# Symposium on Maternal Health in Developing Countries

- What should be done to meet the Millennium Development Goals? -

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# REDUCING MATERNAL MORTALITY:
# PROGRESS AT LAST !

*Deborah Maine, PhD, Director*
*Averting Maternal Death and Disability (AMDD) Program*
*Mailman School of Public Health, Columbia University, New York*

The current Safe Motherhood Initiative (SMI) began in the early 1980s, when a number of high-quality studies of maternal mortality in developing countries were published. In 1987, the SMI was formally launched at an international conference in Nairobi, Kenya. This was followed by a series of advocacy conferences.

Ten years later, at a review conference in Colombo, Sri Lanka, it was widely acknowledged that relatively little had been accomplished. There are probably a number of reasons why this was so, but two of the most important must be:

1. lack of a clear strategy focused on proven mechanisms for preventing deaths from obstetric complications; and
2. lack of field projects generating information on how to design, implement and monitor effective, cost-effective programs.

In 1999, the Gates Foundation awarded Columbia University $50 million for a 5-year program -- the AMDD Program. The aim of this program was to remedy the shortcomings of the SMI to date, by promoting field projects designed to improve the availability, quality and utilization of emergency obstetric care (EmOC). These projects are carried out by AMDD's partner agencies, which include UNICEF, UNFPA, CARE and Save the Children (USA), among others, with financial and technical support from AMDD.

Four years later, we have seen tremendous progress at the project and the policy levels. At the project level, our partners are implementing more than 80 projects in 51 countries with AMDD support. Moreover, they are also replicating these projects using other funds.

Field projects not only save women's lives, but they are extremely valuable in pointing out specific policy barriers at the national and international levels that need to be dismantled. Consequently, we are seeing important policy changes, such as a resurgence of training nurse anesthetists in India, thus increasing the availability of EmOC in small hospitals.

Finally, not only are our partners incorporating EmOC into their ongoing program activities, but other donors are supporting, expanding and replicating these efforts. Thus, there is now a global momentum to reduce maternal mortality, at last. A number of key roles that Japan and UNICEF can play will be discussed in this presentation.

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# Ensuring Women's Access to Emergency Obstetric Care: The UNICEF Experience

*Marilen Danguilan*
*Sr. Adviser, Maternal Health*
*UNICEF*

To this day, women continue to die from the age-old and most common complications of pregnancy and childbirth -- hemorrhage, infections, unsafe abortion, obstructed labour, and the hypertensive disorders of pregnancy.

Since the launching of the Safe Motherhood Initiative in 1987, most efforts have been concentrated on predicting and preventing obstetric complications, i.e., antenatal care; training traditional birth attendants; micronutrients; and community mobilization. On their own and without any linkages to life-saving services, these initiatives have not succeeded in preventing maternal deaths and disabilities.

The most important fact about maternal deaths is that any pregnant woman can develop complications at any time during pregnancy, at delivery, or in the postpartum period. This means that all pregnant women are at risk. We cannot predict or prevent most of the obstetric complications that lead to death. But they can be treated.

Thus, agencies and governments have to ensure that health facilities are able to ensure that women have access to quality emergency obstetric care (EmOC).

Substantial evidence, historical and current, show that EmOC saves women's lives. For instance, studies show that maternal mortality fell so steeply in England and Wales in 1950 that the MMR was only a fifth of the ratio in 1935; Scotland shows a similar trend. The dramatic decline in maternal mortality was a result of the introduction of penicillin, blood transfusion on a large scale, and improved obstetric care in general.[1]

Given all these, providing EmOC is UNICEF's core strategy in preventing maternal deaths. Once EmOC is in place or is assured of being put in place, UNICEF can work on other measures such as strengthening referral systems, i.e., making sure that a woman in a village is able to get to the hospital on time; community mobilization, i.e., organizing for health financing, transport, and communications; antenatal care, i.e., providing information to women and their families regarding the "danger signs of pregnancy" as well as providing other services such as promotion of family planning, anti-malarial therapy, voluntary and confidential counseling and testing for HIV/AIDS, tetanus toxoid immunization, and micronutrients.

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[1] Loudon, I. Death in child-birth: an international study of maternal care and maternal mortality 1800-1950. Oxford University Press, 1992.

# Accelerating Efforts to Reduce Maternal Death and Disability
## -- The Power of Partnership

*Yasmin Haque*
*Project Officer, Health*
*UNICEF Bangladesh*

The context of Bangladesh is one characterised by low levels of utilisation of essential maternal health services and high rates of maternal mortality. This situation is aggravated by low status of women, strong patriarchy, neglect and harmful practices during pregnancy and childbirth. Emergency Obstetric Care (EmOC) is now globally accepted as a necessary intervention for preventing the death and disability of women who develop life-threatening complications. The Government of Bangladesh has formulated the national strategy for maternal health, which includes plans for establishment of EmOC Services in all district hospital (DH) and 120 Upazila Health Complexes (UHCs) as a major area of focus for reducing maternal mortality. Efforts have focused on programming for reducing the three delays that lie between a woman with obstetric complications and the care that she needs to prevent death or disability – delay in deciding to seek care, delay in reaching a facility where care is available, and, delay in getting appropriate and quality treatment. A positive trend in utilisation is already evident. Comparison of the situation of the process indicators in 1994 and 1999 revealed that nationally the met need of EmOC – proportion of women with obstetric complications treated at facilities – had increased from 5% to 27%, and, proportion of births by caesarean section has increased from 0.7% to 2.2%.

The Women's Right to life and Health Initiative is a collaborative effort of the Government of Bangladesh, UNICEF and the Averting Maternal Death and Disability programme of Columbia University. It aims to contribute to an improvement in the availability and use of EmOC, to focus on the deeper quality issues, and to promote action in family and community. The focus is on three overlapping domains of ensuring quality technology, excellence in management of services, and, respect for human rights. Major activities include capacity building and training of "EmOC teams", provision of necessary equipment and instruments, and establishment and strengthening of MIS for generating data on process indicators. Early success of the initiative is evident from a comparison of the baseline (1999-2000) and 2002 status and performance of selected facilities which shows a 106% increase in complicated cases managed, a 49% increase in births, and 53% increase in caesarean section performed.

Government of Japan (GoJ) support has significantly contributed to these achievements. In 1998, in response to UNICEF support for GoB Emergency assistance appeal, GoJ provided USD 3Million for programming in health sector of which USD1.2 million was used to procure Operation Theatre Equipment for 22 Comprehensive EmOC sites and other hospital supplies and drug kits for 179 facilities. Japan Government has also supported the construction and upgrading of the Maternal and Child Health Training Institute and provides important technical assistance to human resource development for maternal health care, including EmOC. In 2001, GoJ committed to equip more Comprehensive and Basic EmOC sites. In phase I, 27 CEmOC facilities and 64 BEmOC facilities have been equipped by Feb 2003. In phase II, 20 CEmOC facilities and 128 BEmOC facilities will be equipped. UNICEF has assisted in executing GOJ grants through finalisation of specification and supply lists, procurement, providing data of facility needs assessment, monitoring end use of supplies, monitoring and reviewing functioning status, developing capacity human resources, ensuring readiness of facilities.

To conclude, a critical partnership has developed to support the resource (technical and financial) constrained situation that GoB has faced in its effort to ensure provision of life saving services for the women of Bangladesh.

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# Human Resources Development in EOC
## ＜Experiences in Bangladesh＞

*Takako Yamada*
*Former Bureau of International Cooperation*
*International Medical Center of Japan*

Human resources development in reproductive health is the most crucial issue in Bangladesh. The skilled health professionals for reproductive health especially safe delivery, Emergency Obstetric Care (EOC) and essential newborn (ENC) care should be ensured to reduce maternal mortality rate and neonatal mortality rate. HRD aims at having the right people with right skills in the right place at the right time. Appropriate service delivery system is required for skilled professionals to provide their skill to women who need in anywhere at anytime.

There are two major categories of service providers for safe delivery, EOC and ENC. One is a skilled birth attendant for home deliveries so called community midwife (trained midwife in the community who have completed a set course of study and are registered for legally license to practice) and another is medical personnel for institutional deliveries. It is mentioned that there should be one skilled birth attendant per 5,000 population (FIGO 1990) and at least one EOC facilities in where trained medical personnel team for complicated deliveries including Caesarean section is working for 24 hours per 500,000 populations.

JICA has implemented technical cooperation for HRD in reproductive health in Bangladesh from 1999 for five years. Training program for community midwife was conducted at Maternal and child health training institute (MCHTI). Based on the experiences it should be stressed that HRD is not only the training itself, training program in the institute is a part of whole process to reduce maternal mortality rate. Monitoring and evaluation at working site of trainees after the training to measure the impact of the training, follow-up and communication between trainers and trainees, and back-up system for trainees after finishing the training course in the institute are crucial to sustain the effect of the training.

The presentation will be consisted of following issues.

1. Current situation of maternal health in Bangladesh
2. Health and population sector program (HPSP 1998- 2003)
3. Bangladesh national strategy for maternal health
4. Service providers for maternal health
5. Training institutes
6. Community midwife training
7. Follow-up of the training
8. Collaboration of Japanese grant aid and UNICEF for EOC

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# Seizing Opportunities: the Uganda Experience

*Marilen Danguilan*
*Sr. Adviser, Maternal Health, UNICEF*

One of the eight countries that account for most maternal deaths is Uganda. The other countries are Bangladesh, Ethiopia, India, Indonesia, Nepal, Nigeria, and Pakistan. Uganda's maternal mortality ratio is 505/100,000 live births (UDHS 2000/01).

In August 2002, the Ministry of Health (MOH) had an internal meeting in which all the key staff of the different offices of the MOH attended. UNICEF seized this opportunity by suggesting to the MOH that, in the light of this national meeting, it was an opportune time to make a presentation of strategies to the MOH on how best to reduce maternal deaths.

UNICEF therefore presented its core strategy, i.e., provision of EmOC, and argued why EmOC services play a central role in reduction of maternal deaths. Until and unless life-saving services are in place, maternal deaths will not decline. After this meeting, UNICEF Uganda Country Office continued to advocate to the MOH for ensuring that health facilities are capable of providing life-saving services.

The government of Uganda and health sector development partners held the 7th Joint Review Mission (JRM) on the implementation of the health sector strategic plan (HSSP) in October 2002. The aim of the mission was to review the performance of the health sector for the financial year 2001-2002, confirm the sector priorities for financial year 2002-2003, and consider proposals for 2003-2004. The key issues raised during the 7th JRM are the lack of progress in reducing maternal deaths and the need to increase facility-based deliveries. The 7th JRM agreed that maternal mortality reduction is one of the top priorities, which the government should pursue. Further discussion on strategies would take place in the 8th JRM in April 2003.

In response to the 7th JRM undertaking, the Uganda UNICEF Country Office seized this opportunity – the second one -- and supported the Ministry of Health conduct a national needs assessment on health facilities, which can deliver EmOC. The Ministry of Health and UNICEF agreed that the results of the needs assessment on EmOC would be presented to the development partners and donors at the 8th JRM in April 2003.

The preliminary results showed that Uganda had enough health facilities, which could provide comprehensive EmOC but sorely lacked health facilities which could provide basic EmOC. There were no drugs, supplies, equipment, and staff. Many health facilities were not functional and thus, could not operate on a 24-hour basis. Clearly, a situation such as this could not respond effectively and adequately to emergencies.

The MOH in the 8th JRM, which was attended by development partners, and donors presented these results in April 2003. The hard evidence of these data jolted the participants of the 8th JRM to the fact that women are dying because they do not have access to life-saving EmOC. When the tables showing the proportion of facilities actually providing basic or comprehensive EmOC went up on the screen (including some zeros for some categories of facilities), the tone in the room changed. From there on, much of the discussion was about issues such as human resources, supplies and how to make these facilities function.

As a result, the 8th JRM MOH, development partners, and donors agreed that the first step to reduce maternal deaths is to ensure that health facilities should provide life-saving EmOC services.

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# UNICEF Experience in Building Partnerships to Reduce Maternal Mortality: The Egypt Case

*Leila Bisharat*
*Director of the Center for Reproductive Health*
*John Snow Inc.*

The presentation will review UNICEF's assistance in support of Egypt's Ministry of Health over the period 1996-2001 to address the unnecessary loss of mothers' lives during childbirth.

Egypt experienced a sharp decline in maternal mortality during the 1990s, becoming one of the very few countries in the developing world to have gathered high quality evidence of substantial improvements between the World Summit for Children in 1990 and the Special Session on Children.

Partnerships that pursued a focused, practical strategy appear to have been an important part of the dynamic. UNICEF Egypt played a leadership role among the partners, assisting the Government of Egypt to develop an operational safe motherhood strategy emphasizing

1) emergency obstetric response - facility and human resource capacity
2) teambuilding of "high-performing EmOC teams in comprehensive and basic facilities of the Ministry of Health in the most deprived governorates of Upper Egypt
3) understanding barriers that prevented women reach appropriate care for obstetric complications in time, and action steps to remove those barriers working with local NGOs and communities 4) the use of a small set of process indicators by all involved (emergency obstetric teams, in the facilities, district leaders, governors, the central Ministry of Health) to identify performance gaps, address them and track progress.

UNICEF also emphasized across the process measurement that was not only appropriate for action but of the caliber that would stand up to international scrutiny. The presenter will summarize how this was done and the findings of Egypt's national maternal mortality audits – both the 1992-1993 and 2000 audit. Egypt is only one of two developing countries (the other is Honduras) with this depth of "gold standard" evidence on the levels of maternal mortality, and the reasons mothers die.

The presenter will describe how partnerships with a range of organizations - donors, medical professionals, the UN system, local NGOs, Egypt's local government administration - expanded the improvements taking them to scale. But it was the clarity of the "Emergency obstetric care strategy" - with its practical improvement steps within facilities - led by high-performing local medical teams - which accelerated improvements - building confidence as it went among medical staff and families in nearby communities.

From three impoverished governorates in Upper Egypt, political ownership expanded to all 27 of Egypt's governorates with a formalized Safe Motherhood Committee in each governorate keeping this national priority on everyone's agenda. Ownership by leaders in the national medical community proved to be an enabling factor, especially when linked by UNICEF to centers of excellence, such as the AMDD at Columbia University.

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