



## Home Based Life Saving Skills *Where Home Birth Is Common*

Creators: S. Buffington, L. Sibley, D. Beck, D. Armbruster  
American College of Nurse-Midwives

**Home Based Life Saving Skills** is a family focused, community-based program to reduce maternal and neonatal mortality. It increases *access to basic life saving care* within the home and community. It *decreases delays* in reaching referral facilities where life-threatening problems can be managed. This is done through supporting *birth preparedness* and encouraging the *involvement of decision makers* in making *timely decisions*.

Although essential, it is not enough to only upgrade referral facilities and strengthen both technical and communication skills of trained health care providers. The education, motivation, cohesion and mobilization of pregnant women, families and communities are also necessary to improve pregnancy outcomes. Community members must come to a common understanding of the need for and the means to prevent maternal and neonatal deaths.

Home birth with unskilled attendants is often the norm, resulting in high maternal and neonatal mortality. Consequently, there is a great need for an innovative and empowering community-based intervention whose characteristics address this problem at its roots. Home Based LSS accomplishes this in several ways.

Home Based LSS represents a critical re-thinking of conventional community-based approaches. First, Home Based LSS takes into account the social context of childbirth, focusing on the pregnant woman, her family caregivers and the home birth attendant as a team. Secondly, it addresses the challenges inherent in responding to unpredictable life threatening complications, including problem recognition, first aid care, referral decision-making and health seeking. Last, Home Based LSS works to enhance, rather than replace, existing care practices, negotiating safe, feasible and acceptable actions that will be taken in the home setting when life-threatening complications occur.

The Home Based LSS Training Program is a competency based training intervention for women and men within the community. The Home Based LSS approach to behavior change emphasizes the importance of community problem identification, problem solving, negotiation, and respectful consideration of existing solutions before attempting to integrate biomedical practices.

The overall goal is to develop consensus on practices that are not only safe, but also feasible and acceptable to users in a home setting *until they reach a referral facility*. Toward this end, the Home Based LSS model emphasizes community involvement at every step, and uses the principles of adult education and group process to facilitate the multidirectional transfer of information.

The Home Based LSS training manual has a flexible, modular design comprised of 12 preventive and life saving skill topics.<sup>1</sup> Drawing on best practices and current research, HIV awareness and prevention of mother-to-child HIV transmission are integrated into the training manual. To maximize effective communication and learning among community members who may be unable to read, essential content is reinforced through pictorial *Take Action Cards* that are taken home for reference.

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<sup>1</sup> Topics are: Introduction, Woman and Baby Problems, Prevent Problems, Referral, Too Much Bleeding, Sickness with Pain and Fever, Birth Delay, Swelling and Fits, Too Many Children, Baby Has Trouble Breathing At Birth, Baby Born Too Small, Baby Is Sick

Interventions that complement the core training content focus on community mobilization for the development of an emergency transportation system, for ongoing support of Home Based LSS in the community, and for the dissemination of safe motherhood messages among the community, particularly its leaders and men.

The American College of Nurse-Midwives field-tests of the Home Based LSS materials, process, and activities has resulted in positive outcomes and helpful lessons learned. This field-test information has been used in the 1<sup>st</sup> Edition of the Home Based Life Saving Skills Guidelines and Manual to be available last quarter of 2003. We are grateful to those who willingly participated in the field tests from India, Ethiopia, Viet Nam, Gaza Strip, and the West Bank.

For more information contact:  
**American College of Nurse-Midwives**,  
Department of Global Outreach,  
818 Connecticut Ave. N.W., Suite 900,  
Washington, D.C. 20006, U.S.A.  
Phone 202-728-9864.

Email:  
stbuff@aol.com(Sandy Buffington),  
antls@learnlink.emory.edu(Lynn Sibley)