Maternal Health

An Advocacy Guide for Parliamentarians

Asian Forum of Parliamentarians on Population and Development

Acknowledgements

Asian Forum of Parliamentarians on Population and Development (AFPPD) thanks Dr. Subidita Chatterjee, the writer of this guidebook for her tireless efforts.

AFPPD is grateful to the following experts for reviewing the guidebook: Dr. Zulfiqar A.Bhutta, Husein Lalji Dewraj Professor and Head, Division of Maternal and Child Health, The Aga Khan University, Karachi, Pakistan; Dr. Flavia Bustreo, Director, The Partnership for Maternal Newborn and Child Health (PMNCH) Secretariat, WHO Geneva, Switzerland; Dr. Saramma Mathai, Team Coordinator Maternal Health, APRO-Asia Pacific Regional Office, UNFPA, Bangkok, Thailand; Dr. Shahida Zaidi, Vice President, FIGO (International Federation of Gynecology and Obstetrics) (2006 - 2009).

AFPPD also thanks Dr. Patrick Unterlerchner and Ms. Marta Seoane, Technical Officers, PMNCH for their comments and suggestions which have added to the value of this advocacy guidebook, and Mr. Shiv Khare, Executive Director, AFPPD for his valuable inputs.

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Preface

This Guidebook is a 'Call to Action' for parliamentarians to work in order to reduce maternal death and achieve the Millennium Development Goal 5. It is also a reference document that parliamentarians can use to provide leadership in areas of maternal and newborn health. It cites many good practice examples of the role of parliamentarians in combating maternal death and illness through their representative, legislative, budgetary, oversight, advocacy and accountability functions. It also shows how gender inequality and health inequity are two obstacles, especially for the Asia-Pacific region, that parliamentarians need to be aware of. In addition, it provides guidance to parliamentarians in a step by step fashion on how they may overcome other cultural and socioeconomic constraints and make their mark in the fight to save the lives of mothers. It argues that MDG 5, aimed at improving maternal health, needs the active involvement of policy makers. They need to advocate to governments and donors to make the necessary resources available to achieve MDG 5 by 2015. Parliamentarians need to partner with their national and regional peers and work collaboratively with the UN, civil society, bilaterals/donors and private sector to accomplish these goals. Parliamentarians also need to have the correct knowledge and adequate awareness about maternal and newborn health issues in order to advocate on these issues. Though intended for use in Asia and the Pacific, this guide could benefit parliamentarians and people working with them all over the globe.

Sen. Dr. Pinit Kullavanijaya
Secretary General
AFPPD

August 2010

Message from Chair

The Asian Forum in the last 29 years has made notable progress when in the 1970s UNFPA Executive Director Mr. Rafael Salas initiated a move to mobilize parliamentarians. It was probably never conceived that his move of mobilizing parliamentarians with the aim of resource mobilization for UNFPA, will grow into a high profile parliamentarian movement for population and development which will not only work for UNFPA and IPPF but other UN agencies will also follow this lead and approach parliamentarians.

This all became possible by the most active Asian Forum of Parliamentarians on Population and Development (AFPPD) where Japanese parliamentarians also played an important role. UNFPA and IPPF played significant roles in making the parliamentarian movement a sustainable global program with national level action.

AFPPD itself in last 29 years has 25 parliamentarian standing committees on population and health. They are members of AFPPD and are major parliamentarian forums which also work with UNAIDS, WHO, IFAD, UNIFEM, and MDG campaign of UNDP.

I hope that Asian Forum will continue to progress to be an effective tool to reach not only members of parliament but also elected representatives at all levels.

Hon. Yasuo Fukuda
Chairman AFPPD
(Former Prime Minister of Japan)

August 2010

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Acronyms & Abbreviations

EC	Emergency Contraception
EmOC	Emergency Obstetric Care
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development (held in Cairo, Egypt in 1994)
IHP	International Health Partnership
ILO	International Labour Organization
IMF	International Monetary Fund
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MoH	Ministry of Health
NGO	Non-governmental Organization
OOP	Out of pocket
PHC	Primary Health Care
SRH	Sexual and Reproductive Health
SRHR	Sexual Reproductive Health and Rights
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VHW	Voluntary Health Worker
WHO	World Health Organization

Section 1:

Introduction

Introducing the basics, regional situation analysis and historical developments from the policy makers perspective

1.1 About this Guidebook

This practical guidebook is a 'Call to Action' that pinpoints the challenges in advocating for and providing adequate maternal health. It highlights the decisive role that parliamentarians can play in addressing these challenges. Its primary purpose is to provide guidance and orientation on how to improve maternal and newborn health. Its primary target audience, parliamentarians and other elected representatives, will find it very useful for advocacy purposes and awareness generation in the area of maternal health. Though meant for Asia and the Pacific, it would be found useful by parliamentarians around the globe.

The subject matter of this guidebook is built upon earlier work done with parliamentarians on MDG 5, (reduction of maternal deaths and access to reproductive health) globally and regionally. It has three main parts.

- Part one begins with introducing the guide and some terms used in maternal health, regional situation analysis and overview of the historical developments in maternal health from the policy-makers' viewpoint
- Part two deals with the challenges and evidence based strategies to overcome these challenges
- Part three explains the role of parliamentarians

Further, this guidebook builds on the outcome of the following meetings/statements but consolidates everything into a strong evidence based framework highlighting the most practical steps that could reduce maternal and newborn deaths, but through a continuum of care approach.

The AFPPD-UNFPA consultation in Bali in August in 2009[2] called for parliamentarians to monitor national implementation of maternal health related plans. The Addis Call to Urgent Action for Maternal Health[3] (2009), is from the IPCI meeting organized by UNFPA, Government of Netherlands and AFPPD and other regional parliamentarian organizations. Here 400 parliamentarians attended. They recommended access to reproductive health services including family planning, safe abortion/post abortion and special focus on adolescents as key to reducing maternal deaths. The Countdown to 2015 held in April 2008 recommended five areas where parliamentarians can make contributions: To advocate nationally and internationally for the MDGs; To oversee government accountability to implement policies; To budget for maternal, newborn and child health; To legislate to ensure universal access to essential care; To represent the voices of women and children.[4] The roadmap for parliamentarians for maternal health (an outcome of a meeting held with parliamentarians at the Hague in November 2008) recommended seven pillars: political commitment, legislation, financial resources, health systems, education, cultural practices and partnerships.[5] The MNCH consensus statement at the UN General Assembly by 12 heads of states in Sept. 2009 recommended 5 pillars. Political leadership and community engagement; Effective health systems; Removing barriers to access; Skilled and motivated health workers; Accountability at all levels.[6]

For best results, this guidebook should be read from cover to cover. The take home messages summarize the key action points and are a must read. The checklist at the end will help identify gaps in national programming.

1.2 Why do Parliamentarians need to Advocate for Maternal Health ?

One mother dies every minute. 1500 mothers die every day. This cumulates to half a million maternal deaths every year*. In spite of the global community taking specific actions, this annual number has hardly reduced in the past 15 years. Ironically, most of these maternal deaths are preventable, though not predictable.

In the year 2000, the Millennium Declaration brought together 189 Nation States. Through MDG 5 they called for the biggest global push to reduce MMR (Maternal Mortality Ratio) by three quarters (between 1990-2015) and universal access to reproductive health by 2015. The prediction is that most countries in the Asia Pacific region will not be able to meet the MDG goals if immediate action is not taken and it is "business as usual".

Of the global share, 44% of maternal deaths (Two-fifths) and 56% (half) of newborn deaths take place in the Asia Pacific region. "13 countries out of 43 countries in the Asia Pacific region have high or very high maternal mortality ratios. 17 countries are predicted not to reach the MDG 5b of universal access to reproductive health. Presently 55% of women with unmet need for contraception, who lack access to family planning services, reside in the Asia Pacific region" .[1]

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Parliamentarians are the law makers and have the power to take the voice of women and their families to other policymakers. They have the power to monitor the work of local level administrators. They have the power to be accountable and make others accountable for the death of mothers and newborn. They decide on budget allocations on maternal and newborn health. They need to understand the significance of MDGs 5 and 4 and their inter-relation with MDG 3. It is they who can make a difference to the health of mothers and newborns. To be on track there needs to be an annual decline in maternal deaths of 5.5% though the current average is only 2.3%.*

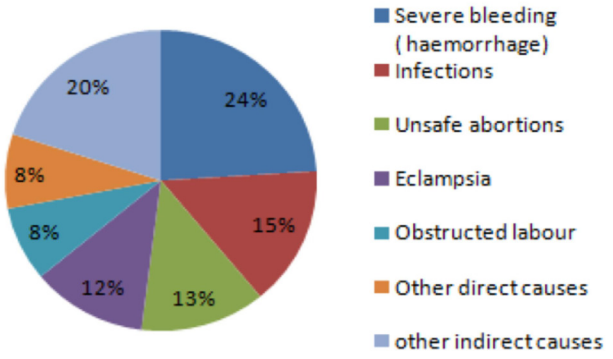
*A recent systematic review from 181 countries in the Lancet claimed that maternal mortality was reducing and there were 342,900 maternal deaths worldwide in 2008, down from 526,300 in 1980. (Hogan, MC et al., The Lancet, Volume 375, Issue 9726, Pages 1609 - 1623, 8 May 2010)

1.3 Introducing the basics

Causes of Maternal Death

The most common causes of maternal death are severe bleeding (24%), infections (15%), unsafe abortion (13%), Eclampsia-when a pregnant woman with high blood pressure suffers from convulsions (12%), obstructed labour (8%), and other direct causes.[7] Other indirect causes can be related to social factors. For example, domestic violence has been the second largest cause of deaths in pregnancy in India.[8]

Causes of Maternal Death

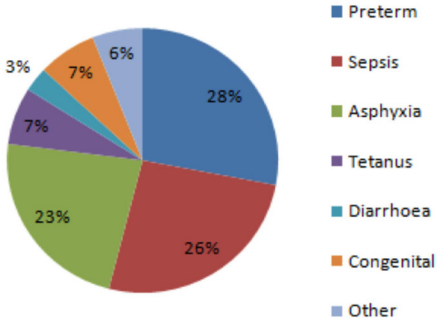


Source: WHO 2005, Making every mother and child count

Importance of Newborn Health

The health of the newborn is closely linked to the health of the mother. If the mother has been given tetanus vaccinations during her pregnancy, it saves the baby from tetanus. If her early breaking of waters has been treated with antibiotics, it may save the child from infection during labour. If labour starts before term and the mother isn't given adequate rest and necessary medications, the baby will be born before term with lesser chances of survival.

Causes of Newborn Death



Source: Lawn et al 2005

Maternal death is the death of a woman during pregnancy or within 42 days of childbirth, resulting from pregnancy or childbirth.

Direct maternal death occurs due to a complication of pregnancy, childbirth or post partum period (period after childbirth).

Indirect maternal death occurs as a result of a cause that has been exacerbated due to pregnancy.

MMR stands for Maternal Mortality Ratio. This is the number of maternal deaths occurring per 100,000 live births. This is used as a measure of women dying from childbirth in a particular country.

Underlying Social Causes of Maternal Death

Before going into the reasons, one needs to look at the underlying social causes for this tragedy in South Asia (the biggest contributor of maternal deaths in Asia).

Gender discriminatory' eating practices lead to ill nourishment in adolescent years. This in turn shows up as stunted growth and short stature among women. This leads to obstructed labour and increases their chances of needing an operative delivery to 60%.[8]

The anaemia that starts in adolescence is further exacerbated by early childbirth and repeated childbirths in quick succession. As a result, the mother loses her ability to cope with blood loss during delivery.

Conservative and judgmental attitudes of health care providers and lack of privacy and confidentiality push unmarried pregnant women to seek unsafe and illegal abortions. Among all unsafe abortions in Asia, 9% occur in women aged 15 to 19 while 23% occur in young women aged 20-24.[9]

Early childbirth, which is endemic in several countries of the region, means greater chances of obstructed labour, infections, severe bleeding during childbirth and hypertensive disorders of pregnancy with or without convulsions.

There is a strong correlation between the younger age of the mother and her death from childbirth (maternal mortality) or illness resulting from pregnancy or childbirth (morbidity). Ten to 14 year olds are five times and 15-19 year olds are two times more likely than 20-24 year olds to die from child birth (UNFPA fact sheet 2007).

Unmet need for contraception further adds to high rates of pregnancy. Fertility remains high in Afghanistan, Pakistan and Laos PDR. (2008 World Population Data sheet PRB)

Diseases such as HIV/AIDS, malaria and tuberculosis contribute to mortality risks and should be tackled during pregnancy.[8]

Low social status and social pressure to have children, contributes to an environment where women do not have full decision making ability in the choice to have children.

Harmful traditional practices often become a cause for maternal mortality. Using unsterile bamboo to cut the cord or smearing cowdung on the umbilical cord could lead to sepsis both for the mother or for the newborn. Female genital mutilation, where practiced, often leads to difficulty in delivery in the future.

Excessive out of pocket expenses and catastrophic expenditures for health, leave families and communities further impoverished.[1]

Causes related to the health system

There is inadequate and inequitable access to skilled birth attendants (doctors, nurses or midwives) during pregnancy, childbirth or postpartum. There is also inequitable access to emergency obstetric care.

Additionally, women have inequitable and discriminatory access to quality reproductive health services for family planning, safe abortions or adolescent sexual and reproductive health services. Lack of health care infrastructure or governance hampers the health of mothers.

In some countries there are not enough skilled professionals to conduct caesarean sections or other obstetric maneuvers compared to the patient load. Studies have shown that midwifery skills need to be upgraded in certain countries to maintain the quality of care. Countries have inadequate notifications on maternal deaths, especially, for those who die at home while giving birth.

Programming for Maternal Health

Maternal health can no longer be programmed successfully, unless done in tandem with neonatal, child and adolescent health.

The evidence base for interventions for maternal health have changed over the last decade. Accordingly, the earlier modes of programming and beliefs have shifted. The earlier support for training of unskilled traditional birth attendants (TBA) for conducting home deliveries has shifted to using TBA and Voluntary Health Workers (VHW) as community mobilizers. They are now considered more suitable for referring and accompanying women to health facilities for delivery.

There is evidence that even if women go for the four recommended antenatal checkups, unless they have access to emergency obstetric care and skilled birth attendants, their chances of maternal death remain high.

Maternal/neonatal deaths are mostly related to events during labour and the first 24-48 hours after delivery. So it is important that health facilities keep women for at least that time.[10]

There are examples from some countries who have been able to bring down their MMR through scaled up efforts. Better monitoring, evaluation and research is required so that good practice examples can be replicated more widely based on evidence.

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Political commitment and funding concerns

The political will among leaders has been inadequate until recently. The high level UN meeting on MDGs in September 2008 in New York concluded that urgent global action was needed to increase investment and political commitment to scale up the life-saving services for mothers, newborns and children.

Governments and donors have not been investing enough. Another US$10 billion is required from donors to meet MDG 5 by 2015. Most governments from countries with high MMRs invest less than 5% of their GDP in health. Evidence shows that investing less than an additional US$3 per capita per year on a core package would bring in considerable gains for MDG 5 for Asia-Pacific countries. However, to get long-term benefits and achieve the MDGs by 2015, an additional US$10 per capita per year will be required.[1]

There is a new political momentum on the basis of the High Level Task Force for Innovative Financing. This advocates additional investment urgently required across the health MDGs, highlighted at the UN General Assembly in September 2009, as well as 2009 MNCH Consensus with its 5 pillars for action and US$30 billion ask for MDGs 4 & 5, launched with broad international endorsement and referenced in the 2009 G8 Communiqué -- another landmark event for MNCH advocacy.[6]

The returns on such investment go far beyond healthy mothers and newborns. Apart from preventing needless deaths through time tested interventions, it would cut down on governmental expenditure on treatments; families could spend less out of their pockets for health; the future workforce of the nation would be born healthy; with improvement in maternal health, the health system would improve in general.[1]

In Asia and the Pacific, parliamentarians are much more aware and active on the issue of maternal and newborn health than before - thanks to the 29 years of work by the Asian forum of Parliamentarians on Population and Development (AFPPD). A large meeting on maternal health in August 2009 in Bali organized by the Asian Forum of Parliamentarians for Population and Development and UNFPA showed a remarkable turn out of parliamentarians and they affirmed their commitments to maternal and newborn health.[2]

Dr Donya Aziz, an MP from Pakistan urged- "Civil society to further engage parliamentarians and provide them evidence-based information and statistics so as to enable them to take more proactive legislative actions." Though she was speaking of HIV, the same applies to maternal health.

1.4 Historical Perspectives in Maternal Health

While Europe, North America and other developed regions have seen a decline in maternal mortality by the beginning of the 20th century, in the developing world (sub-Saharan Africa, Asia Pacific and Latin America) such a decline has not taken place.

ICPD, Beijing Conference

The International Conference on Population and Development (ICPD) was held in Cairo in 1994. Here the term 'Reproductive Health' was coined and maternal health considered a human right. The role of policy makers in this battle was highlighted for the first time.[13] Applying the 3 delays model to save maternal lives was discussed in 1994. The fourth World Conference of Women in Beijing in 1995 was another turning point of tagging up reproductive health and MCH programmes. In 1997, uptake of essential obstetric care, case-fatality rate, and coverage of skilled attendance at birth were accepted as indicators to monitor the availability and use of obstetric services. Additionally, the need for skilled birth attendance as an essential step came up at the ICPD +5 meeting in 1999 in an UN declaration.[14]

Millennium Declaration

The major boost for reducing maternal and newborn deaths came with the Millennium Declaration in 2000. MDG 5 dealt with the reduction of Maternal Mortality Ratio by three quarters between 1990 and 2015, along with universal access' to reproductive health by 2015. (Latter part added in 2007 through advocacy efforts of UNFPA, IPPF and several other organizations working in reproductive health).

Millennium Development Goals

In the year 2000, 189 nation states came together to ratify the Millennium Declaration. This specified eight goals to be achieved by 2015 with specific targets and indicators for each goal. The Millennium Development Goal (MDG)5 deals with improving maternal health.

MDG 5 Targets

TARGET 5.a:

Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

Indicators
5.1 Maternal mortality ratio
5.2 Proportion of births attended by skilled health personnel

TARGET 5.b:

Achieve, by 2015, universal access to reproductive health

Indicators
5.3 Contraceptive prevalence rate
5.4 Adolescent birth rate
5.5 Antenatal care coverage (at least one to four visits)
5.6 Unmet need for family planning

Partnership for Maternal, Newborn and Child Health

The Delhi Declaration following the 'Lives in Balance' conference in New Delhi, India in 2005, decided on the need for joint programming for maternal, newborn and child health and the need for a global partnership. The Partnership for Maternal Newborn and Child Health was formed in 2005 when the world's three leading alliances merged: Partnership for Safe Motherhood and Newborn Health, (hosted by WHO and established in 2004, with linkages to the 1987 Safe Motherhood Initiative), the Healthy Newborn Partnership 2000, (based at Save the Children) and the Child Survival Partnership 2004, (hosted by UNICEF).[15] The Partnership for Maternal Newborn and Childhealth started their advocacy with parliamentarians in 2005, with a strong push from 2007 onwards.

Global Coalitions for Maternal Health

The Deliver Now for Women and Children, a global advocacy campaign was launched in September 2007 by Prime Ministers of Norway, Great Britain and Canada and other dignitaries.[15] On 18-20 October, 2007 nearly 2,000 activists, governments, NGOs, and UN representatives came together from 115 countries to call for increased political will and investment in maternal health at the Women Deliver Conference.[15] The 2010 Women Deliver conference hosted a parliamentarian's forum where-"Parliamentarians called for additional US$12 billion a year to be invested in women and girls and to actively work towards the establishment of a global funding mechanism for family planning, mothers and children with other international donors". These coalitions for maternal health are providing increasing support and advocacy for reproductive health campaigns in the Asia-Pacific region.

Involvement of Parliamentarians

UNFPA is the one agency which initiated parliamentarians' involvement in population and reproductive health issues since 1981. It promoted the forming of regional parliamentarians' fora to involve member parliaments on population and development related issues including maternal health. AFPPD has been promoting parliamentarian informal education and involving high number of advocacy campaigns for parliamentarians.

> "Indonesia now have a programme to appoint trained midwife in villages. The president of Indonesia considers Family Planning and help to present mothers and newborns a very important issue."
>
> Hon. Dr. Sumarjati Arjoso, MP, Former Chair, BKKBN Indonesia, at AFPPD/UNFPA Asia Pacific Consultation on Maternal Health, Bali

In April 2008, the Countdown to 2015 conference was held in Cape Town, South Africa where 150 parliamentarians participated and made a commitment to work for maternal health.[4] In September 2008, a UN High Level Meeting on MDGs was held. The UK Prime Minister pledged to commit £450 million to support the national health plans for the IHP countries (e.g. Cambodia and Nepal). This would provide one million new health workers and 400 million births in quality facilities. The Prime Minister of Norway reported back on the Global partnership on health MDGs stating that an extra US$2.4 billion in 2009 is needed, increasing to 7 billion in 2015, which could save 3 million mothers and 7 million newborns. He invited global leaders to join the Network of Global Leaders for Health MDGs' which proved very much active. In September 2008, the Maternal Mortality Campaign was launched by the White Ribbon Alliance, with national governments, NGOs, civil society, clinicians and the business community. They worked in unity to end the shame of needless maternal deaths, through acting and holding stakeholders to account.[16] In November 2008, parliamentarians met in the Hague to discuss the agenda and future commitments in Maternal Health. They decided on a road map for maternal health which consisted of seven pillars to address the problem.[17] Other activities in 2008 included meetings held with parliamentarians for advancement of MDG 5 by the World Health Organization, UNICEF and other major players. The investment case for Maternal, Newborn and Child Health for Asia and the Pacific was developed by a working group in the region consisting of 12 UN and donor agencies.[1]

In June 2009, as a result of lobbying by UNFPA and partners, the United Nations Human Rights Council adopted a ground-breaking resolution on "Preventable Maternal Mortality, Morbidity and Human Rights". In August 2009, in Bali, AFPPD supported by UNFPA (APRO) conducted a large meeting on maternal health with parliamentarians and partners.[2] In October 2009 an international meeting of 400 Parliamentarians was held in Ethiopia on maternal health and MDG5. This was co-organized by AFPPD and other regional parliamentarian groups. This was co-hosted by UNFPA, Dutch minister for Development Cooperation and the Ethiopian health minister. This resulted in the Addis Call to Urgent Action for Maternal Health.[3]

The future is expected to show the return on investments in maternal health, with the achievement of the targets for MDG5 by 2015.

"For some women to visit health facilities they have to seek permission from their husbands. Efforts should be made to ensure that girls are educated, financially independent and have freedom to make decisions."
Prema Cariappa, MP (India)

Section 2:

Challenges & Strategies

An overview of the challenges and evidence based strategies to overcome these challenges

2.1 Primary Healthcare Delivery

Challenges:

Health services that can save a mother's life are not always ***available***, ***accessible*** and ***affordable***.

Parliamentarians need to give priority to these when developing national health policies and other policies involving mothers and newborns. They need to overcome the legislative and budgetary constraints.

Strategy 1:

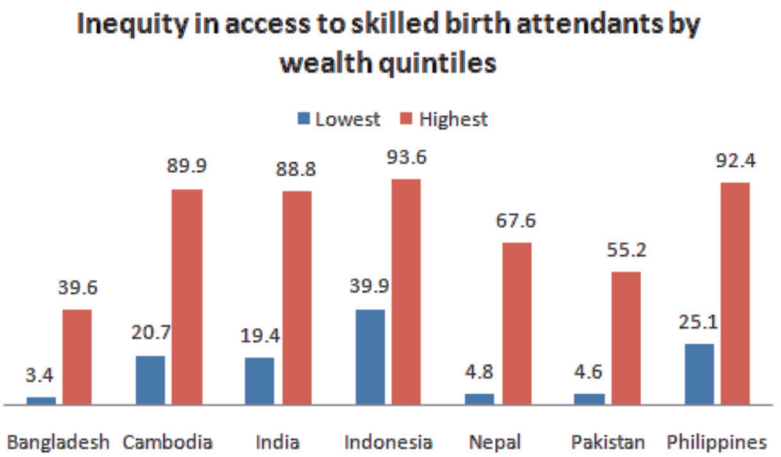
Access to skilled birth attendants

(...before, during and immediately after childbirth can save maternal lives)

South Asia is the greatest contributor to maternal deaths in Asia. About 80% of deliveries take place at home by unskilled traditional birth attendants.

Traditional birth attendants need to be used for community mobilization and/or as escorts to accompany women for facility deliveries instead of performing deliveries themselves. Countries like Bangladesh, Indonesia and Honduras have worked to use skilled midwives for home deliveries.

There is inequity (injustice or unfairness) in access to skilled birth attendants between rich and poor women. Programmes need to ensure that skilled birth attendants are available for poorer women.



Source: Based on data from World Health Statistics 2008

Unless emergency obstetric care is available at the primary health care (PHC) level, pregnant women will get referred to another higher facility. According to the three delays model (discussed on page 16) this referral could lose vital time. Thus, such a situation could pose a risk to their lives.

So, policies need to be in place to ensure that basic obstetric care is present at the primary health care level. These should have linkages to emergency obstetric care at secondary health care levels, where facilities for caesarean section or blood transfusion are usually available. (See box on page 21)

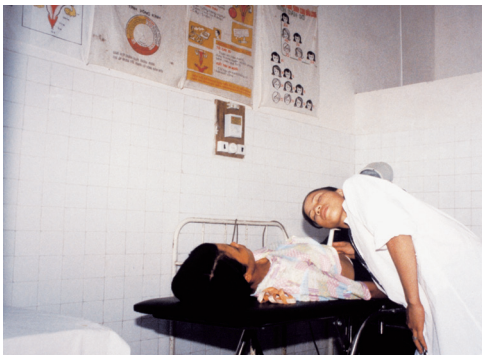
Strategy 2:

Access to emergency obstetric care

(during delivery and complications)

Strengthening Emergency Obstetric Care (EmOC) at the primary health care level

Emergency Obstetric Care (EmOC) is an important prerequisite to reducing the Maternal Mortality Ratio (MMR). To reduce MMR below 100 per 100,000 live births, four models have been tried.



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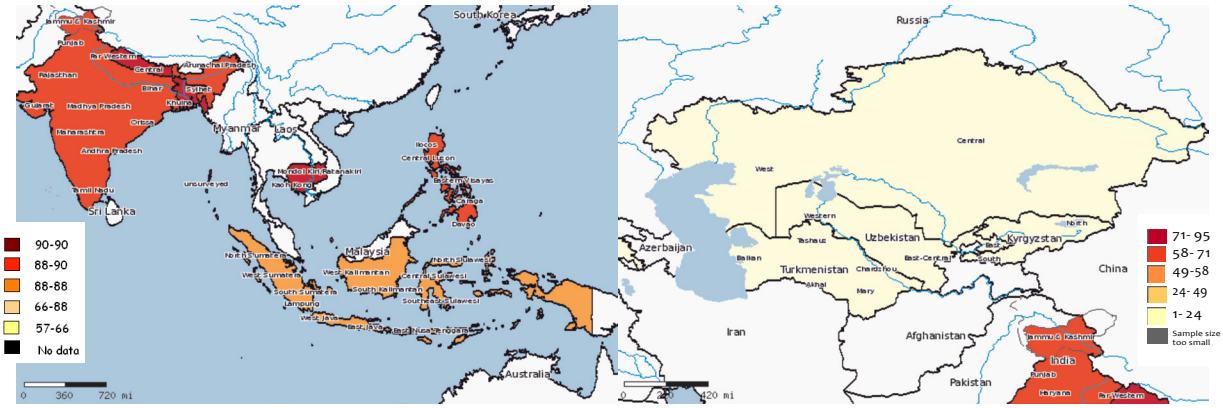
Model 1. Unskilled birth attendant conducts home delivery. (This model is no longer recommended)
Model 2. Skilled birth attendant conducts home delivery with linkages to referrals when required.
Model 3. Woman delivers at health facility with skilled birth attendant and facility provides only basic essential obstetric care (bEOC) with linkages to a comprehensive emergency obstetric care facility, when requiring blood transfusion or surgery.
Model 4. Delivery by skilled birth attendant at comprehensive obstetric care facility.

Though ideally Model 4 is the best, studies show that Models 3 or 2 are better for the developing country context because they are more cost effective. Model 3 is the best model for South Asia and East Asia for countries where MMR is still above 100. This includes upgrading primary health centres as basic essential obstetric care centres (bEOC) and linking them up to comprehensive obstetric care centres (which have facilities for operations and blood transfusion).[7] If that is not possible, Model 2 should be in place which provides incentives to skilled birth attendants to deliver at home and take complicated cases to referral centres.

Several governments in the Asia-Pacific region and South Asia in particular, give free/almost free primary health care to all women. However, it is also necessary to develop schemes to see that emergency obstetric care in general and delivery costs in particular, can be made affordable without pressuring families to spend more 'Out of pocket' (OOP) expenses. Some countries have started demand side initiatives such as conditional cash transfers for women. Also, they are arranging for subsidies by the state to ensure that women deliver in a health facility (e.g. JSY Scheme in India). Performance based incentives are some examples of supply side initiatives. These are used to motivate health care providers to improve the quality of care and keep health facilities open for 24 hours.

A good proxy marker to assess the unmet need for emergency obstetric care in a country is the rate of caesarean sections being done. It has been estimated that normally at least 5% (Ideally 10-15% as per WHO recommendations) of deliveries need to be undertaken by caesarean section. However, in three countries of Asia the rates are very low, Nepal 1%, Vietnam 3.4%, Indonesia 3.2%.[11]

Figure 1. Percentage of home deliveries (3 years before survey date within last 5 years)



Source DHS, Source data includes surveys from: Bangladesh 2004, Cambodia 2000, India 1998/99, Indonesia 2002/03, Nepal 2001, Philippines 2003. Source data includes surveys from: Armenia 2000, Bangladesh 2004, Benin 2001, Bolivia 2003, Brazil 1996, Burkina Faso 2003, Cambodia 2000, Cameroon 2004, Central African Republic 1994/95, Chad 1996/97, Colombia 2000, Comoros 1996, Cote d Ivoire 1998/99, Dominican Republic 2002, Egypt 2000, Eritrea 2002, Ethiopia 2000, Gabon 2000, Ghana 2003, Guatemala 1998/99, Guinea 1999, Haiti 2000, India 1998/99, Indonesia 2002/03, Jordan 2002, Kazakhstan 1999, Kenya 2003, Kyrgyz Republic 1997, Madagascar 2003/04, Malawi 2000, Mali 2001, Mauritania 2000/01, Morocco 2003/04, Mozambique 2003, Namibia 2000, Nepal 2001, Nicaragua 2001, Niger 1998, Nigeria 2003, Peru 2000, Philippines 2003, Rwanda 2000, Senegal 1997, South Africa 1998, Tanzania 1999, Togo 1998, Turkey 1998, Turkmenistan 2000, Uganda 2000/01, Uzbekistan 1996, Yemen 1997, Zambia 2001/02, Zimbabwe 1999

Every year 68,000 women die from unsafe abortions. Conservative and judgmental attitudes of health care providers push young women to seek abortion services illegally with quack practitioners. To save these lives policymakers must give women knowledge about what is allowed by law and how to get access to safe abortion/post abortion services.[11]

Some governments have tried to remove parental/family consent as a prerequisite for adolescent mothers to seek reproductive health services.[18] Thus services have to be adolescent/youth friendly in order to increase their access.

Studies show that one in three maternal deaths could be avoided if women with unmet need for contraception were given expedited access to family planning services.

Strategy 3:

Access to reproductive health services

(family planning, safe abortion, adolescent friendly sexual and reproductive health services)

Women and their babies should have access to skilled obstetric and newborn care for the first 24-48 hours after delivery. A pregnant woman can die due to severe bleeding after delivery in just two hours.[19] So the necessary medications to save her must be available. Facilities/equipment for newborn revival after it is born need to be available wherever deliveries are taking place. Mothers should be counseled to start breast feeding immediately and give the baby the yellow colostrum before white milk appears.

Strategy 4:

Immediate care for mother and newborn after delivery

These first four strategies were decided by the global community of professionals in maternal health at the Women Deliver Conference 2007 as the most important to reduce maternal deaths.[20]

The Three Delays Model

The three delays model is a basis of classifying some of the major barriers to reach emergency obstetric care in time.

First Delay:

Women are often considered an economic liability and thus do not get preferences in health concerns. This hinders families from deciding to take them to a health facility to deliver. This delay in deciding to deliver at a heath facility is called the first delay.

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Second Delay:

The delay in taking a pregnant women to a health facility (which has skilled birth attendants and/or emergency obstetric care) is called the second delay. This occurs because of the delay in arranging for transport, or inability to pay for such transport. Bad roads and remoteness of locations add to this delay.

The Third Delay:

The delay in getting services after a pregnant woman has arrived at a health facility is called the third delay. It is essential to keep emergency obstetric care facilities open round the clock. Though there are markers to make the health systems appropriate for maternal health, strategies outside the health system have to be incorporated into policies and programming by the government. Both demand and supply side financial incentives have been seen to create demand and let skilled providers attend to home deliveries.

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2.2 Community Level

Challenges

- Parliamentarians are often not aware of the needs of pregnant women and thus cannot oversee government ***accountability*** for implementation of policies
- Communities do not know about their entitlements and often do not receive them
- There is lack of capacity of civil society to hold the government ***accountable*** and influence policy

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Micronutrient (minerals and vitamins) supplementation is a very important part of antenatal care. A minimum of four antenatal check-ups are recommended. Iron, folic acid and calcium tablets are a necessary part of antenatal care (care during pregnancy for women) along with the tetanus toxoid injections.

Protein energy supplementation for malnourished mothers is recommended, as well as treatment for HIV, TB, malaria and hypertensive disorders. Commodities such as bednets for malaria control through community-based distribution can play an important role in saving the lives of mothers and newborns.

Strategy 5:

Appropriate attention to diseases and micronutrient supplementation during antenatal checkups

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Emergency preparedness for families is an important preventive measure to save a mother's life. The entire household needs to be involved and aware of this process.

This includes steps such as:
- Justifying why a facility delivery is preferable
- Planning on how to get to the facility, such as keeping money ready for transport
- Arranging beforehand for the delivery cost (starting to save from early months, or getting health insurance)
- Understanding the complications that need immediate hospital delivery
- If family plans on a home delivery, arranging for a skilled birth attendant and preparing the right place and equipment beforehand
- Arranging for a blood transfusion card in countries where, it is difficult to get blood for transfusion at a short notice
- Making families aware of women's entitlements for facility delivery

Strategy 6:

Emergency preparedness and entitlement awareness for the entire family

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Civil society can hold governments to account and influence policy. By engaging civil society in policy decisions and helping to track any maternal deaths through a bottom up approach, civil society could be empowered to be a watchdog to hold governments accountable.

Strategy 7:

Strengthening civil society's capacity to act as a watchdog

2.3 National Governance Level

Challenges

- Absence of advocacy and political will
- Insufficient and uneven coverage of governmental and donor funding
  (Rigidities of government bureaucracy and limited fiscal space for additional public expenditure)
- Lack of supportive policies and legislation for maternal health
- Inadequate human resources for emergency and operative needs
- Inadequate involvement and resources from the private sector

There exists an uncertainty about the global burden of maternal mortality due to under-reporting of maternal deaths. Often national averages overlook the inequity of maternal mortality among geographical areas, socioeconomic strata and ethnic groups.

Where adequate data is present, it is seldom disaggregated (separately grouped) by age, geographical areas, wealth quintiles or population/ethnic groups. These disaggregations are required for good policy making.

Strategy 8:

Ensure reporting of adequate and reliable data on maternal and newborn deaths

The investment case for Maternal, Newborn and Child Health (MNCH) for Asia and the Pacific states that in order to implement a core package of services for MNCH, governments need to spend an additional US$3 per capita per year. However, to achieve the MDGs 4 and 5 by 2015 an additional US$10 per capita per year is necessary.[1] US$10 billion-30 billion are required from donors.

Strategy 9:

Governments and donors to spend more on maternal and newborn health

The finance, education and health sectors, donors, UN, civil society, parliamentary committees and the private sector need to be engaged. The private sector takes care of a large share of the health needs in the Asia-Pacific region. In order to attract the private sector to invest in the maternal and newborn health of poorer sections of societies, there is a need for legislation and funding appropriations. (i.e. setting aside a part of the government budget for this purpose)

Strategy 10:

Parliamentary national committees to engage different sectors and stakeholders in partnerships

Policy makers need to use different constitutional instruments such as parliamentary committees, debates on controversial spending, estimate process and appropriate reporting to constituencies to make sure there is transparency in the disbursement of donor funds.

Strategy 11:

Oversee government accountability for disbursement of donor funds in maternal health

WHO recommends a tool called the Maternal Death Review- a combination of verbal autopsy and clinical audit. A verbal autopsy finds the cause of a death based on an interview with next of kin/caregiver of the diseased mother. Clinical audits are done from service statistics and other records of the health care facilities.

2.4 Regional/Global Level

Challenges

- Countries are overburdened with too frequent reporting back
- After debt relief, fiscal constraints are coming in the way of maternal health
- Insufficient and uneven coverage of donor funding, which mostly funds specific projects
- Insufficient regional cooperation to achieve MDG 5

Some countries owe considerable debt to IMF or donor countries of the developed world. Giving recipient countries more time to pay back their debts or even cancelling such debts wherever possible, could help these countries concentrate their finances in solving maternal health problems.

Strategy 12:

External debt relief

Bilaterals/Donors need to earmark aid so that a substantial portion helps to support the national health budgets of developing countries.

Strategy 13:

Bilaterals/ Donors to support national health budgets

Inter-regional cooperation through exchange of technical expertise and knowledge sharing is urgently needed to help some countries catch up with their human resource needs (e.g.- Nepal). Different countries in the region have situational similarities and so exchange of knowledge and practices could help capacity building of its neighbours.

Strategy 14:

Governments to engage in regional cooperation to achieve MDG 5 by 2015 or beyond

Contracting out and contracting in models for PPP

Some countries have used Public Private Partnerships (PPP) to improve their health systems using the contracting out and contracting in models. Under the Contracting-Out model (CO), the contractor receives full authority and funds for staffing, management, operation costs, medicines and medical supplies. However, the targets are set by the government which include service coverage and system development (including quality indicators). Under the Contracting-In model (CI), the contracted NGOs receive funds to provide technical support to the Operating Districts (OD) but have limited administrative authority over them. The Ministry of Health (MoH) staff maintain the administrative authority working in the OD. Running costs for health services, supply of medications, consumable supplies and staff salaries are the responsibility of the MoH. A good example for where both these models have been piloted, is Cambodia.

Section 3:

Role of Parliamentarians

Parliamentarians need to use their different functions to advance the cause of maternal and newborn health /MDG 5:

- Advocacy function
- Legislative function
- Budgetary function
- Representative function
- Oversight function
- Accountability function

3.1 Advocacy Function

Actions Within the Parliament

Raise the issue and advocate for monitoring and evaluation	Take up a leadership role for maternal health	Propose a bill
Request ministers to report back on the status of maternal health and be answerable	Hold briefings with MPs to advocate for greater budget allocation	Build alliance with gender focus and maternal health as a human right
Raise the issue and advocate for monitoring and evaluation	Advocate for maternal health with evidence based information from health systems research	Present civil society experiences

Actions Outside the Parliament

Speak at public events	Use media	Educate constituents in emergency preparedness
Mobilize constitutents for community participation	Organize study tours and field visits	

"In spite of the Global Push to reduce Maternal Mortality by 3/4 by 2015, the prediction is that this goal will not be met. It is very appropriate that parliamentarians intervene and give required stewardship and introduce appropriate strategies to change its course for the betterment of humanity."

Hon. Nimal Siripala De Silva, Minister of Healthcare and Nutrition, Sri Lanka, at AFPPD/UNFPA Asia Pacific Consultation on Maternal Health, Bali

Specific Advocacy Areas

Advocate for MDG 5/Maternal Newborn and Child Health (MNCH) so that:

- Governments and donors invest more in maternal and newborn health
- Reporting /registration of maternal and newborn deaths takes place
- Basic obstetric care is available at the primary health care level
- National, regional and global consorted action is mobilized for maternal, newborn and childhealth
- Four basic EmOC facilities and one comprehensive EmOC facility are available for every 500,000 people
- There is ownership of a national strategic plan for maternal, newborn and childhealth

Enhance Budget Allocation for Maternal Health

If governments invest more than 10% of their GDP on health, the returns would go far beyond healthy mothers and children. Five reasons why they should invest more.

- The health of women and children is valuable in itself
- There are proven interventions that can cut down maternal and newborn deaths
- It would cut down on governmental expenditure on treatments; families could spend less out of their pockets on health; the future workforce of the nation would be born healthy
- It would bring greater peace and stability in their country
- With improvement in maternal health, the health system would improve in general [1]

The Paris Declaration

The Paris Declaration (2005) aimed at improving the effectiveness and efficiency of aid provided to developing countries to attain the MDGs. It gave emphasis on strong national ownership of developmental strategies, increasing alignment of donor support to national plans and systems along with strengthening their capacity to manage resources, ensuring greater harmonization among donors, managing aid to produce real and measurable results and mutual accountability between partner countries and donors.

Donors to Enhance Support

Donors should invest more in maternal health. Parliamentarians have an important role to play in advocating for increased donor funding for maternal health in the Asia-Pacific region:

- To ensure commitments for an additional US$10-30 billion being mobilized for MNCH
- To arrange for debt relief for countries which have the high maternal and newborn deaths
- To earmark aid so that a substantial portion goes to support the national health budgets

3.2 Legislative Function

Too often maternal death and disability are accepted as natural consequences of pregnancy and delivery. Seldom is it regarded as a tragic failure of policy decisions and public health measures. There is an assumption that women have to accept these inevitable losses. Laws that give access to quality universal maternal care and reproductive health (including family planning and safe abortions) are needed.

Parliamentarians can use their access to legislative processes to advocate for maternal health, including:

- Launch a review on existing laws for maternal and newborn health
- Consult on amendment, enforcement and new legislation
- Ensure maternal and newborn health legislation is consistent with other legal instruments
- Hold hearing with different stakeholders to identify gaps in legislation
- Work with courts to audit and monitor legislation
- Create and work with parliamentary committees

Improve Access to Maternal Health

Parliamentarians can introduce, amend, monitor and enforce laws to improve universal access to maternal healthcare. They can create and review broad laws and policy to provide universal quality services for women during pregnancy and childbirth and adopt legislation to support midwives and skilled birth attendants at primary care level.

Good Practice Example: Laws on Adolescent Health

The government of Nepal adopted a national plan in 2000 to combat its high level of unmarried pregnancies. The plan was an attempt to provide adolescents with comprehensive sexuality education and specified who would be acting as the "educators". It also included service delivery and provided a safe and supportive environment to adolescents. In 2003, the Philippines adopted a law to prevent child exploitation. In 2002, Bangladesh adopted a law against trafficking and sexual exploitation. [Source: Ref.I8]

Ensure Adolescent Reproductive Health Services

Parliamentarians can adopt legislation to protect the human rights of adolescents to access information and services. They can create laws to ensure that young people have access to confidential reproductive health services.

Laws on Abortion

The Programme of Action of the International Conference on Population and Development (ICPD) states that abortion should never be promoted as a method of family planning. Parliamentarians should:

- Strengthen their commitment to deal with unsafe abortions
- Aim to reduce the number of abortions through expanded and improved family planning services
- Provide reliable information and counseling services to women who have unwanted pregnancies
- In circumstances where abortion is not against the law, safe, accessible and reliable services should be provided
- Support laws to decriminalize abortion and give greater access to safe abortion services which have been shown to save more maternal lives

Contraceptive and Family Planning

Parliamentarians can amend existing laws that stand in the way for access to family planning or contraception. They can adopt legislation to provide emergency contraceptive pills (ECP) over the counter. However this have accompanied clear guidelines on who can use them and the fact that ECP is only a measure for failed contraception and should not be used as a contraceptive method for regular use.

Maternity Benefits

Maternity benefits need to be in place in accordance with International Labour Organization (ILO) convection 183. This covers maternity leave and breast feeding rights of working mothers.

Child Marriages

Promote the 'Right to consent to marriage' and raise the age of marriage, as children do not have the maturity to understand about informed consent.

Harmful Practices

To introduce and monitor the enforcement of legislation against harmful traditional practices.

Good Practice Example: China

Strong political will at the national level in China ensured accounting for maternal deaths. This helped China to bring down its MMR from 1500 in 1950s to 74 in rural China in 1998.

China's strong family planning programme had contributed by bringing down the total fertility rate from 5.81 in 1970 to below 2 in 1998 MoPH, China.

Maternal mortality is one of the three main indicators reviewed annually and discussed publicly. The results of this review guides policy.

The national focus has helped document information as to where women are delivering and see that every maternal death is followed up from bottom up throughout the entire health system. [Source : Ref.22]

3.3 Budgetary Function

Parliamentarians can be an intermediary with the budget committee to focus on MDG 5 and can hold ministers accountable for funds spent on MDG 5. They can engage civil society in dialogue for funding issues for MDG 5. They can ensure that national budgets use age and sex disaggregated data.

Parliamentarians can persuade governments to spend an additional US$ 3 per mother and child per year and try to bring down OOP expenses of families to 30% from current 50-80%. Parliamentarians can support micro-finance initiatives, demand side initiatives and provide incentives to take skilled providers to attend to home deliveries or give round the clock services at health facilities.

Good Practice Example: India

Chiranjeevi yojana in Gujrat and Janani Suraksha Yojana in other states motivate poor women to go for facility deliveries. These cover costs to reach the facility, wages for the accompanying person, delivery costs and medicines. Additionally, private gynecologists included in the scheme have their fees reimbursed through state level subsidies. [Source:Ref.22]

Monitor Use of Funds

Parliamentarians can oversee government transparency in disbursement of funds, oversee documentation of funds spent on MDG 5 and champion the cause of removing corruption in disbursement of funds.

3.4 Representative Function

Be the Spokesperson for Pregnant Women

Encourage the formation of watch groups and mother groups among rural/underprivileged women and voice the concerns of pregnant women in the parliament.

Arrange Grievance Cells

Arrange for grievance cells so that pregnant women may lodge their complaints about not getting their entitlements.

Speak Out on Behalf of Disadvantaged Groups

Draw attention to lack of services for disadvantaged groups through media and voice their concerns at high level forums to influence policy.

Grievance cells are a public complaint mechanism where individuals can report and file complaints about faulty or lacking services

3.5 Oversight Function

Monitor Implementation of Policies

• Make services ***available***. Ensure that for every 500,000 people, there are four basic obstetric care facilities and one comprehensive emergency obstetric care facility
• Make services ***accessible***. Upgrade primary health care to include basic obstetric care. Arrange for roads and transport to access them
• Make services ***affordable***. Remove user fees for delivery and emergency obstetric care and/or arrange for reimbursements for the clients such as conditional cash transfers and other financial incentives for facility delivery
• Make services ***effective***. Prioritize strategies for childbirth and first 24 hours. Focus on adolescent mother and poorest sections of the society. Maintain a continuum of care approach and upgrade midwifery skills

Act Globally and Regionally

Reach a common understanding to limit frequent reporting back by countries. Lobby for appropriate and adequate donor funding. Enter into dialogue with donors for external debt relief as appropriate. Engage in inter-regional cooperational initiatives.

"Clergymen in Bangladesh are also supporting the programme for healthcare for mothers and child."
Hon. Mrs. Shirin Sharmin Chaudhury, State Minister for Women and Children Affairs, Bangladesh at AFPPD/ UNFPA Asia Pacific Consultation on Maternal Health, Bali

Good Practice Example: Nepal

Nepal's successes in progressing towards meeting MDG 5 could be attributed to: increasing access to safe abortion services; the female voluntary health workers programme [which increased demand for facility based delivery, tackling post partum haemorrhage (bleeding immediately after childbirth) by innovative approaches, giving Vit.A injections to boost the immunity of mothers after childbirth] and free delivery at public health facilities. [Source :Ref 22]

3.6 Accountability Function

Parliamentarians can encourage governments to adopt a bottom up tracking mechanism for maternal and newborn death, ensure women receive their entitlements, and ensure governments are accountable for every maternal and newborn death. Additionally they can make the health care delivery system ***Accountable***. They need to ensure good quality maternal, newborn and child health services by promoting human resources for health and health infrastructure at the local level.

Take-Home Messages

MDG 5 will not be achieved by a business as usual approach. Policy makers need to convince governments of the return on investments if additional US$3 per capita per year for a core package or US$10 per capita per year is invested in maternal, newborn and child health to achieve MDGs (5&4) by 2015. Each country needs to come up with its own investment policy for allotting money in its national context and primary health care plan. They need to convince donors to invest more in maternal, newborn and child health.

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Parliamentarians need to make greater use of evidence-based information for policy-making, what interventions are to be scaled-up and where to implement them. So policies need to focus on proven interventions that work, such as access to skilled birth attendants, emergency obstetric care, reproductive health services (including family planning, safe abortion/post abortion services and adolescent friendly health services) and immediate care for mother and child after delivery. They need to be aware of the latest innovations as well as the local needs.

Parliamentarians can legislate, budget, advocate and oversee that policies are in place. They can remove barriers to access to health care services such as user fees and high delivery costs, inadequate transport/ communication facilities and lack of demand for facility delivery. These can be done through financing mechanisms such as conditional cash transfers for delivering at a facility or provider incentives for persuading skilled providers for delivering at home. It is also necessary to find new financing mechanisms to cover for exemptions and fees granted to the poorest fringe of the society.

Parliamentarians need to represent the voices of women in the parliament. They need to make sure that women are aware of their entitlements and receive them appropriately. They should ensure that programmes are in place for the education of families (especially men) in emergency preparedness. It is beneficial to speak out against violence and educate male partners of pregnant women for this.

Additionally parliamentarians need to engage civil society as a watch dog to influence policies. They need to see that governments partner and coordinate with civil society, private sector, the UN and bilaterals/ donors to achieve MDG 5. They need to speak out in the parliament, champion the cause, build coalitions, adopt motions, hold briefings, hold ministers accountable, organize public and media events, go for field tours and educate the constituency on MDG 5 issues.

Parliamentarians need to oversee that tracking mechanisms are in place for maternal deaths through the entire health system, with a bottom up approach. This way they can be accountable to their own constituencies for every maternal death.

Annex -1: Check List for Parliamentarians

POLICY IN PLACE	YES (0) NO (X)	COMMENTS
Is there a national policy in place to promote safe motherhood?		
Are safe motherhood programmes monitored and evaluated nationally, regionally and locally?		
Is safe motherhood addressed in -Sector Wide Approaches? -Poverty Reduction Strategy Papers?		
Is the maternal, newborn and child health (MNCH) policy included in the national primary health care plan?		
DATA		
Is MDG 5 & 4 data reported from the national and sub-national levels?		
Are maternal death and disease data disaggregated by age?		
RESOURCE MOBILIZATION		
Is government funding more than 5 % of GDP for maternal and child health?		
Is government funding more than 10 % of GDP for health?		
Are donors funding national health plans? If yes, what percentage of their funding is alloted to this?		
Are demand side financing systems/need based subsidies in place for maternal health?		
Are cost recovery systems in place for maternal health?		
Are public private parternships in place for health or especially maternal health?		
Are incentives in place for skilled providers to conduct deliveries at home?		

COVERAGE & ACCESS	YES (0) NO (X)	COMMENTS
Are there adequate Emergency Obstetric Care (EmOC) services? [Recommended - Four basic essential EmOC facilities and one comprehensive EmOC facility per 500,000 people]		
Are EmOC services available in rural belts and remote areas?		
Are economically disadvantaged and marginalized women having access to EmOC services?		
COMMUNITY MOBILIZATION		
Are there mother groups in rural areas?		
Do community members take part in verbal autopsy?		
BASIC EMOC AND NATURE OF BIRTH ATTENDANTS		
Are PHC facilities working as Basic Emergency Obstetric Care facilities?		
Are the basic EmOC open for 24 hours per day?		
Do they have skilled birth attendants? (doctors, midwives,nurses, professionally trained in midwifery skills)		
Do traditional birth attendants conduct deliveries?		
If yes, in what percentage of deliveries do traditional birth attendants conduct?		
MONITORING MATERNAL DEATHS		
Is there any monitoring /tracking mechanism for maternal deaths?		
A. At the health facility level?		
B. At the community /constituency level?		
c. At the sub-national (district/province/state) level?		

Annex-2: AFPPD and Maternal Health

Since 1981, from the time of its inception, AFPPD and its 25 national committees have been working to empower parliamentarians to increase their understanding of reproductive and maternal health along with other population and development issues. It highlighted the Asia Pacific perspectives of maternal mortality and child survival since 1994 and MDG 4&5 since 2000, mobilising parliamentarians for the same. AFPPD was awarded the UN population award in 2010 for its work with parliamentarians on population, development and related issues.

For maternal, neonatal and child health, AFPPD engaged parliamentarians in special projects such as the person- to- person advocacy project, several study visits and educational opportunities in health. It brought parliamentarians together in discussions through the following meetings and conferences.

1994, September 2-3, Egypt	**International conference of parliamentarians on population and development**. This was held with the ICPD of 1994 **Outcome:** It was a major UNFPA initiative for parliamentarians to start working in reproductive health and rights in addition to maternal health.
1999, Hague, The Netherlands	ICPD +5/**15th International Parliamentarians' Meeting on "Action After The Hague"** **Outcome:** Population issues and unwanted pregnancies were discussed which directly affect maternal health.
2002, July 8-12, Japan	Asian Population and Development Association, (APDA), organized a **Study visit for Lao PDR parliamentarian delegation to Japan** **Outcome:** The study visit covered community based family planning and Maternal and Child Health (MCH) programmes in Japan.
2004,June 29-30, Canberra, Australia	**2nd Asia Pacific Women Parliamentarians and Ministers Conference** **Outcome:** Gender equality and equity for health care of women was highlighted. It reminded parliamentarians about the paradigm shift of ICPD of addressing population by its quality and not by its quantity.
2005, June 29-30, Cebu, Philippines	**First focus group meeting on MDG and RH** **Outcome:** Parliamentarians from 14 countries pledged to work for Reproductive Health as their personal priority.
2005, December 27-28, New Delhi, India	**Second focus group on maternal and child health** **Outcome:** Consensus on moving forward with the parliamentarians who discussed their follow- up plans (20 parliamentarians from Bhutan, India, Iran, Nepal, Pakistan, Sri Lanka, Thailand and Vietnam)
2006, September 1-3, Seoul, Korea	**Parliamentarians workshop on MDGs and the international developmental cooperation with Asia Pacific Region with APPCED** **Outcome:** Health MDGs were highlighted by parliamentarians and actions at the national level were planned for.

2007, October 18-20, London UK	**Women Deliver International Conference, AFPPD/EPF co-hosted a special parliamentarians symposium : Women's health-parliamentary initiatives across the regions of the world** **Outcome:** More than 50 women parliamentarians including US Congress members participated. The conference highlighted the issue of Women Rights and Maternal health.
2007, November 6-7, Bangkok, Thailand	**"Brainstorming meeting on parliamentary advocacy for the MDGs"** **Outcome:** To revitalize the national MDG oversight committees, a policy advocacy tool was developed to incorporate MDGs into the national policy framework and budget plan
2008, September 23-24,Ulaanbaatar, Mongolia	**Regional Conference of Women Ministers and Parliamentarians, "Financing the MDGs with focus on health and gender"** **Outcome:** Plan for financing for MDG 4 & 5 was discussed by more than 100 parliamentarians with UNFPA, the President of Mongolia addressed the issue.
2008, Hanoi, Vietnam	**9th General Assembly of AFFPD, Hanoi, Vietnam** **Outcome:** Questionnaires on MDG 5 and maternal health were circulated to attending parliamentarians enquiring about their work so far in this area.
2008, December 22, New Delhi, India	**Indian Association of Parliamentarians on Population and Development-IAPPD** **Outcome:** A briefing kit on maternal Health was released by the Hon. Prime Minister of India, Dr. Manmohan Singh, in the presence of Union Health Minister Dr. Anbumani Ramadoss and 50 Members of Parliament of India on Maternal health.

Prime Minister of India released a briefing kit on Maternal Health for elected representatives on 22 December 2008 on behalf of IAPPD/AFPPD

2009, August 13-15, Bali, Indonesia	**Asia Pacific Parliamentarians Consultation on Maternal Health and Rights with UNFPA** **Outcome:** Parliamentarians committed to country level action on maternal health and rights.
2009, New Zealand	**Open hearing on maternal health in the Pacific by the New Zealand parliamentarians groups** **Outcome:** The report is a rich source of information on maternal health situation in the Pacific countries.
2009, Ethiopia	**High level meeting on maternal health by the Netherlands Government and UNFPA** **Outcome:** 150 participants, including 17 Ministers, 2 Deputy Ministers, Members of Parliaments, representatives of NGOs and donor agencies along with representatives, regional intergovernmental organizations, youth groups, private sector and civil society from around the world, and regional parliamentary networks and UNFPA with government of the Netherlands. It highlighted: (1) To prioritize family planning as the most cost effective development investment ; (2) To make adolescents a priority by investing in their health, education and livelihoods; and (3) To strengthen health systems with sexual and reproductive health as a priority. A statement was adapted at this meeting. AFPPD arranged participation of parliamentarians from Asia-Pacific.
2009, Ethiopia	**"International Parliamentarians Conference on the Implementation of the ICPD Programme of Action (IPCI/ICPD)", Addis Ababa, Ethiopia** **Outcome:** More than 400 Parliamentarians from all regions of this world discussed issues related to population, Reproductive and Maternal Health and Women Empowerment and made an urgent call to action for Maternal Health. It was co-organized by AFPPD and other regional parliamentarian's forum.
2010, Thailand	**The Senate Sub-committee on Public Health in Thailand held an open hearing of the population sub-committee on MDG-5** **Outcome:** Among their discussions and hearings on Maternal Health and MDG-5 discrepancies between the national statistics for maternal deaths and the international reporting for Thailand was mentioned. The reasons were discussed.

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We The policy makers

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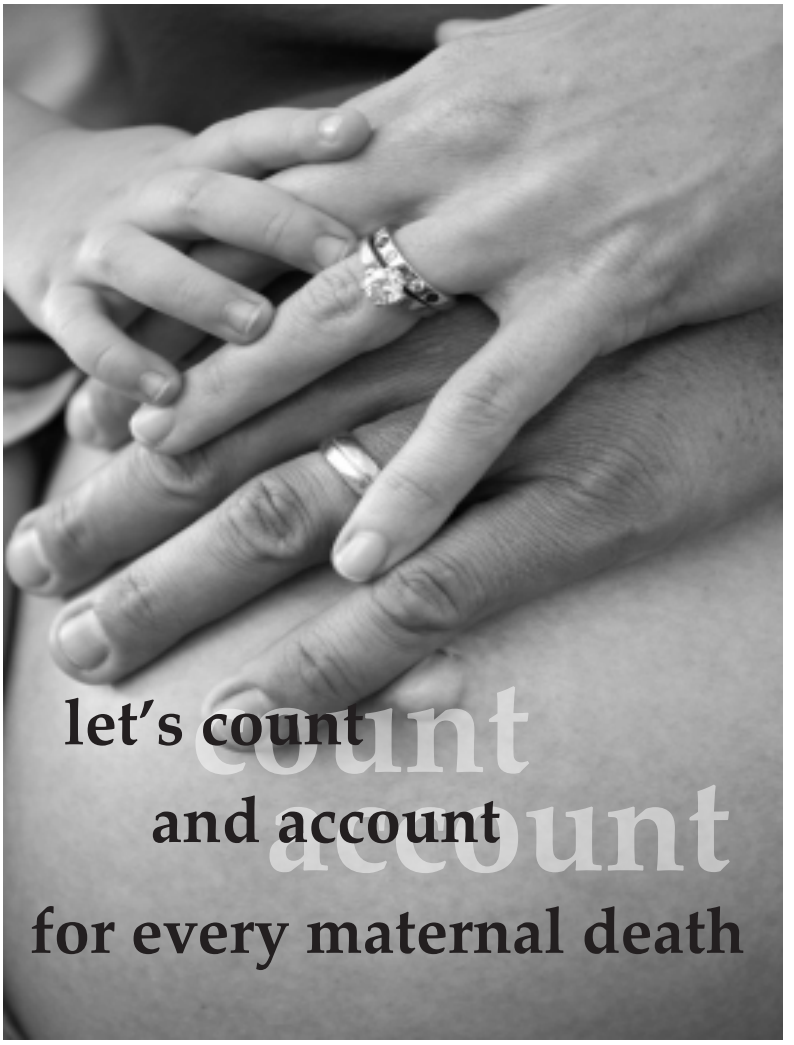
You The family members

TOGETHER WE CAN !



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