase skilled care during childbirth,
- **improve** provider performance through training and supervisory support for midwives and other skilled health professionals,
- **provide** essential equipment and supplies along with inputs to strengthen routine maintenance and resupply,
- **reinforce** linkages for referral, and
- **increase** utilisation of services by supporting behaviour change interventions in the community.

The skilled care approach aims to improve maternal health services where women can most easily access them and where the need is greatest—in the health centres and dispensaries closest to women. This technical brief reviews the elements of the enabling environment that are critical for the provision of skilled care, and provides an overview of FCI's methodology for assessing the quality and availability of skilled care. The brief also summarises baseline findings from FCI's intervention districts.

THE ENABLING ENVIRONMENT FOR SKILLED CARE

The World Health Organization (WHO) has identified the procedures and services that should be available at each level of the health system for maternity care:

- **At the dispensary level:** basic maternal health services, including the provision of obstetric first aid (such as the administration of antibiotics and sedatives, and the injection of anticonvulsants);
- **At the health centre level:** basic essential obstetric care (BEOC), including the administration of oxytoxics and antibiotics, assisted normal delivery,[1] manual removal of the placenta, and vacuum aspiration to treat complications from incomplete abortion; and
- **At the hospital level:** comprehensive essential obstetric care (CEOC), including BEOC as well as blood transfusion, intravenous antibiotics, and Caesarean section.

Actual provision of these services requires not only skilled attendants but also **essential equipment, supplies, and drugs**, which need to be incorporated into a country's essential drugs list. A functioning system of supply should also be in place, and skilled birth attendants need to be authorised to use the necessary equipment and drugs to perform life-saving interventions. Facilities must have basic services

THE ENABLING ENVIRONMENT BEYOND HEALTH FACILITIES

While this paper focusses on the enabling environment at the health facility level, for skilled care to be offered and used on a sustained basis requires other key elements as well, including:

- Political commitment to increasing access to skilled care, including the **development of long-term strategies** and their consistent implementation. The strategies should define realistic targets for training and deploying skilled attendants, supported by specific activities and budgetary allocations. For the purpose of programme design and human resource planning, the International Confederation of Midwives (ICM) and the International Federation of Gynaecology and Obstetrics (FIGO) propose a target of one person with midwifery skills per 5,000 people; if a crude birth rate of 40 per 1,000 is assumed, this target would translate into one skilled attendant per 200 births per year.[2]
- The **establishment of policies, laws, and regulations** that authorise skilled health providers at all levels (primary to referral) to perform essential life-saving interventions. Traditionally, in many settings mid-level providers such as midwives were not trained or authorised to perform some of the procedures required of a skilled attendant, including the management of complications of incomplete abortion, vacuum extraction, and various manual procedures. However, experience and evidence from a variety of contexts has helped forge a global consensus that with appropriate training, equipment, supplies, and support, midwives can safely and competently perform these life-saving procedures. In view of the shortage of physicians in most developing country settings—as well as their concentration in urban areas far from the communities where the majority of women live—there is a clear rationale for promoting the role of skilled attendants and strengthening health systems to ensure that skilled care is available and accessible for all women.
- **Behaviour-change communication (BCC)** interventions are critical in helping women and communities recognise the importance of skilled care during childbirth, understand when a higher level of care in needed, and plan for delivery by setting aside funds and making other preparations. Financial barriers to emergency care should also be addressed, for example, by establishing community loan funds.

Papers describing SCI interventions to improve the enabling environment can be accessed through FCI's website: www.familycareintl.org.

[1] N.b., forceps or vacuum extractor.
[2] World Health Organization. *Human Development for Maternal Health and Safe Motherhood Services*. Geneva: WHO, 1990.

such as electrical power, clean water, and sanitation facilities.

Also essential are **systems of communication, transport, and referral** so that all women with complications can access emergency obstetric care in a timely manner. Effective communication mechanisms can include the use of telephone or radio for consultations and referral, while prompt transport to referral facilities can be via ambulance or through community–health system partnerships.

A nurse at the district hospital in Igunga receives a call on the radio.

ASSESSING QUALITY AND AVAILABILITY OF SKILLED CARE: FCI'S EXPERIENCE

As a basis for developing locally-responsive interventions, FCI assessed the enabling environment in the SCI districts. This paper focuses on the health systems findings. The assessment of provider knowledge and skills is described in the SCI paper, *Which Childbirth Attendants are "Skilled"?: Assessing Provider Skills*.

Various international agencies have developed methodologies and tools for assessing the quality and availability of maternal health care, including the Population Council, Unicef, WHO, and Columbia University. To conduct the baseline survey for the Skilled Care Initiative, FCI adapted WHO's Safe Motherhood Needs Assessment methodology. The WHO methodology was selected as a point of departure for two reasons. First, it covers the entire spectrum of maternal health care and safe motherhood. Second, it prioritises the collection and analysis of data by district, reflecting the district's role as the central unit for organising, funding, and providing basic health services and for linking families and communities with the health system.

Drawing on our extensive experience in conducting similar assessments in various contexts, FCI modified the WHO instruments to focus specifically on skilled care, integrated some items from the other tools referenced above, and developed new questions to assess providers'

THE SCI EVALUATION STRATEGY

SCI includes a rigorous evaluation strategy to assess the project's overall effectiveness, with the goal of generating evidence-based strategies for implementing skilled care in rural, developing-country contexts.

The quasi-experimental pre-test/post-test evaluation design consists of the following elements:

- A survey of health facilities in the project districts on the quality, availability, and utilisation of maternal health services.
- A household survey to collect information on the use of skilled care at delivery, and knowledge, attitudes, and care-seeking behaviours during pregnancy and childbirth.

In Burkina Faso and Tanzania, one intervention and one comparison district were selected. In the intervention districts, FCI is working to improve maternal health services in facilities and to influence health-seeking behaviour through a behaviour-change component that mobilises women, families, and the broader community. The comparison district receives no intervention.

In Kenya, in one district the "full" intervention package is being implemented, including both facility-based service improvements and community-mobilisation interventions, while in the other district only interventions to improve facility-based services are being implemented.

knowledge, skills, and training; staff supervision; record-keeping; and logistics. The full set of survey instruments included[3]:

- **Structured interviews with district health management teams** to collect information about the management of maternal health services, as well as the number, categories, and training of available health personnel; the availability of emergency transport for referral; and health education and communication activities.
- **Facility management surveys** to gather detailed information on available maternal health services, as well as the physical infrastructure and management structure of each facility, including equipment, consumable supplies and medicines, and capacity to provide essential obstetric care or to refer complicated cases.
- **Reviews of facility records** to gather information on antenatal attendance and delivery care; the type, number, and management of obstetric complications; the number of Caesarean sections performed, maternal and neonatal deaths, and stillbirths; and the provision of family planning services.
- **Interviews with midwifery personnel** to collect data on the number, qualifications, training, supervision, and practices of those providing delivery care at each health facility.
- **Exit interviews with antenatal and postpartum clients** to assess the content and quality of available services, as well as knowledge about signs of complications.

DISTRIBUTION OF HEALTH PERSONNEL IN OUARGAYE DISTRICT

WHO suggests the following distribution of health personnel:

- Physicians: 1 per 10,000 population
- Pharmacists: 1 per 20,000 population
- Nurse-midwives: 1 per 5,000 population
- Registered nurses: 1 per 5,000 population
- Technical/enrolled nurses: 1 per 1,000 population
- Auxiliary midwives: 1 per 1,000 population

Ouargaye district had:

- 1 physician per 213,690 population
- 1 registered midwife per 106,845 population
- 1 nurse (all types combined) per 8,361 population
- 1 auxiliary midwife per 26,444 population

The questionnaires were translated into French for use in Burkina Faso and into Swahili for use in Tanzania. In Kenya, the questionnaires were administered in English.

In each country, FCI worked with local partners (the Ministry of Health in both Burkina Faso and Kenya, and the Institute of Public Health in Tanzania) to implement the study. Health care providers (nurse/midwives and others) from other districts were hired as surveyors, so that no surveyor would be responsible for reviewing sites in her or his own district. Staff from FCI and partner organisations served as data collection supervisors.

Surveyors participated in intensive five-day training courses. Questionnaires were pre-tested in neighbouring districts (outside the study area). Data were then collected in each of the three countries in September and October 2001.

Data were entered using Epi-Info version 6, with a double-entry system to improve accuracy. Data analysis was then carried out using either Epi-Info or SPSS version 10.0; general frequencies of all the variables were generated, and specific variables were cross-tabulated by district and facility type.

The sampling framework varied slightly by district. In Burkina Faso and Tanzania, all health facilities provide maternal health services and were sampled. In Kenya, where many dispensaries do not nominally provide care for normal deliveries and where more than 100 private clinics existed in one district, a purposive sampling frame was designed to maintain a feasible sample size. Table 1 summarises the sample.

ASSESSMENT FINDINGS

The facility assessment illuminated weaknesses that constrained the provision of skilled care in the SCI project districts. Although all levels of the health system were found to be deficient, mid- and lower-level

[3] The full set of instruments can be downloaded in English, French, and Swahili from the FCI website: www.familycareintl.org

health facilities faced particularly severe gaps that substantially reduced their capacity to provide skilled care. Key findings related to infrastructure and staffing are reviewed below, followed by a discussion on the capacity and readiness of health facilities to provide skilled care throughout pregnancy, childbirth, and the postpartum period, and to manage obstetric complications. The findings discussed in this paper focus on the material resources needed to provide skilled care, as opposed to provider skills and competencies, which are described in another SCI technical brief, *Strengthening Provider Competencies and Performance in Skilled Care*.

CAPACITY OF THE HEALTH SYSTEM

In all three countries, the **basic health system infrastructure** was weak and in need of rehabilitation. A number of health facilities in the project districts were found to have structural problems (e.g., cracked walls and floors, leaking roofs, bat-infested ceilings, etc.). In addition, essential resources required for the delivery of basic health services and adherence to universal precautions for infection prevention—such as reliable sources of running water—were not universally available, even at some of the hospitals where patients needing comprehensive essential obstetric care are referred. In Kenya and Burkina Faso, for example, only one-quarter of facilities surveyed had a reliable source of water; in Tanzania, only 15% of sites had access to running water. Wells and roof catchment systems were found to be the most common sources of water, and thus for many sites with inadequate water storage, water was extremely scarce during dry seasons. In Kenya, at some sites clients must bring their own water at certain times of the year.

The majority of mid- and lower-level health facilities did not have electricity (i.e., were not connected to the national grid) or another power source, making it a challenge to conduct deliveries at night, as well as

TABLE 1: TOTAL NUMBER OF FACILITIES SURVEYED, BY COUNTRY AND FACILITY TYPE

COUNTRY	FACILITY LEVEL	NUMBER OF FACILITIES [PERCENTAGE SAMPLED OF TOTAL SITES IN DISTRICT(S)]
BURKINA FASO (OUARGAYE DISTRICT)	Hospital	1
	Health Centre	18
	Dispensary	1
	TOTAL	**20 (100%)**
KENYA (HOMABAY DISTRICT, MIGORI DISTRICT)	Hospital	5
	Health Centre	21
	Dispensary	10
	Clinics/Nursing Homes	4
	TOTAL	**40 (42.6%)**
TANZANIA (IGUNGA DISTRICT)	Hospital	2
	Health Centre	5
	Dispensary	27
	TOTAL	**34 (100%)**

to properly decontaminate or sterilise medical equipment and instruments. Many facilities were reliant on kerosene lamps. A few in each country had solar power or an electric generator.

In all three countries, emergency communications and transportation systems were not functioning well, making it difficult for district health systems to perform effectively and to ensure that patients received higher levels of care when needed. Most hospitals had ambulances available; however, there were no communications systems in place to allow mid- and lower-level facilities to contact the hospitals to request an ambulance for a patient requiring advanced care. Only 9% of sites in Tanzania, 18% in Kenya, and 15% in Burkina Faso had a working telephone or radio transmitter. All other facilities relied on motorcycles or public transport to convey individuals needing higher-level care to a referral centre.

The staffing shortages that are pervasive throughout sub-Saharan Africa were also severe in the SCI project districts. No sites met their respective national norms for staffing levels, even for mid- and lower-level cadres. For example, less than half of the established nurse/midwife positions were filled in Tanzania. Higher-level cadres, such as physicians, were in especially short supply, as were staff with specialised skills, such as anaesthetists and pharmacists. Obstetrician/gynaecologists were absent in Burkina Faso and virtually so in Kenya and Tanzania. In Kenya, only three of 10 public-sector posts for physicians were filled at the time of the survey, and there were an additional 20 vacancies for physicians at private and mission facilities. Similarly, in Tanzania, there were only two physicians available to provide services for the entire district. In Burkina Faso, the project district had one physician, but he was not trained to provide Caesarean section or other surgical interventions.

READINESS AND CAPACITY TO PROVIDE SKILLED CARE

The postnatal ward at Igurubi Health Centre in Tanzania

As noted earlier, skilled care refers to a continuum of care from pregnancy through childbirth and the postpartum period. The baseline assessment explored the capacity of each level of the health system in

the project districts to provide this continuum of care, identifying gaps and priority steps for making services available and accessible to women, and as close as possible to where they live.

Antenatal care: Antenatal care was provided by all facilities surveyed in the three countries; however, interviews with maternity care providers and clients, as well as reviews of required equipment and commodities, highlighted areas where interventions were needed to ensure that essential diagnostic functions and preventive measures were routinely provided to pregnant women. For example, basic equipment, such as working blood pressure gauges, stethoscopes, and adult weighing scales were missing at many health facilities or were not available in the MCH clinic or unit where antenatal check-ups are performed. Particularly severe at mid- and lower-level facilities where the majority of antenatal clients are seen, these equipment gaps made it difficult for providers to monitor pregnancy and detect problems, such as pregnancy-induced hypertension.

Although tetanus toxoid vaccines were available at the majority of facilities in Kenya and Tanzania and about half of those in Burkina Faso, essential consumable supplies, such as iron/folate supplements, urine dip sticks, reagents for syphilis testing, malaria prophylaxis, and client education materials on birth preparedness and obstetric complications were not available at many facilities in the three countries. Without these supplies, antenatal care providers reportedly focused on taking clients' pregnancy history, conducting the pallor test to detect anaemia, and performing abdominal examinations—suggesting that important opportunities to promote maternal health and to detect complications early were being missed.

Maternity services in general, and antenatal services in particular, are in a unique position to respond to the HIV epidemic, offering excellent opportunities to educate women and their families about prevention as well as to facilitate their access to voluntary counselling and testing, prevention of mother to child transmission (PMCT) services, and treatment and care for infected women and their families. Yet the assessment found that no facilities in Burkina Faso and only two in Tanzania had HIV test kits; in Kenya 17% of facilities had kits. PMCT services were available at one site in Kenya but were unavailable in the Burkina and Tanzania districts at the time of the assessment.

NORMAL DELIVERY CARE

Achieving national and international targets for skilled care during childbirth requires that normal delivery care be available as close as possible to where women live. Ideally, such services should be available at all levels of the health system to minimise the distances women must travel when labour begins.

FCI's baseline assessments revealed many gaps that needed to be addressed—particularly at front-line facilities—to strengthen their capacity to provide normal delivery care. For example, while all hospitals were equipped to provide normal delivery care, many mid- and lower-level facilities were lacking essential equipment, such as a delivery bed, adequate lighting, and complete delivery kits. Dispensaries were particularly ill-equipped, especially in Kenya where these facilities nominally provide delivery care on an emergency basis only. As a result, at some dispensaries, staff conducted deliveries on the floor.

Essential drugs and supplies for delivery care were also missing at many facilities, indicating that logistics systems for obstetric care were not functioning well (Table 2). These gaps were particularly severe in Burkina Faso. Although most facilities in each country had basic items, such as gloves and syringes, other supplies such as blank partograph forms, oxytocic drugs, suturing materials, and cord ties were not universally available. As a result, maternity care providers were unable to adhere to recommended practices, such as monitoring labour progress and actively managing the third stage of labour, which can prevent haemorrhage.

TABLE 2: PERCENTAGE OF SITES WITH BASIC EQUIPMENT FOR NORMAL DELIVERIES

	BURKINA FASO	KENYA	TANZANIA
Delivery set (cord scissors, cord clamps, etc.)	15	60	35
Blood pressure apparatus	35	73	79
Stethoscope	55	85	84
Foetal stethoscope	85	85	89
Adult weighing scale	35	75	53
Infant weighing scale	25	77	71
Thermometer	50	68	84
Suture needles and material	10	40	59
Blank partographs	15	18	36
Sterile packing material or sterile sanitary pads	0	33	12
Oxytocics (Ergometrine)	75	60	56

Supplies for infection prevention were also inadequate, raising concerns about skilled attendants' ability to adhere to universal precautions to protect both themselves and their clients from HIV and other infections. Ten percent of sites in Burkina Faso, 20% in Kenya, and 35% in Tanzania lacked disposable gloves; many sites required clients to purchase their own. Most sites lacked the solutions—bleach, iodine, chlorhexidine—needed to decontaminate medical equipment and to clean rooms and surfaces where clinical services are provided. One particularly troubling finding was that chlorine bleach, an essential disinfectant and decontaminant, was only available in 15% of Tanzanian facilities. Even soap was in short supply; one out of four facilities in Tanzania had no soap available. Findings were similar in other districts; for example, in one of the project districts in Kenya, less than two-thirds of facilities (59%) had bleach solution, and only half had soap.

CAPACITY TO MANAGE OBSTETRIC COMPLICATIONS

About 9–15% of pregnant women develop serious obstetric complications, and all levels of the health system should be sufficiently equipped to be able to diagnose and manage these complications, or to refer them, as appropriate, for advanced care. In assessing the readiness of health facilities to manage obstetric complications, FCI emphasised the identification of gaps at lower-level facilities as part of a strategy to decentralise services to the lowest level that could provide them safely and appropriately.

The facility assessment showed that much needed to be done to furnish facilities in the project districts with the equipment and tools to diagnose obstetric complications and provide essential life-saving interventions (see Table 3). As noted earlier, essential equipment for monitoring maternity patients and detecting complications, such as blood pressure cuffs, stethoscopes, foetoscopes, etc., were not universally available. Similarly, many facilities were missing equipment required for performing life-saving procedures. For

example, although most hospitals[4] were equipped to provide assisted delivery and to perform Caesarean section for cases of obstructed and prolonged labour, most mid-level facilities could not augment labour or provide assisted delivery (using vacuum extraction or obstetric forceps). This gap was not surprising given that national guidelines and norms in the countries do not stipulate that these services be provided at mid-level facilities.[5] Similarly, the data also showed that few facilities were equipped to manage complications of abortion or miscarriage. Dilatation and curettage kits were available at some hospitals, but manual vacuum aspiration equipment for treating incomplete abortion was not available at any sites (hospitals included) in Burkina Faso or Tanzania; availability in Kenya was slightly better (15% overall).

Essential drugs and supplies for stabilising emergency cases and managing complications were also lacking (see Table 3). For example, half to three-quarters of the facilities surveyed did not have IV sets or rehydration solutions such as normal saline, Ringer's lactate, dextrose solutions. These gaps were particularly acute at mid- and lower-level facilities, which should be able to stabilise such patients before managing or referring them.

Drugs for preventing infection and managing sepsis were inadequate at all levels of the health system in all three countries. For example, broad-spectrum antibiotic regimens, such as a combination of ampicillin, gentamycin, and metronidazole, are routinely used to prevent infection when women present with early rupture of the membranes, prolonged labour, retained placenta, or abortion complications. While many facilities had some type of antibiotic drug, most were not able to provide an optimally effective combination. These gaps were particularly pronounced in Kenya and Tanzania. Other pervasive drug and supply gaps included anticonvulsant drugs for managing severe pre-eclampsia and eclampsia, analgaesics, and injectable oxytocin for augmenting labour. As with other drugs and supplies, these gaps were particularly acute at mid- and lower-level facilities.

TABLE 3: PERCENTAGE OF SITES WITH THE CAPACITY TO TREAT OBSTETRIC COMPLICATIONS

	BURKINA FASO	KENYA	TANZANIA
Amniotomy hook	15	13	6
Vacuum extraction equipment	0	15	6
MVA equipment	0	15	0
IV sets	25	50	53
Oxytocin (injection)	22	22	18
Broad-spectrum antibiotic regimens	60	28	21
Local anaesthesia	60	70	91
Anti-convulsants (Magnesium sulphate)	5	15	12
Analgaesics	5	18	12

[4] The district hospital in Burkina Faso and district hospital in one of the project districts in Kenya lacked surgical facilities, and thus had to refer patients needing C-sections.

[5] International standards for skilled attendance, on the other hand, recommend that vacuum extraction be available at the health centre level.

POSTPARTUM CARE

The period immediately after delivery is an important time for identifying and managing complications in mothers and newborns, and for providing contraceptive information, counselling, and services to women who want to delay or prevent subsequent pregnancies. Postpartum care does not require specialised equipment or supplies, other than basic items such as an examination couch, blood pressure gauge, speculum, and contraceptive commodities. Thus all facilities that provide antenatal care services should have the capacity to provide maternal postpartum care as well.

Community members in Migori stand on the foundation they have just built for a new water tank for their local dispensary.

In practice, however, FCI's facility assessments showed that in all three countries, postpartum care was one of the least available maternal health services—a finding that can largely be attributed to the fact that national service delivery guidelines related to postpartum care in the three countries have not traditionally emphasised the maternal side of the mother–baby dyad. Thus, although most women come to health facilities for newborn check-ups and examinations, their own health is rarely checked.

The majority of facilities in Kenya and Tanzania had the basic equipment (e.g., gynaecological examination tables and speculums) required for postpartum care; however, relatively few facilities in Burkina Faso had speculums (20%) or suitable facilities for examining new mothers (25%). In contrast, about three-quarters of facilities in all three countries had supplies of contraceptive pills, though other methods (e.g., injections, implants, condoms, IUDs, and permanent methods) were available in far fewer sites; condoms, for example, were out of stock in 88% of sites in Burkina Faso and 38% of Tanzanian sites, but were available in 78% of Kenyan facilities.

DISCUSSION

FCI's baseline assessments convincingly showed that the health system environment in the SCI intervention areas was not conducive to the provision of skilled maternity care—particularly at health centres and dispensaries that are closest to the rural communities where most women live. Health facilities were generally in poor condition and ill-equipped to offer the continuum of essential maternity care services. In addition, with treatment for obstetric complications confined to the hospital level, the overall health system was not being used rationally to maximise women's access to life-saving care. Exacerbating this problem, emergency communications and transportation systems were non-functional, making it difficult for mid- and lower-level facilities to ensure that women with complications could quickly reach sites where advanced care was available.

This study highlighted numerous immediate infrastructure and equipment gaps that FCI, in collaboration with district teams, has since addressed through SCI interventions. Efforts to upgrade and rehabilitate health facilities and furnish them with essential obstetric care tools are particularly critical at mid- and lower-level facilities, which could play a much larger role in the delivery of skilled care if appropriately equipped and supported. In addition, as described in another technical brief (see *The Enabling Environment for Skilled Care: A Health Systems Approach*), FCI is working to complement these investments with broader efforts to strengthen underlying systems that enable health facilities to function effectively and efficiently—such as logistics systems for obstetric drugs and supplies, record-keeping systems, supportive supervision, and quality improvement approaches. In implementing these strategies, FCI has sought to foster partnerships and to engender community involvement and local ownership of the health care infrastructure, which are essential for ensuring the long-term sustainability of short-term interventions to promote skilled care.

Endline facility assessments, to be conducted in the first half of 2006, will measure the impact of SCI interventions on the enabling environment and capacity for skilled care in the project areas.

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