The Department of Making Pregnancy Safer
Regional Highlights 2009

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Of the estimated 529,000 maternal deaths that occur globally every year, 48% are in the African region, a region that constitutes only 12% of the world’s population and 17% of all births.

**Involving communities, preventing mother-to-child transmission of HIV/AIDS**
1. Roadmap for Accelerating the Attainment of the MDGs related to Maternal and Newborn Health in Africa. WHO – 2004


ROLLING OUT THE ROADMAPS

The WHO African Region has the highest maternal and neonatal mortality in the world and the lowest reduction in the number of maternal deaths in the past decade. Maternal and newborn health programmes in the Region face many challenges, including the lack of national commitment and financial support, inadequate coordination among partners and poorly functioning health systems.

For the past five years the Region has focused on developing and implementing national roadmaps to help countries speed up progress towards achieving MDGs 4 and 5. The key objectives of the roadmaps are to provide skilled attendance during pregnancy, childbirth, and the postnatal period at all levels of the health care delivery system including strengthening of the capacity of individuals, families, and communities to improve maternal and newborn health.

Roadmaps are now being implemented in 43 out of 46 countries in the Region. Among these, WHO is supporting 17 countries to strengthen the maternal and newborn health component in their district operational plans so that now 25 countries drew up focused district plans.

IMPROVING ACCESS TO SKILLED BIRTH ATTENDANTS

To save the lives of women and newborns, emergency obstetric maternal and neonatal care (EmOC) has to be available around the clock. In 2009, MPS helped to conduct EmOC needs assessments in Angola, Ethiopia, Malawi, Mozambique, Rwanda and Sierra Leone, and introduced them in a further 15 countries. The findings have been disseminated and used to mobilize resources at all levels and to develop new strategies to address the gaps in essential services.

To help support countries in building the capacity of staff responsible for providing emergency obstetric care, a guide entitled Recommendations pour la pratique clinique des soins obstétricaux et néonataux d’urgence en Afrique (Recommendations for clinical practice of EmOC in Africa) was developed and launched in collaboration with the African Society of Gynaecologists and Obstetricians (SAGO) and UNFPA. Pre-service and in-service training in EmOC was carried out in 24 countries. A total of 17 countries were supported to improve skills of health care providers.

COMMUNITY HEALTH PROMOTION

In 2009 a framework for developing integrated health promotion actions at community level was finalized and AFRO organized a regional expert consultation aimed at improving community participation in MNH programmes in the Region. A total of 11 countries were supported in implementing community initiatives. These were designed to increase awareness of MNH issues and the socio-cultural factors that are responsible for health inequities and unequal access to health services and are thus also contributing to maternal and newborn deaths.
1. Roadmap for Accelerating the Attainment of the MDGs related to Maternal and Newborn Health in Africa. WHO – 2004

2. Angola, Benin, Botswana, Burkina Faso, Burundi, Chad, Kenya, Malawi, Mali, Niger and United Republic of Tanzania, removed the financial barriers to skilled care at birth and emergency obstetric and neonatal care, by providing free maternity care or by subsidizing MNH services. These initiatives are expected to increase the use of maternal health services and reduce maternal and newborn mortality.

As a result of continued advocacy, 10 countries in the WHO African Region, Angola, Benin, Burkina Faso, Burundi, Chad, Kenya, Malawi, Mali, Niger and United Republic of Tanzania, removed the financial barriers to skilled care at birth and emergency obstetric and neonatal care, by providing free maternity care or by subsidizing MNH services. These initiatives are expected to increase the use of maternal health services and reduce maternal and newborn mortality.

3. The Accelerated Comprehensive PMTCT plans on PMTCT.

Since 2008, nine countries in the Region with high levels of HIV-related disease have been implementing PMTCT activities supported by the Canadian International Development Agency (CIDA). A mid-term review of the programme carried out in Zambia in April 2009 revealed that after just one year some innovative approaches had emerged as good practice.

For example, the recruitment and training of “motorcycle riders” to transport laboratory samples in the mountainous country of Lesotho improved the turn around time for laboratory results from six to three weeks. In Swaziland, outsourcing of activities to NGOs helped alleviate the human resource constraints within the public sector. The method was used successfully with HIV testing and counselling (HTC) and also helped speed up implementation. In Zambia, innovative approaches such as the use of the Mother Baby Pack increased the number of women delivering in facilities and attending postnatal services.

An increasing number of maternal deaths in the Region are due to indirect causes, such as HIV/AIDS, TB and malaria. Many pregnant women in Africa are being diagnosed with HIV. In some regions of southern, east and central Africa, 20-30% of all pregnant women are infected. In some countries, HIV infection transmission rates from mother to child range from 25% to 40%.

Accelerated comprehensive PMTCT plans have been implemented in 34 countries in the Region. This has contributed to a significant increase in PMTCT interventions. In addition, 16 countries have adapted their national curricula and developed national training plans on PMTCT.
INCREASE OF THE PERCENTAGE OF WOMEN WITH HIV RECEIVING RETROVIRAL TREATMENT FOR PMTCT FROM 2005-2008

- **Sub-Saharan Africa**
  - 2005: 16
  - 2006: 24
  - 2007: 34
  - 2009: 45

- **West and Central Africa**
  - 2005: 11
  - 2006: 7
  - 2007: 16
  - 2009: 16

- **Eastern and Southern Africa**
  - 2005: 19
  - 2006: 31
  - 2007: 43
  - 2009: 58

Legend:
- 2009
- 2007
- 2006
- 2005
WHO provided technical and financial support for the organization of a Maternal, Newborn and Child Health Week in Liberia. The event aimed to raise the profile of maternal and newborn health in a country where maternal mortality remains high and to advocate for a presidential declaration on the designation of one week in May as “Maternal, Newborn and Child Health Week”.

A further goal was to obtain consensus on and promote delivery of a life saving package of essential services for women and newborns that would be used nationwide at health and community facilities beyond the first “MNCH Week”.

The event was launched on 2 December 2009 in a rural community in Margibi County. Under the slogan “Healthy community, healthy people, healthy nation” WHO, the Ministry of Health and Social Welfare and the county health team worked with the local clan chief to mobilize the entire district. The event was a huge success. More than 50 towns took part and people turned out en masse. As part of the launch, free equipment for newborns, mostly clothing, was donated by the Church of the Latter Day Saints and immunization services, for example for yellow fever, were provided.
In Ethiopia, a country where just 6% of births are attended by skilled staff, a small district health office in the Tigray region carried out a successful project to encourage more women to give birth at health facilities.

In order to find out why women from Maichew town were not giving birth in the local hospital, officials from the Maichew Woreda health office conducted a study supported by MPS. They discovered that women did not want to travel to and from the hospital in daylight due to deep-rooted traditional beliefs stating that a woman who gives birth should stay inside the house for 40 days. If the woman does not respect this rule she will fall into her grave, which remains open for 40 days after the birth and die. Unfortunately, the 40 days after childbirth are the period of maximum risk for a mother and her newborn baby.

To solve the problem, the Maichew district health office decided to allocate funds to pay for the hospital ambulance to take mothers back to their homes after they had given birth in hospital. This simple solution has increased the willingness of women to give birth in hospital rather than at home. Health officials now want to conduct a wider study to see if this solution could be adopted elsewhere in the Region.
PAYING FOR PERFORMANCE IN RWANDA

One of the most innovative schemes to encourage health facilities and staff to provide higher standards of care for women and children has been the Paying for Performance programme (P4P) operating in Rwanda. The scheme, which was introduced in 2005, rewards clinics and health facilities financially if they meet a defined set of quality targets and deducts payments if they do not.

An evaluation of the programme revealed that the scheme, which uses WHO guidelines and tools to assess the quality of services provided, has resulted in higher standards of antenatal care and many more women giving birth in a facility.

The use of the MPS-promoted partograph during childbirth is one of the indicators applied to measure the quality of care at facility level.

The evaluation of the project carried out by The World Bank used data collected from 166 of Rwanda's 401 primary health care facilities over a two-year period and comparison data collected from a random sample of 2158 households. Clinics were offered the equivalent of $1.83 for women, who were new contraceptive users, $4.59 for each woman who delivered her baby safely on their premises with skilled midwives, $1.83 for each referral of a malnourished child for treatment and 92 cents for every child who completed vaccinations on time.

The evaluation found that P4P had increased the number of institutional deliveries and preventive care visits by young children, and improved the quality of antenatal care. However, it did not increase the number of antenatal care visits and had no effect on immunization rates.

IN THE REGIONS
Regional Office for The Americas (AMRO)

KEY STATISTICS

Maternal Mortality ratio was 87 per 100 000 live births in 2005 compared with 130 in 1990.

Annual percentage change in MMR between 1990-2005 = -2.0

Proportion of births attended by skilled personnel ranges from a high of 99% in Chile to a low of 26% in Haiti.

Perinatal Mortality rate ranges from 51 per 1000 births in Haiti to 13 per 1000 births in Argentina.

Updating information systems, improving monitoring, promoting networks

In 2009, the Pan American Health Organization (PAHO) which serves as the WHO Regional Office for the Americas (AMRO) focused on updating the Perinatal Information System (SIP) providing high quality information relating to reproductive health and maternal and neonatal mortality in the Region.
During 2009, work in PAHO was concentrated on updating the maternal and neonatal health modules of the Perinatal Information System (SIP) through a process of regional consensus. SIP is an information collection and monitoring system designed to produce accurate and timely data relating to reproductive health and the causes of maternal and neonatal death.

The technical input for this work is provided by the Latin American Centre for Perinatology and Women’s Reproductive Health (CLAP/WR) the regional technical centre of PAHO. As well as updating the perinatal clinical records system, CLAP/WR also developed a module for women being cared for during an abortion and a neonatal module containing admission and discharge information and daily nursing charts.

In 2009, reducing maternal mortality was made a high priority by governments and health officials. PAHO worked closely with countries to make sure that the link between the collection of data relating to maternal deaths and making real progress towards achieving the MDGs was accepted and understood, both centrally and at local level.

Adapting the SIP for use at community level was another focus for the Region. In addition, a specific module for use in rural areas and among ethnic minorities was developed. The use of tools such as mobile phones to increase the speed at which information can be passed from community to central level, is currently being tested. The Regional Office tries to make sure that the SIP is adapted to local needs so that information collected at “grassroots” level is forwarded to the level where health system planning takes place.
A SUCCESS STORY FOR SIP IN EL SALVADOR

El Salvador introduced the SIP in 1985, in cooperation with the Maternal and Newborn Health Department of the country’s national maternity hospital. This was the basis for the development of the Perinatal Clinical History (HCP) that is now being used in the 28 maternity clinics in the country.

First, it was important to ensure that the information recorded in the HCP was correct. Next, this information had to be entered correctly into the SIP programme. Finally, the data on standardized indicators in all maternity clinics was analysed and evaluated in order to obtain an accurate picture of the use of maternal and neonatal services in the facilities.

The SIP has served many different purposes:
- monitoring the distribution of maternal and neonatal mortality across the country;  
- verifying the application of norms and standards relating to family planning and maternal and newborn services;  
- evaluating new strategies and interventions by tracking indicators;  
- strengthening the results-based management of programmes for mothers and newborns at all levels;  
- supporting research on service delivery and audits of maternal and newborn services.

To be an effective tool for monitoring and supervision, SIP requires teamwork. In El Salvador, the use of the system has strengthened the relationship between administrative and technical staff and between health staff and IT professionals who need to work together in hospitals. Teamwork is fundamental to obtaining high-quality data which will hopefully help to reduce the numbers of maternal and newborn deaths in the country.
NETWORKING TO ENCOURAGE SURVEILLANCE

A major achievement of South-South cooperation during 2009 was the establishment of the sub-regional Central American network for maternal-neonatal surveillance based on the SIP, as a standard tool for comparisons and sharing of experience.

The use of the SIP in El Salvador, the introduction of a law in Panama, which designates SIP as the unique registration system to be used in the country and the local experience with the SIP in Honduras and Nicaragua, represent important building blocks for the new network.

TRAINING TO PREVENT TRAGEDY

In spite of the progress made in the area of maternal and newborn health in the Region, major inequalities in access to MNH services continue to exist in particular in Latin American and Caribbean countries. Women with lower incomes still tend to give birth in the community assisted only by traditional birth attendants in unsafe conditions. Therefore, unsafe deliveries and the lack of postpartum care due to limited resources and training opportunities remain a challenge.

There is an urgent need to improve undergraduate and in-service training of staff responsible for antenatal, delivery and postnatal care. The training should focus on the identification of early warning signs of obstetric emergencies so that they can be prevented or treated on time.

Indigenous women, rural workers and adolescents are the most vulnerable women in the Region. Special strategies need to be developed to improve these women’s access to safe and culturally appropriate care.

In 2009, CLAP/WR worked with the Universities of Chile, Pennsylvania, Emory and Puerto Rico, to update the curricula for midwifery training in Paraguay and Guyana. CLAP/WR has also strengthened primary health care in Bolivia where an inter-cultural approach to midwifery was applied. A Community of Practices was established for Spanish and English speaking countries to reduce the technical gap through the cooperation of peers.
EMPOWERMENT AND HEALTH PROMOTION FOR MATERNAL AND NEWBORN HEALTH

The Certificate Course in “Empowerment and Health Promotion for Maternal and Newborn Health,” organized at the Universidad de Antioquia in Medellín, Colombia (UdeA) uses the WHO Making Pregnancy Safer strategic framework “Working with individuals, families and communities to improve maternal and newborn health” (IFC) and is intended to strengthen the capacity of maternal, neonatal, child and adolescent health programme managers in priority countries to implement health promotion efforts within the national maternal and newborn health strategies.

The course is a joint initiative of MPS, the Department of Child and Adolescent Health and Development (CAH), the PAHO Family and Community Health Cluster (PAHO/FCH/CLAP/WHR and FCH/CA), PAHO/Colombia and the Swiss NGO Enfants du Monde (EdM). The participating faculties from the University include Medicine (represented by Centro Nacer) Public Health, Nursing and Education.

The first group cohort began in October 2009 with country teams from El Salvador and Colombia, representing different levels of the health system.

Six modules were designed to develop the key competencies needed to implement the IFC framework including knowledge of health systems, primary health care, social protection, health promotion concepts, social determinants and leadership and management for changing the way the health services work with other partners and communities.

Four of the modules are virtual and two modules require presence at the University in Colombia. The evaluation of the performance of the participants will focus on the IFC proposal that the team develops, as well as on how they interact and function as country teams.
In Honduras, health officials are developing a National Policy to Accelerate the Reduction of Maternal and Childhood Mortality (RAMNI). Provided with technical support from a number of different agencies, including PAHO. The aim of this policy is to accelerate progress towards achieving MDGs 4 and 5 by 2015. This would mean reducing the maternal mortality rate from 108 per 100,000 live births to 45 and the number of neonatal deaths from 30 per 1000 live births to 19.
Brenda Marleth Rodríguez, is a 32 year old mother of four children. She lives in the village of Cataulaca, in the Municipality of San Juan, within the health region of Intibucá.

When she was pregnant with her fourth child, Mrs Rodríguez became a maternal “fugitive” resulting in health workers across three different health regions trying to track her down and save her life and that of her unborn baby. How and why did this happen?

Mrs Rodríguez had been diagnosed with pre-eclampsia and had been admitted to the Hospital de Occidente, in the health region of Copan, located 120 kilometres from her local hospital. After four days she discharged herself. “As I felt well and was worried about my other children, I decided to leave,” she said.

Staff from the Hospital de Occidente contacted their colleagues in neighbouring health regions and gave them the details of Mrs Rodríguez’s condition. But in these regions there was no record of Mrs Rodríguez or the fact that she was pregnant.

Refusing to give up their search, the health workers began looking for Mrs Rodríguez in local communities. Eventually they found her at home, in the village of Cataulaca, where a local doctor persuaded her to give birth in a facility. He told Mrs Rodríguez that she might die if she gave birth at home.

Mrs Rodríguez gave birth by caesarean section and now has a healthy baby girl. After the birth Mrs Rodríguez requested sterilization, in order to prevent further pregnancies. Interviewed about her experience of giving birth in hospital, she said that what she liked most about it was the cleanliness and the high standard of care and attention she received from the staff.

When she was asked why she had gone to the Hospital de Occidente instead of her local hospital, she replied that it was much easier to get transportation there, even though it was much further away from where she lived.
IN THE REGIONS
Regional Office for South-East Asia (SEARO)

KEY STATISTICS

MATERNAL MORTALITY RATIO WAS 450 PER 100 000 LIVE BIRTHS IN 2005 COMPARED WITH 650 IN 1990

ANNUAL PERCENTAGE CHANGE IN MMR BETWEEN 1990 AND 2005 = -2.4

PROPORTION OF BIRTHS ATTENDED BY SKILLED PERSONNEL RANGES FROM UNIVERSAL ACCESS IN DPR KOREA, MALDIVES, SRI LANKA, AND THAILAND TO A LOW OF 19% IN NEPAL

PERINATAL MORTALITY RATES RANGE FROM 70 PER 1000 BIRTHS IN INDIA TO 20 PER 1000 BIRTHS IN SRI LANKA AND THAILAND

Strengthening management, promoting skilled care at birth and newborn health

The WHO South-East Asia Region accounts for approximately one third of maternal and neonatal mortality worldwide. Lack of skilled care and staff remain major obstacles to reducing maternal and newborn mortality in some parts of the Region.
Increasing the quality and coverage of skilled care at birth, remained the priority in the Region in 2009. The Regional Office focused in particular on supporting pre-service and in-service training for health workers in Bangladesh, India, Maldives, Myanmar, Nepal, Sri Lanka and Timor-Leste.

Most countries now accept that a combination of family planning, skilled care at birth, the availability of high quality emergency obstetric care and improved access to these services are key to reducing the number of maternal and neonatal deaths. However, widespread differences in the number of births attended by skilled personnel persist, ranging from universal access in the Democratic People’s Republic of Korea, Maldives, Sri Lanka, and Thailand to a low of 19% in Nepal.

For those countries where the level of skilled care at birth is low, the lack of adequate human resources remains a major obstacle. More community-based health providers with midwifery skills need to be trained and the quality of the services they provide has to be improved.

Public-private partnership is a new platform created to help increase the availability of SBAs in India. The Government of India and WHO support the accreditation of private health facilities to provide SBA-training. The training of specialized health care workers in the participating health facilities will be assessed against Indian Public Health Standards.

The promotion of WHO Integrated Management of Pregnancy and Childbirth (IMPAC) guidelines continued throughout the Region in 2009. All countries in the Region, except Thailand, are supported to use IMPAC to improve the quality of maternal and neonatal health services. However, the use of the guidelines in daily practice at all levels remains a major challenge.

The WHO Essential Newborn Care Course focusing on the training of primary health care providers was carried out in nine countries in the Region. In addition, a long-term project on newborn health has begun in Myanmar.

Strengthening the management of maternal and newborn health programmes throughout the Region remains a priority. Eight countries implemented a variety of activities aimed at improving health staff’s management skills and capacities. These activities included District Team Problem Solving, Local Area Monitoring and the strengthening of community involvement.

SAFER PREGNANCY IN TAMIL NADU: FROM VISION TO REALITY

India has the highest numbers of maternal and newborn deaths in the world. However, there are major differences in what individual states have achieved. The southern Indian State of Tamil Nadu is a good example of how over a relatively short period of time, an optimal combination of high level commitment, good technical leadership and strengthening of the health system have contributed to significant reductions in maternal and newborn mortality and improvements in the quality of life of women and children.

Between 1980 and 2006, the maternal mortality ratio in Tamil Nadu fell from 450 to 90 per 100 000 live births. In 1971, 53 babies died in the first month after birth whereas in 2005, the neonatal mortality rate had fallen to 26 per 1000 live births. Making pregnancy safer in Tamil Nadu,\(^1\) tells the story of how it was done.

The state adopted a three-pronged approach to achieve its ambitious goals: provision of services for the prevention and termination of unwanted pregnancies; provision of accessible, high-quality antenatal care, essential care for childbirth and basic emergency obstetric care at primary level; and provision of accessible, high-quality emergency obstetric care at the first referral level.

Social changes, supported by all political parties, along with a radical shift in public health policy to emphasize maternal and newborn health were among the key factors to making progress. Improved literacy, reduced incidence of early marriage, early pregnancy and frequent pregnancies, combined with a high level of public awareness of family planning and good nutrition, also contributed to the improvements in maternal and newborn health.

The publication challenges the view that maternal and newborn health cannot be improved through a health systems approach. This report is also encouraging for health staff and managers working in resource-poor settings as they can use similar approaches to work towards safe motherhood.

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\(^1\) Making pregnancy safer in Tamil Nadu

WHO Regional Office for South-East Asia
SAVING A MOTHER’S LIFE IN MYANMAR

Ma Kyaing, aged 28, was pregnant with her third child. She and her husband are poor farmers living in Thaung Gyi village in the Sagaing Division of Myanmar. The village is not far from the Nabet rural health centre but separated from this facility by a river without a bridge. Ma Kyaing’s first two deliveries were attended by a traditional birth attendant. After the birth of her second child, she had a retained placenta.

Khine Zar Win is a voluntary health worker in the village who joined the Maternal and Newborn Team in 2007. She advised Ma Kyaing to see a midwife who then told her to get regular antenatal check-ups and to give birth in a hospital. Ma Kyaing ignored this advice and did not go for further check-ups.

Khine Zar Win did not give up. She alerted the driver of the Nabet health centre trawlergy, a mini truck for emergency transportation given to the centre under a WHO/UNFPA programme in 2007.

Ma Kyaing went into labour at midnight on 18 October 2009 and at 3.00am gave birth to a baby boy assisted by a traditional birth attendant. Confirming the health worker’s fears, Ma Kyaing’s placenta was retained, followed by postpartum haemorrhage.

Khine Zar Win who had remained nearby arranged for the emergency transportation with money received from the village’s monk. Ma Kyaing, her family and Khine Zar Win crossed the river in a boat. Then they travelled in a bullock cart, arriving at Nabet health centre at 5.00am. The midwife and a health assistant inserted a drip line and set off for Myaung Hospital, five miles from Nabet in the trawlergy. By the time they arrived at Myaung it was 6.00am. Ma Kyaing’s blood pressure had fallen dramatically. But her life was saved because she had access to emergency care on time.

This story shows how anticipation, rapid response and community support can prevent maternal deaths. There are many mothers like Ma Kyaing who, for many complex reasons, do not believe complications can happen during pregnancy and birth and that their lives could be at risk. In addition to public sector work, community empowerment and the commitment of health workers like Khine Zar Win are key to overcoming cultural barriers and preventing unnecessary maternal deaths.
Two thirds of maternal and neonatal deaths in the WHO South-East Asia Region occur in the first two days after birth, with postpartum haemorrhage (PPH) and the failure to provide high-quality newborn care, being among the main causes. In July 2009, health officials from the Region met in New Delhi to review the WHO guidelines on prevention and management of PPH and information on postnatal care to help countries develop strategies for improving the quality of maternal and newborn care.

The controversial practice of using misoprostol rather than oxytocin to prevent PPH was also discussed. The latest WHO guidelines on the prevention of PPH recommend the use of injectable oxytocin as the drug of choice because it has few side effects, is cheap, available and most nurses are able to administer it. The guidelines state that misoprostol, which is associated with higher blood loss and other side effects, should only be used if oxytocin is not available.

The meeting provided an important platform to discuss and review current practices and to emphasize the importance of the implementation of WHO guidelines in accelerating progress towards achieving MDGs 4 and 5.

Together, the countries of the WHO Western Pacific Region and South-East Asia Region account for more than 44% of maternal deaths and 56% of neonatal deaths globally. Socio-cultural factors contribute significantly to the continuing high numbers of maternal and newborn deaths. Overcoming these barriers to access high-quality maternal and newborn care, particularly at primary care level, is therefore one of the key challenges for healthcare providers in both regions. In August 2009, SEARO in collaboration with WPRO, MPS and the Department of Reproductive Health and Research (RHR) organized the Bi-regional consultation for the application of socio-cultural approaches to accelerate the achievement of MDGs 4 and 5.

Participants reviewed the draft strategic framework for application of a socio-cultural approach for accelerating the reduction of maternal and neonatal mortality, discussed the guideline on empowering women, families and communities in key issues surrounding maternal and neonatal health and facilitated the establishment of an Asia-Pacific network for addressing the socio-cultural aspects of maternal and neonatal health.
IN THE REGIONS
Regional Office for Europe (EURO)

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<td>ANNUAL PERCENTAGE CHANGE IN MMR BETWEEN 1990 AND 2005 = -2.4%</td>
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<td>BIRTHS ATTENDED BY SKILLED PERSONNEL RANGE FROM A HIGH OF 100% IN MANY COUNTRIES TO A LOW OF 83% IN TAJIKISTAN</td>
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Creating partnerships and providing tools for change

In 2009 the EURO region focused on working in cooperation with different partners to continue implementing the MPS strategy despite increasing financial and staffing constraints.
THE IMPORTANCE OF PARTNERSHIPS

Nearly all activities relating to maternal and neonatal health in the Region in 2009 were dependent on cost-sharing and collaboration with partner organizations. All country offices in the Region, especially those with National Professional Officers (NPOs) in place, are working closely together to improve maternal and newborn health.

In 2009, the Region achieved an implementation rate of 100% at both country and inter-country level in spite of financial and staffing shortages.

The MPS Department carried out primarily activities based on Biennial Collaborative Agreements in 17 countries. These activities focused for example on the improvement of monitoring and data collection.

MPS launched a maternal mortality and morbidity audit using the WHO Beyond the Numbers approach which was introduced and piloted in Armenia, Moldova, Kazakhstan, Kyrgyzstan, Tajikistan, Ukraine, and Uzbekistan. The audit will allow more accurate collection and recording of data relating to maternal mortality and morbidity.

One of the key components of the audit has been to address the “culture of blame“, which has existed in many countries in the Region. In the past, many countries were reluctant to investigate the underlying causes of maternal deaths because staff were afraid they would be blamed for them instead of being helped to understand what had gone wrong and why. Helping countries to understand that audits are an important aspect of improving health systems and providing high-quality care which can reduce the number of deaths, is an essential part of the work done by MPS.

FOCUS ON QUALITY CARE ASSESSMENT

An assessment of the quality of hospital care for mothers and newborn babies was carried out in Albania, Kazakhstan and Turkmenistan. In addition, an assessment of health system functions designed to improve maternal and neonatal health was performed in Albania and Kazakhstan. The assessments judged the quality of care provided by a health facility and whether it was adhering to evidence-based guidelines. The results showed that improved teamwork, a clear definition of the different roles of health staff and sufficient supplies of essential drugs could improve the hospital care for mothers and newborns.

The importance of developing and implementing training and assessment tools to help improve the quality of care was also emphasized during 2009. Some countries in the Region introduced MPS tools for assessing health system functions and the quality of hospital care for mothers and newborns, as well as a training package for Effective Perinatal Care.
DISCUSSION OF POLICIES AND PRIORITIES

EURO organized a workshop on strengthening health systems to improve maternal and neonatal health in south-eastern Europe in Sofia, Bulgaria in March 2009. In November 2009 a workshop on the dissemination and use of updated assessment tools provided by EURO was held in Oslo, Norway. Both meetings were part of the Stability Pact project to improve maternal and neonatal health in south-eastern Europe, supported by Norway and organized in collaboration with MPS.

CHALLENGES

Budgetary constraints had a significant impact on MPS activities in the Region. A high level inter-country meeting in Istanbul due to take place in May 2009 had to be cancelled because of lack of funds. The participants of the meeting were expected to discuss lessons learned from implementing maternal mortality and morbidity audits using the WHO Beyond the Numbers approach.

In addition, shortages of both professional and administrative staff have limited the assistance provided to Member States.
A WORKSHOP FOR FATHERS IN MOLDOVA

“How do I help my wife get ready to give birth? Well, she organizes everything herself and I just bring her the things she asks for!” says a heavily-built man with large, farmworker hands. He looks at the group of men seated around him, seeking support and sympathy. Together with 16 other fathers, he is taking part in a WHO roundtable discussion about the health of mothers and newborns. For most of the men, it is the first time they are discussing the subject outside a doctor’s office.

The discussion was held in September 2009 in Volontir in Moldova. It is a very busy time in the village as the grapes are being harvested during this period of the year. Wine is one of the major export products of the small country.

Despite favourable economic growth in recent years, Moldova retains its position as one of the poorest countries in Europe. More than a quarter of the population lives below the poverty line, most of them in small towns and rural areas, like Volontir.

Maternal and perinatal mortality rates are among the highest in Eastern Europe, which is why MPS has invited the fathers of Volontir to discuss these problems and their possible solutions.

The constant lack of money is continually raised as one of the main obstacles to improving the conditions for mothers and newborns, as well as the absence of a centralized water and gas system. The fact that many of the men have to work abroad for large parts of the year, and thus cannot be of much practical help to their wives, is another major issue.

One of the fathers taking part is 25 year old Victor Costin, a married construction worker who works in Moscow for up to four months at a time and then has only one week off to come home to visit his wife and son. “I really liked the fact that all fathers voiced their opinion and talked about what is in their hearts,” said Victor after the meeting.
In 2009 the Region continued to highlight the importance of the community component in reducing maternal and neonatal mortality in countries and on the implementation of best practices in reproductive health programmes.

**Key Statistics**

- Maternal Mortality Ratio was 377 per 100,000 live births in 2005 compared with 465 in 1990.\(^1\)

- Annual percentage change in MMR between 1990 and 2005 = 1.3%.

- Births attended by skilled personnel range from a high of 100% in Kuwait, Qatar and United Arab Emirates to a low of 19% in Afghanistan.\(^2\)

- Perinatal mortality rates range from 97 per 1000 births in Afghanistan to 5 per 1000 births in Bahrain.\(^2\)

**Sharing skills to meet targets**

In 2009 the Region continued to highlight the importance of the community component in reducing maternal and neonatal mortality in countries and on the implementation of best practices in reproductive health programmes.
SHARING KNOWLEDGE, HIGHLIGHTING BEST PRACTICES

Improving knowledge and skills related to lifesaving interventions has also been recognized as key to achieving targets for reducing the number of maternal and neonatal deaths. This work has been particularly difficult in conflict zones such as Afghanistan where maternal mortality has actually increased in recent years.

All Member States are monitoring the implementation of strategies to accelerate the reduction of maternal mortality. Special attention is given to the progress in the eight MDG priority countries: Afghanistan, Djibouti, Iraq, Morocco, Pakistan, Somalia, Sudan and Yemen. Syria and Tunisia are also being monitored.

A key issue for the Regional Office continues to be the effort to increase the number of countries in the Region adopting the WHO Integrated Management of Pregnancy and Childbirth guidelines. By 2009, eight Member States had adopted the guidelines, including Afghanistan, Egypt, Iran, Iraq, Morocco, Oman, Pakistan, Sudan, Syria, and Yemen.

WORKING WITH REDUCED STAFF AND FUNDS

While countries in the Region are working hard to reduce the number of maternal deaths, many of them are facing cuts in both staff and financing. These constraints are posing a major threat to the ability in particular of Afghanistan, Pakistan, Somalia and Sudan to achieve the MDGs.

Due to reduced WHO budget allocations the low-income countries of the Region, which are also those with the highest maternal mortality ratio, will probably not be able to meet the MDG targets by 2015.

INTER-COUNTRY WORKSHOP ON MONITORING AND EVALUATION

Data on reproductive health is scarce in many countries in the Region. When available, the data are either of poor quality or not fully used for decision-making and planning purposes. Lack of disaggregated data prevents decision-makers from allocating appropriate resources according to needs. Health workers in charge of data collection often lack training and are frequently overloaded with other assignments and responsibilities. Data collection is often seen as an additional burden rather than an essential activity to improve health services.

To discuss how this situation could be improved, an inter-country workshop on strengthening reproductive health monitoring and evaluation was organized by EMRO in Cairo in March 2009. Its aim was to assess

1. The work of WHO in the Eastern Mediterranean Region: Annual report of the Regional Director; 1990-2005

the progress made in the use of data for decision-making in the Region, to review and exchange relevant experiences, spread knowledge and skills in data surveillance and reporting and develop proposals to improve data collection in the participating countries.

Delegates at the meeting urged countries to strengthen their existing national recording, reporting and surveillance systems in order to identify trends in mortality and morbidity of mothers and newborn babies so that health systems could respond effectively and the number of maternal and neonatal deaths could be reduced.
MATERNAL SURVEILLANCE SYSTEM IN IRAN

Iran introduced its national maternal mortality surveillance system in 2001. The system was intended to ensure that data were timely and accurate, to identify the risk factors associated with maternal mortality, to use the information collected to make health systems more responsive and to reduce the numbers of maternal deaths. The results have been impressive:

- The quality of services offered in hospitals and health centres providing outpatient care has improved;
- High-risk cases have been identified on time and delays in decision-making have been avoided;
- Delays in providing maternal health services, especially in emergencies, have been reduced;
- Family planning services have been improved and made accessible;
- Family awareness of potential complications arising from pregnancy and childbirth has increased;
- Coverage of antenatal and postnatal care has increased.

According to EMRO statistics, maternal mortality in the Region has remained constant, at around 22 to 25 deaths per 100 000 live births for the past few years. Concerned that Iran might not achieve MDG 5 by 2015, health officials have expanded the data monitoring programme to capture more information about the underlying causes of maternal mortality in the country.
Targeting priorities to accelerate progress

The WHO Western-Pacific Region has made significant progress in reducing the number of maternal deaths. However, wide inter-country differences remain, with almost half the annual 20,000 maternal deaths taking place in seven priority countries – Cambodia, China, Lao People’s Democratic Republic, Mongolia, Papua New Guinea, the Philippines and Viet Nam.
These seven countries fall into three groups, based on their rate of progress towards achieving MDGs 4 and 5: Much progress has been made in China and Mongolia, where the Maternal Mortality Ratio (MMR) is less than 100 per 100 000 live births. However, within China there are still huge regional disparities. And although Mongolia has significantly reduced its maternal mortality and has met MDG 5, the deaths of four pregnant mothers from the H1N1 virus in 2009 will increase the MMR for 2009.

Some progress has been made in Viet Nam and the Philippines where the MMR remains between 100-200 per 100 000 live births. In these countries faster progress is needed if they are to achieve MDG 5 by 2015.

Very little progress has been made in Cambodia, the Lao People’s Democratic Republic and Papua New Guinea, countries where the MMR remains at more than 400 per 100 000 live births.

Among the Pacific Island countries, the Solomon Islands, Vanuatu and Kiribati have a high MMR. However, due to the small populations of these countries the actual number of maternal deaths is low. In July 2009, maternal and newborn health in the Pacific Islands received greater political attention when the health ministers met in Papua New Guinea for their eighth biennial meeting and discussed, for the first time, the issue of maternal, newborn, child and adolescent health.

**NEW REGIONAL DIRECTOR BRINGS RENEWED HOPE FOR PROGRESS**

Although the seven priority countries in the Region have not yet been able to reduce maternal mortality significantly, the Regional Office’s new Director, Dr Shin Young Soo, stated that he was giving high priority to this issue. He aimed at helping all countries in the Region to achieve MDGs 4 and 5, and renewed countries’ hope that resources will be made available to increase their rate of progress.

Taking up his post in February 2009, Dr Shin said that accelerating progress towards achieving the health-related MDGs was one of his four key priorities for the Region. He also highlighted the need to strengthen health infrastructure at country level, and to focus in particular on primary health care and health workforce.

**TARGETING PRIORITIES**

- In Lao People’s Democratic Republic, two districts, Khoun (Xiengkuang Province) and Khongxedon (Salavan Province), were identified for a specific initiative in district health system strengthening, which focuses on primary health care. This initiative is based on an integrated package of Maternal Neonatal and Child Health Services (MNCH) (see Box on p.32);
A situational assessment was made in Papua New Guinea, where the number of maternal deaths has started to increase again and a project will be implemented as soon as funds are available;

- In Cambodia, a “Situation Room” was established to implement maternal death surveillance and address the significant under-reporting of maternal deaths in the country (see box on p.33);

- Technical assistance for maternal death auditing and for monitoring and evaluation work was provided in Viet Nam as part of a Safe Motherhood project. This project was funded by the Dutch Government and focused on ethnic minority groups, which comprise only 14% of the population but account for 80% of maternal deaths in the country.

**TRAINING THE TRAINERS IN ESSENTIAL NEWBORN CARE**

Every year approximately 300,000 newborns die within 24 hours of birth in the Region. Of these deaths, 90% occur in the priority countries of Cambodia, China, Lao People’s Democratic Republic, Papua New Guinea, Philippines and Viet Nam.

An essential component of making pregnancy safer is to focus on improving the care for newborns. In January 2009, WPRO conducted its first Regional Training for Trainers, focusing on Essential Newborn Care. Five of the priority countries of the Region took part. The event was a starting point for the countries involved and encouraged them to develop and conduct their own national training schemes.

**IMPLEMENTATION GUIDE FOR PRIORITY COUNTRIES**

To help identify key areas for action in the priority countries, the Regional Office began to develop an “Implementation Guide for Priority Countries in the WHO Western Pacific Region to Accelerate and Sustain Achievement of MDG5”.

While it is recognized that many countries are making progress, the Implementation Guide focuses specifically on MDG 5A – reducing the maternal mortality ratio by three quarters between 1990 and 2015. This target is most off track. The lack of progress is partly due to the fact that the indicators to monitor progress are not clearly defined.
NEONATAL AND CHILD HEALTH SERVICES IMPROVE MATERNAL, NEWBORN AND CHILD HEALTH IN LAO PEOPLE’S DEMOCRATIC REPUBLIC

Lao People’s Democratic Republic (Lao PDR) is one of the least developed countries in the Region with very high maternal and newborn mortality. Its maternal mortality ratio was 405 per 100,000 live births in 2005 and the national goal is to reduce it to 260 by 2015. In the same period the country aims to cut infant mortality rate from 70 to 45 per 1000 live births. A recent MDG review carried out by the Government and UN agencies including WHO indicated that Lao PDR is seriously off track in attaining MDG 5.

One reason for pregnant women not to seek health care in a facility is the cost involved, reports Som, a nurse in the local health centre in Paikéo village in southern Lao PDR. “Many women in this area cannot afford to go to the hospital for delivery. When they cut the umbilical cord they only have mai kasang (a stick). Then they put charcoal and ash on the cord.”

To improve access to health services and the quality of the care provided, the Integrated Package of Maternal, Neonatal and Child Health Services has been developed by the Government together with partners and is currently being implemented in some provinces. Under this initiative, for example, village health volunteers are trained to support antenatal and postnatal care, promote hygienic delivery and nutrition, assist in referring obstetric emergency cases, prevent malaria as well as regularly collect and report key maternal, newborn and child health information. Village leaders and women’s unions in communities are mobilized to participate and support the integrated maternal neonatal and child health services. Health centre workers are also trained to improve service quality and encouraged to reach out to individuals, families and communities. Poor women receive support to access essential health services.

Som is very pleased with the integrated services. “Now when we go to villages we provide different services that women and children need, not just one kind of services. Government and development donors are supporting my health centre and villages to provide a package of services.”
CAMBODIA - COUNTING THE NUMBER OF MATERNAL DEATHS

It is estimated that in Cambodia about 1600 women a year die as a result of pregnancy or childbirth, yet the country’s current health information system registers just 100-150 per year — a fraction of the estimated total. To help improve the reporting and registration system for maternal deaths, WHO supported the Ministry of Health in Cambodia in setting up a Situation Room in the heart of the Ministry building, beside the office of the Health Minister.

The Situation Room will depend on a network of “key informers”, for example health workers, community workers, relatives or members of NGOs. These individuals will notify the Situation Room of any deaths as soon as they occur via a toll-free phone line or email. Notification will be simple and require only enough information to identify the woman and the location of her death.

Health officials in Cambodia hope that improving the reporting system for maternal deaths will lead to more Maternal Death Audits (MDAs) designed to identify the exact causes, as well as the geographical distribution of maternal deaths. This crucial evidence is expected to help health officials to target interventions aimed at reducing the number of maternal deaths more effectively.

Photo Credit (Top): Family affected by typhoon Ondoy in the Philippines
WHO/WPRO
Photo Credit (bottom): In Cambodia a Situation Room was established to improve maternal death surveillance
WHO/WPRO
MATERNAL HEALTH IN CRISIS SETTINGS

In 2009, both the Philippines and Tonga were struck by typhoons. Ensuring that mothers and newborns were not deprived of essential services during and after the typhoons and subsequent flooding in these countries was a challenge for the Regional Office. In December 2009, WHO Director-General, Dr Margaret Chan, visited the Philippines to assess the damage caused by Typhoon Ondoy.

BI-REGIONAL CONSULTATION ON SOCIO-CULTURAL DETERMINANTS OF MATERNAL HEALTH

A key bi-regional consultation on the socio-cultural determinants of maternal and child health held in Bali in August 2009, focused on the WHO Individuals, Families and Communities approach (IFC) as a means of addressing socio-cultural issues.

THE CHALLENGES AHEAD

With the deadline for achieving MDGs 4 and 5 just five years away, widespread disparities between countries in the Region remain. Weak health systems, financial constraints, cultural differences and the need to address the underlying causes of maternal and neonatal death and morbidity are among the complex challenges which lie ahead.

Photo Credits: Saving the lives of newborns - MPS carried out training on essential newborn care in the Philippines
WHO/ Dr Severin Ritter von Xylander
ESSENTIAL NEWBORN CARE PROTOCOL SAVES THE LIVES OF NEONATES IN THE PHILIPPINES

An outbreak of neonatal sepsis at the Ospital ng Makati in the Philippines in May 2008, which resulted in the deaths of 34 newborns prompted a nationwide study into its causes. The study, involving 51 large hospitals throughout the country, revealed that 6% of all newborn babies develop neonatal sepsis. The study also documented high neonatal mortality rates.

Further investigation revealed that the medical care given to newborn babies in the Philippines was below WHO standards, depriving newborns of essential care and protection during the first hour of life. For example, the babies were not vaccinated and breastfeeding was not initiated.

Following the study, the Philippines hosted a regional WHO Essential Newborn Care Course, and rolled it out to high-level Philippines trainers in January 2009. The WHO Integrated Management of Pregnancy and Childbirth (IMPAC) guidelines for childbirth, postpartum and newborn care were incorporated into the Essential Newborn Care Protocol designed to address the gaps in the quality of care provided for newborn babies. The Protocol was developed with the participation of experts and stakeholders and was launched in December 2009 by the Philippines Department of Health and WHO as part of the campaign “The First Embrace” (Unang Yakap).

The Protocol is now being discussed widely with government officials, hospital administrators, academics, nursing and midwifery staff in order to incorporate it into hospital policies and practices. Preliminary results have revealed a nine-fold reduction in the neonatal sepsis rate in one hospital, the Quirino Memorial Medical Centre. There has also been a dramatic increase in the number of babies who continue to be breastfed one week after birth and discharge from hospital.

Interestingly, in addition to improved neonatal outcomes, maternal care and hospital infection control practices were also improved as a result of the new protocol. For example hand washing rates rose phenomenally, with a new “culture” of staff reminding others to wash their hands.

For normal deliveries, routine IV insertions, administration of prophylactic antibiotics and application of fundal pressure ceased. The women were encouraged to walk around and deliver in their position of choice. The impact of the Essential Newborn Care implementation extended beyond achieving clinical excellence and helped to improve the quality, safety and efficiency of hospital services.