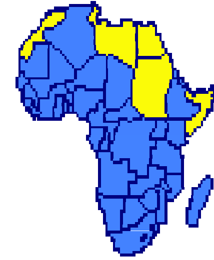
THE WORLD HEALTH ORGANISATION
AFRICA REGION



IMPLEMENTATION OF THE

MAKING PREGNANCY SAFER INITIATIVE (MPS) WITHIN THE CONTEXT OF THE ROAD MAP FOR ACCELERATING THE ATTAINMENT OF THE MILLENIUM DEVELOPMENT GOALS (MDG's) RELATED TO MATERNAL AND NEWBORN HEALTH (MNH) IN AFRICA

TABLE OF CONTENTS:

		Page
	List of Abbreviations	3
1.0	Executive Summary	4
2.0	Introduction	6
3.0	Background	9
4.0	Millennium Development Goals	17
5.0	Making Pregnancy Safer	19
	5.1 MPS	19
	5.2 The Interrelationship Between SMI and MPS	19
	5.3 The Vision	19
	5.4 The Mission	19
	5.5 Key Messages	20
	5.6 The Guiding Principles	20
	5.7 Priority Actions for MPS	21
6.0	The Road Map	22
	6.1 The MPS Initiative and the Road Map	22
	6.2 Goal	22
	6.3 Objectives	22
	6.4 Implementing Strategies	23
7.0	Indicators for Assessing MNH Progress	27
	7.1 Indicators at Country level	27
	7.2 Indicators for measuring progress of the Road map	28
8.0	The Role of WHO in Implementing MPS Initiative	29
9.0	The Regional Advisor for MPS	30
10.0	References	31

i. LIST OF ABBREVIATIONS:

No.	Abbreviation	Meaning
1.	**AIDS**	Acquired Immunodeficiency Syndrome
2.	**AFRO**	World Health Organization Regional Office for Africa
3.	**CRHCS**	Commonwealth Regional Health Community Secretariat
4.	**DHMT**	District Health Management Team
5.	**DHS**	Demographic and Health Survey
6.	**FCI**	Family Care International
7.	**FHI**	Family Health International
8.	**FP**	Family Planning
9.	**FWCW**	Fourth World Conference on Women
10.	**HIV**	Human Immunodeficiency Virus
11.	**HIS**	Health Information System
12.	**IAG**	Inter-Agency Group
13.	**ICPD**	International Conference on Population and Development
14.	**IMR**	Infant Mortality Rate
15.	**JHPIEGO**	Johns Hopkins University Program for International Education in Gynaecology and Obstetrics
16.	**MDG**	Millennium Development Goal
17.	**MM**	Maternal Mortality
18.	**MMR**	Maternal Mortality Ratio
19.	**MNH**	Maternal and Newborn Health
20.	**MOH**	Ministry of Health
21.	**MPS**	Making Pregnancy Safer
22.	**MSD**	Millennium Summit Declaration
23.	**NGO**	Non-governmental Organisation
24.	**NMR**	Neonatal Mortality Rate
25.	**PND**	Perinatal Death
26.	**RHRU**	Reproductive Health Research Unit
27.	**SMI**	Safe Motherhood Initiative
28.	**SSA**	Sub-Saharan Africa
29.	**STD's**	Sexually Transmitted Diseases
30.	**UN**	United Nations
31.	**UNFPA**	United Nations Population Fund
32.	**UNICEF**	United Nations Children's Fund
33.	**USAID**	United States Agency for International Aid
34.	**WAH**	World Health Assembly
35.	**WAHO**	West African Health Organisation
36.	**WHO**	World Health Organisation
37.	**WR**	World Health Organisation Country Representative

1.0 EXECUTIVE SUMMARY:

A series of global conferences organised by the United Nations in the 1990's identified maternal mortality and morbidity as urgent public health priorities and mobilised international commitment to address them. Governments around the world pledged to ensure access to a range of high quality and affordable reproductive health services including safe motherhood and family planning. The main goal of the Global Safe Motherhood Initiative (SMI) (1987) was to reduce maternal mortality by 50% by the year 2000. At the International Conference on Population and Development (ICPD) (1994) governments agreed to cut down the number of maternal deaths by 50% by the year 2000 and a further 50% by the year 2015. The Fourth World Congress of Women (FWCW) (1995) reiterated the commitments made at the ICPD.

Despite the various international and national strategies and efforts, maternal mortality ratio (MMR) in Africa has continued to increase instead of declining as in the other regions of the world. Reports indicate that the average MMR in the African Region rose from about 870/100,000 live births in 1900 to 1,000/100,000 live births in 2001.

Each year approximately 4.0 million are still born and an additional 4.3 million newborn infants die within the first month of life. Many of these deaths are due to complications their mothers experience during pregnancy and/or childbirth. Evidence shows a close association between maternal deaths and newborn/perinatal survival and well-being. Countries with high maternal mortality ratios and or morbidities have high neonatal mortality and morbidities as well. The African Continent has the highest neonatal mortality rate globally, estimated at 45/1000 live births. Thus improving maternal health will contribute directly and indirectly to better neonatal and perinatal survival and well-being.

A woman's death is more than a personal tragedy or a "statistic", as some people have been known to say. It represents an enormous cost to her family, her community and her nation. When a mother dies, children and other members of the family lose their primary caregiver, communities are denied her paid and unpaid labour and countries forgo her contributions to economic and social development.

Excluding the recent additional contribution of HIV and AIDS, the main causes and predisposing factors to maternal and neonatal deaths and morbidities in Africa have remained largely the same over the past decade or two.

Programmes aimed at reducing the high maternal and neonatal mortalities and morbidities in Africa have not yielded the desired results, because of the numerous challenges facing the health sector in most of our countries. These include:

- Lack of national political commitment and adequate resource allocation
- Lack of or unclear policies, standards, guidelines, and protocols concerning service delivery and practice regulation
- Poor logistics for managing drugs, supplies and equipment, etc.
- Weak national human development and management policies, strategies, etc.
- Poor coordination amongst partners and even departments in the same institution
- Poorly functioning health systems, with weak or non-existent referral systems

In 2000, the UN outlined specific international development goals. These goals build upon agreements and commitments made by governments at the ICPD (1994) and FWCW (1995). They include reduction of maternal deaths by 75% and child hood mortality by 2/3 by 2015.

The high MMR and child mortality have been topics of major concern at several recent international and regional forums. More than a decade of research has shown that small and affordable measures can significantly reduce the health risks that women face when they become pregnant. Most maternal deaths could be prevented if women had access to appropriate health care during pregnancy, childbirth and immediately afterwards.

In 2000, the WHO launched the Making Pregnancy Safer (MPS) Initiative, a health-sector focussed initiative, which seeks to contribute to the improvement of maternal and perinatal health. It supports efforts to accelerate the reduction of maternal and perinatal mortality, thus contributing to the attainment of the millennium development goals (MDG's) and the goals and targets articulated at the ICPD (1994) and FWCW (1995). The key message in the initiative is the need to ensure skilled care at every birth within a continuum of care, through out pregnancy, labour and childbirth and the postnatal period. Ministers of Health endorsed the MPS Initiative at the WHA in 2004.

In order to support countries in Africa to move towards the attainment of the MDG's related to maternal and newborn health, the Africa Regional Reproductive Health Task Force (Dakar 2003), called on all partners to develop and implement a Road Map for accelerated maternal and newborn mortality reduction. This was followed by a meeting of key partners in health in Harare Zimbabwe, (2004), which developed a generic Regional Road Map for accelerating the attainment of MDG's related to maternal and newborn health in Africa.

The Road Map provides a framework for building strategic partnerships for increased investments in maternal and newborn health at institutional and programme levels. It offers an opportunity to all partners and programmes to focus on two major levels of care, namely the health service delivery and the community.

The Road Map for accelerating the attainment of MDG's related to maternal and newborn health will be implemented in two phases, Phase 1 – 2004-2009; and Phase 2 – 2010-2014 with the final report in 2015. The indicators for monitoring and evaluation will be adopted for country level use. Annual reports will be shared with the Regional Economic Committee and the African Union.

2.0 INTRODUCTION:

When the nations of the world signed the UN Charter establishing the WHO in 1948, they pledged to improve the health of the peoples of the world. Included in this pledge was the need to pay special attention to the health of women and children **(1).**

Over the past 57 years, there have been remarkable successes with regards to the control of communicable diseases such as measles, polio and the elimination of others such as smallpox, through intense and well-coordinated global efforts. Sadly though, there have not been similar successes with regards to maternal health. Maternal health indices have continued to worsen especially in the resource-poor countries of the world **(2,3,4)**.

A series of recent international conferences and/or summits have identified reduction of maternal mortality and provision of appropriate health care during pregnancy, labour and childbirth and the postnatal period as central objectives for all reproductive health services.

Reducing maternal mortality by 50% by the year 2000 was put forth as a major development goal at the Global Safe Motherhood Conference (1987) **(5).** At the ICPD (1994), governments agreed to reduce maternal deaths by 50% by the year 2000 and by another 50% by the year 2015 **(6).** The FWCW (1995) gave substantial attention to maternal mortality and reiterated the commitments made at the ICPD **(7).** Other conferences that have addressed these issues include the World Summit for Children (1990); the World Summit on Social Development (1995) **(8,9).**

As a result of these, governments have agreed to:

- Develop comprehensive national strategies to ensure universal access for all individuals and couples of appropriate ages throughout the life cycle, to a full range of high quality affordable sexual and reproductive health services, with particular attention to maternal and emergency obstetric acre.
- Establish or strengthen integrated safe motherhood programmes within the context of primary health care, with goals and target dates to reduce maternal mortality and morbidity **(10,11).**

Despite all the above well-intended declarations or documents, maternal mortality has continued to rise in Africa **(2,3,4,12)**. The Sub-Saharan African Region has witnessed the biggest increases, with the MMR almost doubling in some countries between 1990 and 2000 **(3)**. Some of the reasons for the increases were well articulated at the SM-IAG Consultative Technical Meeting in Colombo, Sri Lanka (1997). They included the fact that:

- Priorities were not always clearly defined
- The proposed interventions were not always focussed or the most effective
- Some strategies had too broad approaches
- Information on what works was inadequate
- Some strategies were too ambitious and expensive
- Some interventions known to be effective in reducing maternal mortality were omitted from SMI
- There was no coordination amongst departments, even at the facility level.
- Technical and programming guidelines, training curricula, etc, were not widely available

- Inadequate national political commitment and resource allocation
- Lack of clear high-level commitment amongst UN agencies to a joint program of action.
- Economic difficulties at country level due to debts, SWAPS, SAP's, social/civil strife, etc **(2).**

Echoing the Inter-Agency Group (IAG) (1997) observations and key messages, the WHO made Safe Motherhood the theme for the World Health Day (1998), at which several key messages were put forth, namely:

- Safe motherhood is a vital social and economic investment;
- Safe motherhood: A matter of human rights and social justice;
- Importance of delaying child bearing
- Every pregnancy faces risks;
- Ensuring skilled attendance at delivery;
- Improving access to maternal health services;
- Improving the quality of maternal health services;
- Prevention of unwanted pregnancy;
- Addressing unsafe abortion **(13).**

The UN Millennium Declaration (2000) led to the development of eight development goals, three of which, numbers 4, 5, and 6 are directly related to health. There is also a direct or indirect relationship between the other five goals and health. For example poverty has a great impact on maternal health and newborn survival, as well as child health and vice versa. Reduction of maternal and child hood mortality are two key MDG's **(14).**

Making motherhood safe for the world's women calls on national governments, funding agencies, the NGO's to make maternal health an urgent health priority and to ensure that there is political and financial support dedicated to this effort. Safe motherhood can be achieved by,

i) Ensuring access to and providing high quality maternal health services to all during pregnancy, childbirth and the postpartum period, including.
   - Care by skilled personnel before, during and after child birth,
   - Emergency care for life-threatening obstetric complications
   - Services to prevent and manage the complications of unsafe abortion
   - FP to enable women plan their pregnancies and prevent unwanted pregnancies
   - Health education and services for adolescents
   - Community education for women, their families and decision makers.

ii) Addressing gender inequalities.

   Women's status must be improved and full value accorded to their reproductive and productive roles. Family and community attitudes that prevent women from receiving proper care during pregnancy, childbirth and the postnatal period must be changed **(2,9,10,11)**.

The WHO (2000), launched the Making Pregnancy Safer (MPS) Initiative, a health-sector focused initiative, which seeks to contribute to the improvement of maternal and perinatal

health. It supports efforts to accelerate the reduction of maternal and perinatal mortality; thus contributing to the attainment of the MDG's and the goals and targets articulated at the ICPD (1994) and FWCW (1995). The key message in the MPS Initiative is the need to ensure skilled care at every birth. It was developed in response to the high levels of maternal and newborn mortality and morbidity coupled with the knowledge of their determinants and causes and experience of how to tackle them **(15).** In a way it is a renewed commitment to safe Motherhood. The Ministers of Health endorsed the MPS Initiative at the 57th World Health Assembly in May 2004**.**

In order to support countries in Africa to move towards the attainment of the MDG's, the African Regional Reproductive Health Task Force held in Dakar (2003), called on all partners to develop and implement national Road Maps for accelerated maternal and newborn mortality reduction. A meeting was subsequently held in Harare Zimbabwe (2004), bringing together a number of partners, including several UN agencies, to develop a Regional Road Map. The Road Map offers a new and revitalised dimension of efforts. Its main objective is to accelerate the reduction of maternal and newborn mortality towards the attainment of the MDG's in Africa.

3.0 BACKGROUND:

According to the WHO, UNICEF and UNFPA Maternal Mortality Ratio estimates (2000), there were 529,000 maternal deaths globally. This gives an estimated 1600 maternal deaths daily. At the same time 5000 newborns die every day due to complications related to pregnancy, labour and childbirth **(3).**

Of the global burden of maternal deaths, 99 % and 98% of the 5.8 million perinatal deaths, occur in the developing world. Almost 50% of the global burden of maternal deaths, occur in Africa, while less than 1%, occur in the developed regions of the world. The risk of maternal death is more than 140 times in some areas of the developing world compared to the developed world **(3,16). (Table 1)**

MMR is a measure of the risk of maternal death associated with each pregnancy. Each pregnancy faces a risk. The higher the number of pregnancies, the higher is the risk and therefore the MMR. Both scenarios are prevalent in the less-resourced countries, the African continent being a good example. The global MMR is estimated at 400/100,000 live births. On a regional basis, SSA has the highest MMR, estimated at an average of 1000/100,000 live births, compared with the next region in rank, Asia with a MMR of 330/100,000 live births **(3)**. There are wide variations amongst countries in Africa **(Table 2)** and even within countries, with urban and more affluent areas having generally lower MMR's than the rural and less privileged areas.

TABLE 1: LIFETIME RISK OF MATERNAL DEATH, 1995 BY REGIONS OF THE WORLD

Region	**Lifetime Risk of Maternal Death**
Africa	1 in 16
Asia*	1 in 110
Latin America & Caribbean	1 in 160
Europe	1 in 2,000
North America	1 in 3,500

* Excluding Japan and New Zealand/Australia

Source: *Maternal Mortality in 1995: Estimates developed by WHO, UNICEF, UNFPA*. World Health Organization, Geneva, 2001.

N.B. **Lifetime risk of maternal death** is the risk of an individual woman dying from pregnancy or childbirth during her lifetime. A lifetime risk of 1 in 3000 represents a low risk of dying from pregnancy and childbirth, while 1 in 100 is a high risk.

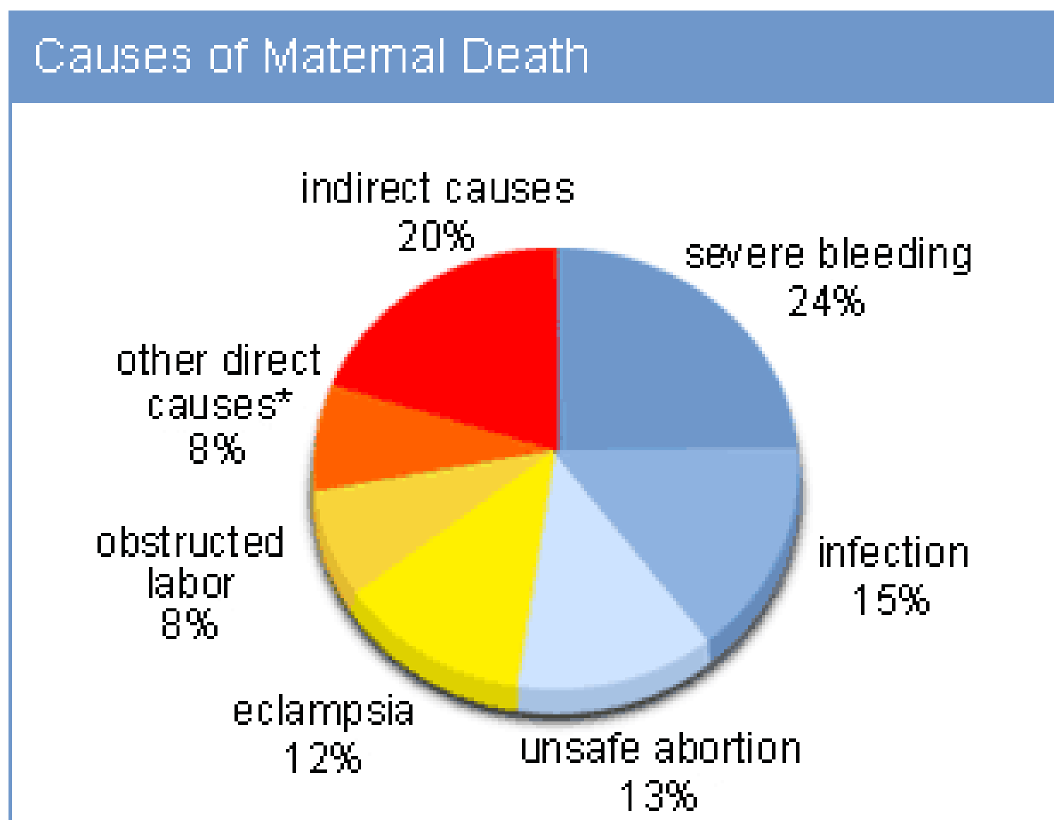
TABLE 2: MATERNAL MORTALITY RATIOS (MMR) IN THE WHO AFRICAN REGION - YEAR 2001

COUNTRY	MMR (/100,000 live births)
Algeria	132
Angola	1500
Benin	498
Botswana	326
BurkinaFaso	980
Burundi	800
Cameroun	430
Cape Verde	76
CentralAfricanRepublic	650
Chad	380
Comoros	45
Congo	890
CoteD'ivoire	480
Equatorial Guinea	352
Eritrea	1200
Ethiopia	1100
Gabon	509
Gambia	1000
Ghana	650
Guinea-Bissau	370
Kenya	600
Lesotho	700
Liberia	780
Madagascar	488
Malawi	1120
Mali	800
Mauritania	930
Mauritius	5
Mozambique	1500
Namibia	271
Niger	680
Nigeria	800
Reunion	120
RDC	1837
Rwanda	810
SaoTome&Principe	450
Senegal	510
Sierra Leone	1800
South Africa	150
Swaziland	229
Seychelles	-
Togo	478
Uganda	506
United Rep. of Tanzania	980
Zambia	649
Zimbabwe	570

The top five direct causes of MD's are:

- Obstetric haemorrhage = 25%
- Obstetric Sepsis = 15%
- Unsafe abortion complications = 13%
- Hypertensive disorders of pregnancy = 12%
- Obstructed labour = 8% **(14)**

Figure 1: Causes of Maternal Death



- Other direct causes include ectopic pregnancy, embolism, anaesthesia-related.
- Indirect causes include: anaemia, malaria, and heart disease, HIV/AIDS.

***Source: "Maternal Health Around the World". World Health Organization and World Bank, 1997*(17)**

The causes of maternal deaths need to be considered in the context of the contributing or predisposing factors. These include:

- **Lack of skilled attendance during pregnancy, childbirth and the postnatal period**
- **Poor quality of care**
- **Lack of political commitment and resource allocation**

- **Socio-cultural, traditional factors**
- **Poverty**
- **Geographical terrains**
- **Poor health systems – including lack of referral systems, etc**

On top of these deaths, hundreds of thousands other mothers sustain serious short and long-term morbidities, some of which are quite debilitating. It is estimated that for every maternal death up to 20 other women suffer serious pregnancy-related morbidities. These include infertility, anaemia, chronic pelvic pain, dysmenorrhoea and injury to the reproductive organs, e.g. fistulae, perineal tears, symphyiolysis **(2,3,5,6,10,16,17)**. So maternal death is only the tip of a much larger iceberg of health consequences women suffer in the course of fulfilling their biological role of procreation in Africa.

Perinatal mortality and morbidity tends to follow the same geographical pattern as for maternal deaths and morbidities. The WHO estimates that 98 % of the infant deaths globally occur in the developing world. About 1/3 of the PND's occurring in the developing countries are related to intrapartum complications which lead to birth asphyxia. Preterm delivery, foetal malformations and infections related to pregnancy and birth contribute to the remainder of the early neonatal deaths. Newborn deaths contribute significantly to infant deaths. It is estimated that two-thirds of infant deaths occur in the first month of life, i.e. are perinatal deaths. Of the perinatal deaths, two thirds occur in the first week of life and of the latter, two thirds occur in the first twenty-four hours after birth **(8,18,19,20,21).** It has been stated that we cannot reduce IMR further without reducing NMR substantially, and that if we are to attain the MDG of reducing by 2/3 the child hood mortality we must reduce the current levels of NMR by at least 50%.

Maternal mortality and morbidity are very closely associated with perinatal morbidity and mortality. The causes of maternal deaths and morbidities are often the same causes or determinants of perinatal mortality and morbidities. Furthermore, maternal morbidity and mortality have a direct negative impact on the survival of the newborns. A newborn, whose mother dies, has up to 10 times risk of dying compared to one whose mother survives **(18,19,20,21).**

Most of these deaths and ill health could be averted if appropriate care was made available throughout pregnancy, in labour and childbirth as well as the postnatal period. Evidence shows that at least 15% of all pregnant women develop serious complications, which require access to life-saving quality obstetric care. Studies have also shown that skilled attendance at birth is perhaps the single most important intervention to avert maternal and perinatal mortality and morbidity. Skilled attendance at birth is fairly low (<40%) in the majority of countries in SSA **(22) (Figure 2).** There are also wide variations amongst the countries (**Table 3).**

The high MMR and NMR in sub-Saharan Africa have been said to be not only socio-economic development issues but human rights' issues as well. MM is regarded as an example of social injustice and violation of women's basic human rights **(5,9,23,24).** Reduction of maternal mortality has been endorsed as a key development goal by countries and is included in consensus documents emanating from several international conferences.

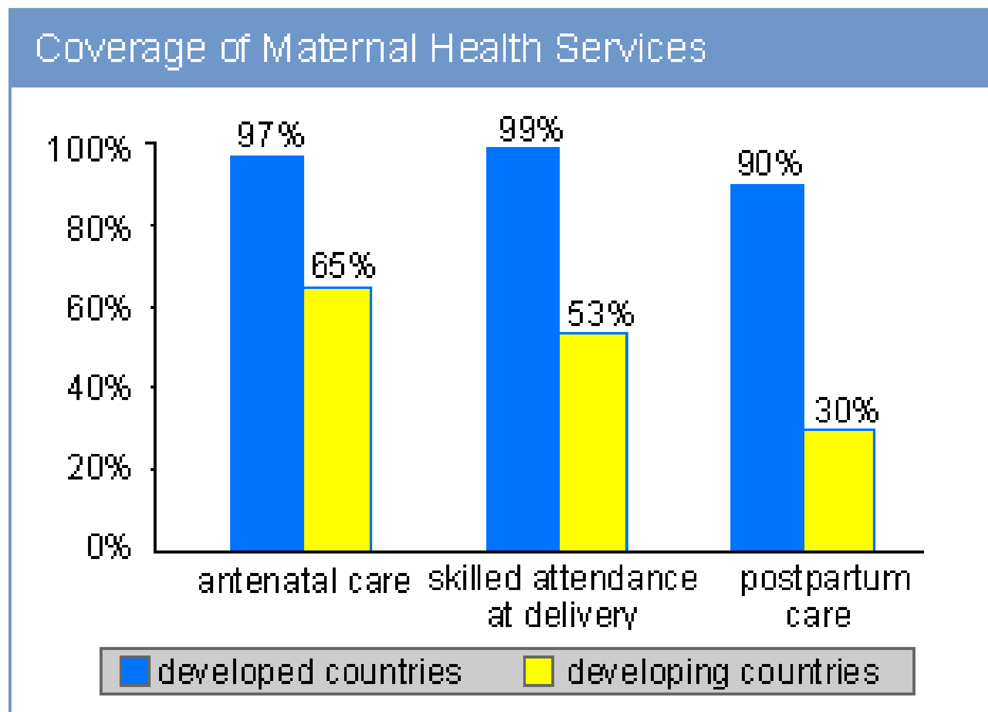
The MDG's No 4 and 5, Targets No 5 and 6 – talk of reduction of child mortality by 2/3 and maternal mortality by 75% between 1990 and 2015, respectively **(14).**

It is estimated that without serious and concerted efforts, over the next ten years or so:

- 2.5 million mothers will die of pregnancy and childbirth related complications
- 49 million mothers will sustain serious morbidities some of which will be debilitating and life-long**.**

Evidence indicate that at least 75% of the maternal deaths occurring in SSA are preventable and with little or no extra resources.

Figure 2: Coverage of Maternal Health Services



Source: "Coverage of Maternal Care: A Listing of Available Information, Fourth Edition". World Health Organization, Geneva, 1997.

Skilled attendance at birth and the postnatal period is very low in Africa as indicated. Majority (at least 60%) of maternal deaths occur in labour and the first 24 hours after delivery. It is no wonder then that maternal mortality ratios are high in our countries.

TABLE 3: NATIONAL ESTIMATES OF ANTENATAL CARE, DELIVERIES IN HEALTH FACILITIES AND DELIVERIES WITH SKILLED ATTENDANT IN DEVELOPING COUNTRIES

	Antenatal care		Deliveries in health facilities		Skilled attendant at delivery	
	%	1000s	%	1000s	%	1000s
AFRICA						
Eastern Africa						
Burundi	88	250	20	60	24	70
Comoros	69	20	20*	10	24	10
Djibouti	76	20	75*	20	79	20
Eritrea	19	30	5*	10	6	10
Ethiopia	20	540	8	220	8	220
Kenya	95	1240	44	570	45	590
Madagascar	78	520	45	300	57	380
Malawi	90	500	55	300	55	300
Mauritius	99	20	95	20	97	20
Mozambique	54	400	27	200	30	220
Reunion	95*	10	96	10	97	10
Rwanda	94	340	25	90	26	90
Somalia	40*	190	2	10	2	10
Uganda	87	970	30*	330	38	420
United Rep. of Tanzania	92	1200	53	690	44	690
Zambia	92	390	51	220	51	220
Zimbabwe	93	400	69	300	69	300

Middle Africa						
Angola	25	150	16	90	17	100
Cameroon	73	410	62	350	58	350
Central African Republic	67	90	50	70	46	70
Chad	30	90	15*	40	15	40
Congo	55*	70	n.a.		50*	+60
Equatorial Guinea	37	10	5	<1	5	<1
Gabon	86	50	79	40	80	40
Zaire	66	1410	n.a.		n.a.	
Northern Africa						
Algeria	58	470	76	610	77	620
Egypt	53	920	27	470	46	800
Libyan Arab Jamahiriya	100	240	n.a.		76	180
Morocco	45	320	37	270	40	290
Sudan	54	620	18	210	86°	990
Tunisia	71	150	86	180	90	190
Southern Africa						
Botswana	92	50	66	40	77	40
Lesotho	91	70	50	40	50	40
Namibia	88	50	67	40	68	40
South Africa	89	1150	79	1020	82	1060
Swaziland	70	20	56	20	56	20
Western Africa						
Benin	60	160	20	50	38	100
Burkina Faso	59	290	43	210	43	210
Cape Verde	99	10	n.a.		n.a.	

Cote d'Ivoire	83	610	45	330	45	330
Gambia	91	40	n.a.		44	20
Ghana	86	640	42	310	44	330
Guinea	59	200	25	90	31	110
Guinea-Bissau	50	20	n.a.		n.a.	
Liberia	83	120	n.a.		58	90
Mali	25	140	24	130	24	130
Mauritanie	49	50	40	40	40	40
Niger	30	150	16	80	15	80
Nigeria	60	3050	31	1580	31	1580
Sénégal	74	270	47	170	47	170
Sierra Leone	30*	70	20*	40	25*	60
Togo	43	80	8	10	32	60

4.0 THE MILLENNIUM DEVELOPMENT GOALS (MDG's):

The Millennium Summit Declaration (MSD) (2000) pledged to eliminate poverty and create a climate for sustainable development. The Millennium Development Goals Millennium were established to create a framework for implementing the declaration. These have now become the standard by which development progress is measured at country level.

There are eight goals, which include;

---

1. ***Eradicate extreme poverty and hunger***
2. ***Achieve universal primary education***
3. ***Promote gender equality and empower women***
4. ***Reduce child mortality***
5. ***Improve maternal health***
6. ***Combat HIV/AIDS, malaria and other diseases***
7. ***Ensure environmental sustainability***
8. ***Develop a global partnership for development (14)***

Goals 4, 5, and 6 are health-related and much specifically to maternal and newborn health. Three of the MDG's draw on issues addressed in the ICPD framework, namely:

- **Reduction of maternal mortality**
- **Reducing the spread of HIV/AIDS**
- **Achieving women empowerment and gender equality**

It has been stated that achievement of the MDG's requires the full implementation of the goals of the ICPD (1994), whose Programme of Action launched a new human rights based approach to population and development focussed on meeting needs and goals of individuals, and putting the concept of rights and choice at the centre of population policy.

The Millennium Development Goals tell us where we need to go to achieve the goals of the ICPD.

Each goal has targets and indicators for measuring progress:

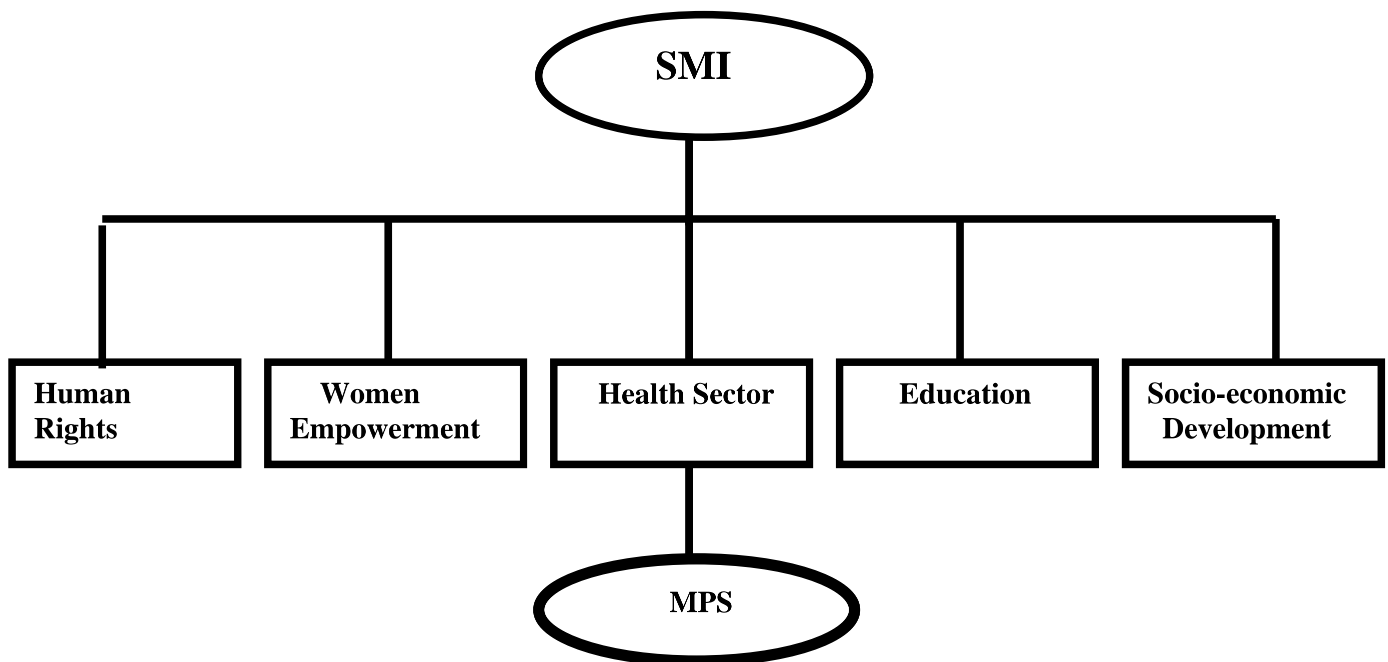
Goals and targets		Indicators
Goal 4	**Reduce child mortality** Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	• 13. Under-five mortality rate • 14. Infant mortality rate • 15. Proportion of one-year-old children immunized against measles
Goal 5	**Improve maternal health** Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	• 16. Maternal mortality ratio • 17. Proportion of births attended by skilled health personnel
Goal 6	**Combat HIV/AIDS, malaria, and other diseases** Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	• 18. HIV prevalence among pregnant women ages 15- to 24 • 19. Condom use rate of the contraceptive prevalence rate [c]* • 19a.Condom use at last high-risk sex* • 19b.Percentage of 15-24-year-olds with comprehensive correct knowledge of HIV/AIDS [d]* • 19c.Contraceptive prevalence rate • 20. Ratio of school attendance of orphans to school attendance on non-orphans ages 10-14
	Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	• 21. Prevalence and death rates associated with malaria • 22. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures [e] • 23. Prevalence and death rates associated with tuberculosis • 24. Proportion of TB cases detected & cured under directly observed treatment short course (DOTS)

5.0 MAKING PREGNANCY SAFER (MPS) INITIATIVE:

5.1 WHO launched making Pregnancy Safer Initiative in 2000 in response to the deteriorating maternal and newborn health indices in some parts of the world, Africa in particular.

- It is a strategy for accelerated MM reduction through strengthening health system capacities to reduce the risk associated with pregnancy.
- It builds on the global SMI, focusing on health sector response.
- It supports efforts to accelerate the reduction of maternal and newborn mortality, thus contributing to the attainment of MDG's and goals and targets articulated at the ICPD (1994) and FWCW (1995).

5.2 THE INTER-RELATIONSHIP BETWEEN THE GLOBAL SMI AND MPS



5.3 <u>The Vision;</u>

"All women go safely thorough pregnancy and childbirth, and their infants are born alive and healthy ".

5.4. <u>The Mission</u>

To provide governments and partner agencies with:

- ***guidance***
- ***technical support and***
- ***advocacy***

to ensure that safe motherhood is prioritised within their policies and budgets, and that evidence-based norms and standards are appropriately applied.

5.5. <u>Key messages</u>

These are that,

- Safe pregnancy, childbirth and motherhood are basic human rights;
- Every pregnancy should be wanted;
- All pregnant women and their infants should be able to access and receive skilled care;
- All women should be able to reach a functioning health facility to obtain appropriate care for themselves or their newborns when complications arise during pregnancy, delivery or the postnatal period.

5.6 <u>The guiding principles</u>

(a) <u>Core values</u>

- **<u>Human rights</u>**
  - Promotion of women's and newborns rights to life and the highest attainable standard of health

- **<u>Gender Equality</u>**
  - Addressing women's low status and the elimination of all forms of violence against them

- **<u>Equity</u>**
  - Creation of just and equitable global society, with priority attention to the poor and underserved groups.

(b) <u>Operational principles</u>

- **<u>Continuum of care</u>**
  - Is a crucial feature of effective services for pregnant women, mothers and newborn babies.
  - Must result in the best possible care at all levels of the health system from the household to the tertiary level.
  - A chain of caregivers and care setting is crucial for pregnant mothers, those in labour or in the postpartum period especially when complications arise.
  - The chain must be strong enough to effectively manage life-threatening complications
  - Includes the referral system and transfer of appropriate information between care givers

- **<u>Quality of care</u>:**
  - Highest possible
  - Standards should be met to effectively manage routine cases as well as complications

- **<u>Integrated Primary Health Care</u>:**
  - Comprehensive
    - Prevent unintended pregnancies
    - Prevent unsafe abortions

- Links with:
    - Family planning services
    - Immunisation
    - Nutrition
    - Child survival
    - Prevention and treatment of:
        - Malaria
        - STD's
        - HIV
        - Use maternal and newborn health as the entry point.

- **<u>Partnership</u>**
    - Strong and effective
    - Between governments, civil society, professional groups, international agencies and donor groups.

- **<u>Good Governance, Peace and Security</u>**
    - Crucial.

5.7. PRIORITY ACTIONS FOR MAKING PREGNANCY SAFER:

- Achieving political commitment

- Promoting a favourable policy and legislative environment

- Ensuring adequate financing

- Strengthening the delivery of health care services:

- Empowering women, families and communities,

- Strengthening monitoring and evaluation for better decision-making, using process indicators with regular monitoring

- Providing guidance on data collection, interpretation, dissemination and utilisation **(23).**

6.0 THE ROAD MAS FOR ACCELARATING THE ATTAINMENT OF THE MDG's RELATED TO MATERNAL AND NEWBORN HEALTH

6.1 The Making Pregnancy Safer Initiative will be implemented in the context of the Road Map for accelerating the attainment of the Millennium Development Goals (MDG's) related to maternal and newborn health.

The Regional Reproductive Health Task Force (Dakar 2003) called on all partners to develop a Road Map to accelerate maternal and newborn mortality reduction. In response to that a meeting of key partners consisting of, The African Regional Reproductive Health Task Force, UNFPA, UNICEF, USAID, Advance Africa, Engender Health, WAHO, MNH/JHPIEGO, CRHCS, FCI, FHI, RHRU Johannesburg, Representatives of the Global Partnership on Safe Motherhood and New Born Health, Ministries of Health of Tanzania and Zimbabwe and WHO Country Offices, Regional Offices and Headquarters in Geneva, was held in Harare, Zimbabwe (February 2004) at which a generic Regional Road Map for accelerating the attainment of the MDG's related to Maternal and Newborn Health in Africa was developed.

6.2 Goal:

- To provide guidance to Governments in developing country-specific Road Maps to accelerate the attainment of the MDG's related to MNH

6.3 Objectives:

- To provide skilled attendance during pregnancy, childbirth and the postnatal period, at all levels of the health care delivery system.
- To strengthen the capacity of:
  - Individuals
  - Families
  - Communities
  - Civil Society Organisations
  - Governments

  to improve MNH

6.4.0 THE IMPLEMENTING STRATEGIES:

6.4.1. Improving the provision of and access to quality MNH care including FD services

By increasing

- availability
- accessibility
- affordability
- acceptability

of quality skilled care within an enabling environment

Activities:

- Define minimum package of maternal and newborn health and FP services at each level of the health care delivery system in terms of,
  - Human resources
  - Supplies
  - equipment
  - infrastructure
  - financial resources

- Review/revise national policies, norms and protocols using universally acceptable evidence-based MNH and FP standards of care and ensure their dissemination to all health care providers for their adoption and use

- Upgrade health services to ensure accessible and acceptable quality essential MNH care.

- Establish standards of care for emergency obstetric care at all levels.

- Assess training needs, train, retrain and update training in in-service programmes to ensure that service providers at all levels of the health service delivery system have the appropriate competencies/skills, provider attitudes and ethics.

- Assess and update pre-service training curricula and approaches to be in-line with universally acceptable evidence-based standards of care.

- Strengthen pre-service training institutions to provide the necessary skills and competencies

- Introduce and apply performance and quality improvement approaches to strengthen facility-based service delivery including community participation and supportive supervision

6.4. 2. Strengthening the referral system

Functional referral system that effectively links all the different providers and levels of care in order to ensure timely and appropriate management of maternal and newborn complications.

Activities:

- Identify communication and equipment needs for referral system at community and district levels.
- Procure and install appropriate communication equipment including two-way radios and emergency transport means.
- Train providers in early recognition of complications and early pre-referral treatment
- Train other resources persons in emergency response and preparedness.
- Establish community emergency committees (to mobilize community resources for emergency transport, blood donors, etc)

6.4.3. Strengthening district health planning and management of MNH care including FP services.

Build capacity of district health systems to:

- Plan
- Manage
- Monitor
- evaluate

MNH and FP services at the district and community levels.

Activities:

- Build capacity of district health management teams and national ministries of health, finance and planning in the integration of maternal and newborn health programmes in SWAP's, PRSP's, to access in-country funds.
- Strengthen the skills and capacity of DHMT's in programme management including monitoring and supervision.
- Support health finance strategy design and implementation at district level.
- Strengthen HIS for improved decision making.

6.4.4 Advocating for increasing commitment and resources for maternal and newborn health care including FP.

Bring the burden of maternal and newborn morbidity and mortality to the attention of government and allocation of resources necessary to provide skilled attendance.

Appropriate policies governing practice regulations and development of human resources and supportive environment is crucial.

Activities:

- Support countries to update or revise existing advocacy tools to include health, economic and social benefits
- Develop and implement advocacy plans for information dissemination to the public policy change and resource mobilization and use existing forums for advocacy.
- Establish a MNH day or week and support its commemoration.
- Organise a regional summit on maternal and newborn health.

6.4.5. Fostering partnerships

Fostering and establishing strategic partnerships to improve co-ordination and collaboration between communities, partners and among programmes, as well as galvanise resources for long-term sustainable action for maternal and newborn health.

Activities:

- Organise country-level stakeholders' meeting to develop Country-specific Road Map
- Coordinate regularly planning, implementation monitoring and evaluation of MNH activities with key stakeholders at all levels

6.4.6. Promoting household – hospital continuum of care::

Strengthen the capacity of women, their partners, families and communities to ensure self care in the home and to seek and reach health care facilities in a timely manner for improved pregnancy outcome. This will contribute to i8mproved home care and service utilisation.

Activities:

- Provide out reach mechanisms from the health facility level to communities and households.
- Support ministries of health to strengthen existing supervisory systems to link the formal health system to community based resources persons.

- Establish community emergency committees to link with the formal health system

- Institute both preparedness plans at community and household levels, especially for very young adolescents.

6.4.7. Empowering communities – especially women.

Using approaches and mechanisms, such as BCC, communities, particularly women should be empowered to define, demand and access quality skilled care thorough mobilization of community resources.

<u>Activities</u>

- Advocate for increased/community resources and investment in maternal and newborn health and FP.

- Promote male involvement as part of shared responsibility and collective action to improve household health seeking behaviour

- Develop the capacity of community groups to assume their roles as partners in improving MNH and FP.

7.0 INDICATORS FOR ASSESSING MNH PROGRESS:

7.1. Indicators at country level:

a) Community indicators:

- Number of communities that have set up functional emergency preparedness committees and plans for MNH and FP
- Number of pregnant women that have birth preparedness plans
- Coverage of referrals to emergency sites
- Knowledge of danger signs of obstetric and neonatal complications (DHS)
- Number of DHM Task Forces and committees with representation from communities

b) Neonatal indicators:

- Neonatal mortality rates
- Number of district hospitals that have functional newborn resuscitation place in the delivery room
- Postnatal care attendance rate.

c) Family planning indicators:

- Contraceptive prevalence rate by method, by age group, by socio-economic quintiles
- Met need for FP by age groups (DHS)

d) Maternal health indicators:

- MMR
- Proportion of births assisted by a skilled attendant
- Number of facilities offering EmOC services
- Number of facilities offering Comprehensive EmOC services
- Proportion of deliveries taking place in a health facility
- Coverage of met need for obstetric complications
- Proportion of births by caesarean section
- Obstetric case fatality rates
- Proportion of first level facilities (PHC) with 2 or more skilled attendants.

e) Increased political will and commitment indicators:

- Proportion of funds allocated to MNH and FP
- Increase of funds allocated to MNH and FP
- Number of countries that have included MNH and FP I their PSRP's
- Number of countries with policies for increased coverage for skilled care

7.2. Indicators for measuring progress of the Road Map:

- Number of regional partners that have signed the Road Map
- Number of countries that have an inter-agency task force for the implementation of the Road Map
- Total resources mobilised for the Road Map.

8.0 THE ROLE OF THE WORLD HEALTH ORGANIZATION IN IMPLEMENTING MPS INITIATIVE:

WHO will work with governments and partners to,

8.1 Advocate for accelerated reduction of maternal and newborn mortality

It will provide the necessary evidence-based information to countries and regions to facilitate political commitment, policy formulation and programme development and to partners and donors for their active and increased support.

8.2 Building national and local capacity through technical support:

By providing technical support, training and fellowship programmes for technical staff to enable them develop research, adapt and utilise evidence based guidelines for best practices, select strategies and priorities, conduct effective programme planning, improve quality of care, build on lessons learnt, scale-up interventions, improve accountability, mobilise resources and monitor and evaluate programme implementation.

8.3 Providing guidelines and tools:

Support countries in developing their capacities for the adaptation, dissemination and utilisation of WHO technical and managerial tools and guidelines for ensuring safe pregnancy and childbirth at different levels

8.4 Strengthening partnerships:

Promotion of partnerships with various global and national initiatives, UN partners (UNICEF, UNFPA) and the World Bank, other partners and donor agencies, so that governments get maximum support, co-ordinate inputs, create greater synergy between efforts and minimise duplication and maximise resources

8.5 Supporting research and generating evidence:

Build capacity of countries to promote and conduct research and generate evidence of best practices for improved MNH

8.6 Measuring progress:

With countries and partners will improve vital registration, the capacity to conduct country specific surveillance and monitoring, adaptation and integration of indicators on MNH into existing HIS, improved quality of data, data collection and analysis and their iutilisation for measuring progress and programme planning.

Provide technical and other support in evaluating programme performance and impact.

Review of regional and global progress in improving MNH and report to Member Countries on a regular basis

9.0 THE REGIONAL ADVISOR FOR MAKING PREGNANCY SAFER

The Regional Advisor – MPS will be based at the Regional Office in Brazzaville, Congo.

i) Responsibilities

(a) General

- Ensure that MPS work is thoroughly instituted in the health systems at the regional and Country level.
- Coordinate MPS activities in WHO Africa Region
- Provide support to countries in their efforts to reduce Maternal and neonatal mortality and morbidity

ii) Specific responsibilities

1. Coordinate MPS activities at the Regional and Country levels with WR's, in-country MPS/SM, MH theme groups, MOHs, Partner organizations, WHO/AFRO.
2. Undertake annual review of progress.
3. Provide support to countries for the assessment and elaboration of their MPS plans;
4. Provide support to countries in the review and development of their national health policy and policy development process, in order to ensure that the key elements of MPS are incorporated.
5. Drawing upon technical expertise of all relevant divisions in AFRO and at HQ, and country levels when providing support to countries in the local adaptation of the relevant norms, standards, tools, technology and interventions necessary to improve the country's maternal and newborn health care.

10. REFERENCES:

1. United Nations (1948) Report of International Health Conferences. UN Doc. E/772. 11 March 1948. New York.

2. Starrs A. The Safe Motherhood Action Agenda: Priorities fir the Next Decade. Report on the Safe Motherhood Technical Consultation. Colombo Sri Lanka 18-23, October, 1997. New York. Family Health International, 1998

3. WHO/UNICEF/UNFPA maternal Mortality in 2000. Estimates Developed by WHO, UNICEF & UNFPA, Geneva, WHO 2004

4. World Bank. Safe Motherhood and the World bank: Lessons for 10 years of experience. Washington. The World Bank. 1999.

5. World Health Organisation. 1987) Report of the International Safe Motherhood Conference. Nairobi, Kenya, 1987.

6. United nations (1995). Report of the International Conference on Population and Development. Cairo, 5-13, September 1994.

7. United Nations (1995). Report of the FWCW, Beijing China 4-15, September 1995. UN doc. A/Conf.177/20

8. United Nations. World Summit for Children, 29-30, September 1990. News York. 1990.

9. United nations (1995) World Summit on Social Development. Copenhagen 5-12, March 1995. New York, UN 1995.

10. World Health Organisation (1999). Reproductive Health Indicators for Global Monitoring. Report of the 2nd Inter-Agency Meeting. http://www.who.int.reproductive_health/publications/

11. World Health Organisation (1999). Reducing Maternal Mortality. A Joint WHO/UNFPA/World Bank Statement Geneva, WHO, 1999

12. Maine D., Rosenfield A. The Safe Motherhood Initiative: Why has it Stalled? Am. J. Public Health. 1999; 89: 480-482,

13. World Health Organisation World Health Day Safe Motherhood April 7, 1998. Information Kit. Geneva WHO. 1998.

14. United Nations (2004). Millennium Development Goals. http://www.un.org/millenniumgoals 2004

15. World Health Organisation (2000). Making Pregnancy Initiative. WHO. Geneva.

http://www.who.int.pregnancy and EB 107/26 December 2000

16. WHO/UNICEF/UNFPA. Maternal Mortality in 1995: Estimates developed by WHO, UNICEF and UNFPA WHO, Geneva, 2001

17. World Health and World Bank. Maternal Health around the World . 1997

18. World Health Organisation (2001). Perinatal and Neonatal Mortality: Global, Regional and Country Estimates. 3rd Ed. Geneva, WHO

19. Save the Children. (2001) State of the World's Newborn. Washington DC. Save the Children

20. UNICEF (2004). The State of the World's Children. New York. UNICEF. 2003

21. UNICEF. (2004). Maternal Mortality http://www.child-info.org/eddb/mat_mortal/

22. WHO. (1997). Coverage of Maternal Care: A listing of Available Information. 4th Ed. WHO. Geneva.

23. Cook R.J., Dickens B.M. et al. Advancing Safe Motherhood through Human Rights. WHO Geneva. 2001. WHO/RHR/01.5

24. UNICEF (1998). A Hyman Rights Approach to UNICEF. Programming for Children and Women. What it is and some Changes it will Bring. New York. UNICEF.

25. World Health Organoisation (2000) Making Pregnancy Safer: Skilled Attendants http://www.who.int./reproductive_health/mpr/attendant.html