United Nations High Commissioner for Human Rights
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OHCHR REGISTRY
01 APR 2011

The World Health Organization (WHO) presents its compliments to the Office of the United Nations High Commissioner for Human Rights and is pleased to submit herewith WHO’s contribution, as requested in your communication of 13 January 2011, on good and effective practices in adopting a human rights-based approach to eliminating maternal mortality and morbidity.

The World Health Organization avails itself of this opportunity to renew to the Office of the United Nations High Commission for Human Rights the assurance of its highest consideration.

ENCL: as stated.

GENEVA, 1 April 2011
Effective practices in eliminating maternal mortality and morbidity

Contribution by the World Health Organization to an analytical compilation of good or effective practices in adopting a human rights-based approach to eliminating maternal mortality and morbidity, to be prepared by the United Nations High Commissioner for Human Rights, as requested by the United Nations human Rights Council in Resolution A/HRC/15/7.

Introduction

Pregnancy and childbirth are not diseases. Nevertheless, they carry risks that can be reduced by health-care interventions such as access to skilled care and emergency care for complications, the provision of family planning and access to safe abortion care. Most maternal deaths occur during or shortly after childbirth and almost all could be prevented if women were assisted at that time by a health-care professional with the necessary skills, equipment and medicines to prevent and manage complications. However, poorer and less educated women, as well as those living in rural areas, are far less likely to give birth in the presence of a skilled health worker than better-educated women who live in wealthier households or urban areas. The reasons for this include physical inaccessibility and prohibitive costs, household decision-making processes, and poor quality and disrespectful care at services. Availability of services is not sufficient; they must also be accessible and affordable to all, and of high quality, and should be provided in a way that is both culturally appropriate and responsive to women’s needs. Moreover, periods of conflict and instability bring women many additional problems such as violence, trauma and injury, disruption of primary health-care services, and poor access to health care. Such situations may also expose women to adverse environmental factors, and can lead to a shortage of health providers who may be killed, displaced, or injured. Violence during pregnancy is associated with an increased risk of miscarriage, stillbirth, abortion and low birth weight. States affected by conflict or facing other forms of instability have the highest maternal and neonatal mortality rates.²

Maternal mortality: the current situation

In 2010 global maternal mortality estimates for 2008 show an estimated 358 000 maternal deaths occurred, a 34% decline from 1990 levels.² These latest estimates indicate that developing States continued to account for 99% (355 000) of the deaths, with Sub-Saharan Africa and South Asia leading with 87% (313 000) of global maternal deaths. The maternal mortality ratio (MMR) in 2008 was highest in developing regions (290 per 100,000 live births), and in stark contrast to developed regions (14/100 000) and States of the Commonwealth of Independent States (40/100 000). Sub-Saharan Africa recorded the highest MMR (640/100 000), followed by South Asia (280/100 000).

Oceania (230/100 000), South-Eastern Asia (160/100 000), North Africa (92/100 000), Latin America and the Caribbean (85/100 000), Western Asia (68/100 000), and Eastern Asia (41/100 000).³

The reasons for decline in maternal mortality are complex and specific to the local situation, but they share a number of common features. These include increased use of contraception to delay and limit childbearing, better access to and use of high-quality health-care services, prevention and dealing with the consequences of unsafe abortion and broader social changes such as increased education and enhanced status for women. In developing regions the proportion of births attended by skilled health personnel rose from 53% in 1990 to 63% in 2008.⁴ Similarly, the proportion of women who were attended to at least once during pregnancy by skilled health personnel increased from 64% to 80%, while the proportion of women aged 15-49 years using any method of contraception also increased from 52% to 62%.⁵ Eastern Asia, which experienced the greatest MMR decline, has a contraceptive prevalence rate of 86% as opposed to only 22% in sub-Saharan Africa, the region with one of the lowest MMR declines.⁶ Unsafe abortion related deaths have reduced to 47 000 in 2008 from 56 000 in 2003 and 69 000 in 1990; corresponding to the decline in the overall number of maternal deaths, however, the numbers of unsafe abortions have increased from 19.7 million in 2003 although the overall unsafe abortion rate remains unchanged at about 14 unsafe abortions per 1000 women aged 15–44 years.⁷ HIV/AIDS remains a significant contributor to maternal mortality, with the highest numbers occurring in Sub-Saharan Africa where 9% of all maternal deaths were due to HIV/AIDS. Without these deaths, the MMR for sub-Saharan Africa would have been 580 maternal deaths per 100 000 live births instead of 640.⁸

A call for renewed commitment to reduce maternal mortality

While some progress is now being made on reducing maternal mortality, both globally and in specific regions and States, such progress is insufficient however to achieve MDG 5, particularly in Sub-Saharan Africa and South Asia. MDG 5 aims to improve maternal health with a target of reducing MMR by 75% between 1990 and 2015 – that is, it seeks to achieve a 5.5% annual decline in MMR from 1990. However, globally the annual percentage decline in MMR between 1990 and 2008 was only 2.3%.⁹

Not all countries have progressed. Among States with an MMR ≥100 in 1990, it is evident that 30 States have made insufficient or no progress, including 23 States from sub-Saharan Africa. The five States that experienced the estimated largest percentage increases in MMR were Botswana (133%), Zimbabwe (102%), South Africa (80%), Swaziland (62%), and Lesotho (44%). The latter group of States is all in Southern Africa, the subregion with the highest HIV prevalence in the world.\textsuperscript{10}

In this context, the world witnessed a level of attention and renewed commitment to improving the health of women and children not seen since the adoption of the Millennium Development Goals (MDGs) in 2000. Responding to an acute concern among states and other stakeholders as to the slow progress (and in some cases regress) in improving maternal and child health, in September 2010, the UN Secretary-General launched the Global Strategy for Women’s and Children’s Health, aimed at strengthening and renewing commitments, and accelerating coordinated action to help States reaching the targets for MDGs 4 and 5, a two-thirds reduction in under-five mortality, and a three-quarters reduction in maternal mortality and universal access to reproductive health respectively.\textsuperscript{11}

The strategy calls upon all stakeholders to support key areas where action is urgently required to enhance financing, strengthen policy and improve service delivery for women’s and children’s health: (a) country-led health plans, supported by increased, predictable and sustainable investment; (b) integrated delivery of health services and life-saving interventions - so women and their children can access prevention, treatment and care when and where they need it; (c) stronger health systems, with sufficient skilled health workers at their core; (d) innovative approaches to financing, product development and the efficient delivery of health services; and (e) improved monitoring and evaluation to ensure the accountability of all actors for results.


Progress can be made in reducing maternal mortality if sustained attention is paid to these areas for action, as has been shown by a number of States. Sri Lanka has reduced maternal mortality by 87% in the past 40 years by ensuring that 99% of pregnant women receive four antenatal visits and give birth in a health facility. Egypt has integrated child health and family planning programs, upgraded facilities to strengthen safe motherhood programs, combined oral rehydration programs with the expansion of water and sanitation systems, and trained health-care workers in parallel with community outreach programs, resulting in the country being on track to reach the targets set for both MDGs 4 and 5. In India, the Janani Suraksha scheme provides cash to health workers and pregnant women living in poverty if the woman gives birth in a public-health facility or an accredited private-sector facility. Between 2006 and 2008 there was a ten-fold increase in the number of people benefiting from this program. In two indigenous communities in La Paz, Bolivia, maternal mortality has fallen by 75%, because women's groups have implemented education and empowerment programs, educated men about gender equality and reproductive health, and trained community health workers. Dynamic national leadership at the cabinet level, exercised through parliament, is holding local governments accountable for their results. In Rwanda, government ministries must include women-centered actions in their plans and introduce gender budgeting. At a local level, delegations of community leaders conduct investigations into each woman who dies of a pregnancy-related cause, which the government then monitors. This bold, outcome-focused leadership has led to the rapid development of health systems, often through innovative programs to train and retain new health workers. Strong community-based efforts should hold governments and other organizations accountable for delivering on their commitments and ensure all money is used in a transparent manner. Monitoring and evaluation can also benefit from innovation. India’s National Rural Health Mission has a community-based performance-monitoring mechanism to ensure that services reach their targets and that communities participate in delivery. In Peru and Nicaragua, new methods of online data collection have made monthly reporting possible, leading to rapid improvements in health outcomes.


**Successes in maternal mortality reduction: country case studies**

Outlined below are summaries of strategies undertaken in six countries to reduce maternal mortality. Most of these States embraced measures to ensure universal access to care, address inequities and the needs of the poor and marginalized populations, improve the quality of services, improve information, monitoring and/or accountability and involve communities, with coordinated donor support. While the strategies do not necessarily use the term human rights in reference to their programme, these measures reflect the key working principles that form the basis of a human rights approach as put forward in A/HRC/14/39: accountability, participation, transparency, empowerment, sustainability, international cooperation and equality and non-discrimination. The case studies below are not intended to review the human rights situation in the States selected,
nor provide a comprehensive human rights evaluation of maternal mortality reduction programmes and sexual and reproductive health policies in these States. The intent of this paper is to show the practical application of the key strategies embraced by WHO and other international partners to reduce maternal, perinatal and newborn mortality and also address the needs of the poor and marginalized in their societies, and how these global strategies respect human rights.

Haiti 12

During the period 1990 to 2008, Haiti has experienced very difficult conditions including economic crisis, political upheaval, and natural disasters. Nonetheless the country had achieved a 55% reduction in maternal mortality. Despite this progress maternal mortality remains high, estimated at 300 per 100 000 live births or 820 deaths per year. The lifetime risk of maternal death is one in 93.13 Haiti is the poorest country in the Western hemisphere. More than two-thirds of people live on less than US$2 per day, so most women simply cannot afford maternity care. Most poor women give birth at home, assisted by unskilled helpers, as they cannot afford safe birth in a facility. National figures from 2005 confirm this low rate of births attended by a skilled attendant: 15% in rural areas and 47% in urban areas.14

As part of broader efforts to reduce maternal and neonatal mortality in Haiti, to increase access to health services and to improve the capacity of institutions to provide quality care, the Free Obstetric Care project was launched in 2008. The project is led by Haiti’s Ministry of Public Health and Population and supported by the Canadian International Development Agency (CIDA), the Pan American Health Organization (WHO/PAHO) and the EC/ACP/WHO Partnership.15 Under the project 50 health institutions across Haiti receive payment to offer pregnancy, childbirth and post partum/postnatal care. In addition, women are reimbursed for their transport costs to and from facilities, and payments are made to traditional birth attendants who accompany pregnant women to health institutions to give birth. Facilities are only reimbursed if they submit record of the care given to each woman, using a standardized format through the Perinatal Information System.16 The system is also used to monitor performance. In addition, the project supports the rehabilitation of health institutions, purchase of equipment, training of providers and provision of supplies and essential drugs.

12 Free Obstetric Care in Haiti. WHO, Geneva, 2010. The information in this section was taken from this source, unless otherwise referenced.
15 European Community/African, Caribbean and Pacific Group of States/World Health Organization Partnership - a tripartite agreement signed between the three partners and national ministries of eight countries, including Haiti, to support accelerated actions for reaching Millennium Development Goal 5.
16 Developed by WHO/PAHO/Latin American Centre for Perinatology and Women and Reproductive Health Department.
In the South department of Haiti, under the local health units (Unités Communales de Santé - UCS) of Port Salut and Aquin, community members have been recruited and trained to support women to prepare for childbirth and plan to reach a facility when needed. These community agents also serve on maternal mortality surveillance committees, responsible for alerting hospitals about women with potential complications, and convey to hospitals women's opinion of the quality of services received. Pre-paid mobile phones were provided to the maternal and neonatal mortality/health surveillance committees of the UCSs of Port Salut and Aquin to ensure communication between the communities and the health facilities as part of a functional reference system. As a result a decline in the number of maternal deaths was reported in Port Salut and Aquin; a six fold increase in the use of antenatal care and a 62% increase in institutional childbirths.

In order to scale-up and ensure the sustainability of efforts, WHO/PAHO has worked to raise political support for a national policy on free childbirth care. Based on the results achieved, free obstetric care along with care for children under five years has been guaranteed for a further three more years with funding from Canadian International development Agency (CIDA). The Haitian government has decided to develop a social protection in health scheme guaranteeing free access to care for pregnant women and children aged zero to five years.

Malawi

From 1990 to 2008 Malawi achieved a 44% drop in MMR. In 2008 the MMR was estimated at 510 maternal deaths per 100 000 live births with 3000 maternal deaths per year and a lifetime risk of maternal death of one in 36. The use of skilled attendant at birth has increased from to 65% in 2010, although use of antenatal care with a skilled attendant is high at 92%. There is, however, a large disparity in access to skilled care between urban and rural areas.

Since 2005, the Government of Malawi, through the Reproductive Health Unit of the Ministry of Health (MOH), with support from development partners including the United Kingdom's Department for International Development (DFID), the United States Agency for International Development (USAID), WHO, UNICEF and UNFPA, has been implementing the National Roadmap for Maternal and Newborn Mortality and Morbidity Reduction. Reproductive health issues have been integrated into the national Programme

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17 Unités Communales de Santé coordinate health services in a specific area. They bring together health care providers, local authorities and community groups. They include different health facilities, including dispensaries and health centres, and are linked to a referral hospital.
18 Documentation of Best Practices, Challenges, Experiences and Lessons Learnt in Maternal Health and Newborn Care Programme in Malawi. Report commissioned by the EC/ACP/WHO Partnership and the Malawi Ministry of Health Reproductive Health Unit, 2010. The information in this section was taken from this source, unless otherwise referenced. [unpublished document]
of Work and the Essential Health Package. As part of the Sector-Wide Approach (SWAp) funding mechanism, annual planning is undertaken with the involvement of all stakeholders, thereby avoiding duplications and making the best use of available resources. The model also reduces dependency on a single development partner.

Since 2006, the EC/ACP/WHO partnership has undertaken focussed activities in three districts: Ntcheu, Nkhata Bay, and Zomba that includes the provision of Basic Emergency Obstetric and Neonatal Care (BEmOC), training of skilled providers including midwives and medical assistants, and supporting the adoption of WHO guidelines for maternity care and for Youth Friendly Health Services. Health Surveillance Assistants (HSAs) have been employed by the Ministry of Health to do outreach in communities. They have been trained on maternal and neonatal health, maternal death audits and verbal autopsy, malaria prevention, young people’s sexual and reproductive health, prevention of mother to child transmission (PMTCT) and voluntary counselling and testing for HIV. They have also been given registers to record pregnancies and newborn babies in the communities.

The interventions at the community level have focused on the monitoring of maternal deaths, promoting community participation and enhancing political commitment from local authorities. Activities included the training of Village Health Committees (VHCs) and local leaders on data collection for maternal death reporting, the establishment of maternal death audit committees and activities to raise the awareness of maternal health needs including meetings for community leaders and chiefs and popular theatrical performances for the community.

Community-based distribution agents of family planning have been selected by the communities and recruited and trained to increase access to these services. Bicycles and start-up kits have been provided to the agents to ensure that they can reach everyone who needs the service within their communities. Meanwhile, HSAs have been trained to provide injectable contraceptives to improve access to those that live far from health facilities.

To address transport needs, districts are divided into clusters and an ambulance is stationed at a health facility in each cluster. Motorbike ambulances have been provided to the district hospitals. Some communities have developed their own transport systems for carrying pregnant women and those in labour to health facilities. For example, in hilly or lakeshore areas wooden stretchers carried by at least four men in turns have been used. To enhance communication between the health centres and the district or central hospitals solar-powered radio communication systems have been established and cellular phones have been provided to rural health centres.
Republic of Moldova

From 1990 to 2008 the Republic of Moldova achieved a 49% drop in MMR. In 2008, it was estimated at 32 per 100,000 live births with 14 maternal deaths per year and a lifetime risk of maternal death of one in 2000. As of 2005, there was a skilled attendant at nearly 100% of births. The government has shown commitment by the passing of laws and policies in favour of women's and children's health, including the law on obligatory health insurance. It implemented programmes on improving quality of care including of establishing family-friendly maternity centres with the focus on respecting privacy, confidentiality, and participation of women in decision-making.

In 2005, the Republic of Moldova began the implementation of the Beyond the Numbers Programme, with a focus on near-miss case reviews (NMCR - of women who had severe complications during pregnancy, childbirth or up to 42 days after termination of pregnancy) in referral level facilities, and confidential enquiries into maternal death (CEMD) at national level. These two programmes, as well as ongoing maternal death audits in some facilities, have contributed to the identification of the causes of maternal mortality, including of socioeconomic factors such as migratory lifestyle and rural residency. They also contributed to the identification and implementation of actions to improve access to quality care.

A strategic assessment of policies and quality of services on contraception and abortion care was conducted in 2005 which revealed that the provision of services differed greatly among institutions and service providers. Subsequently a model was developed for the provision of comprehensive contraceptive services, safe abortion and post-abortion care accompanied by awareness raising and public education campaigns. Since 2009, the National Health Insurance Programme has covered the costs of contraception for women who could not afford services otherwise; national standards for safe abortion were developed; obstetricians-gynecologists were trained on the provisions of comprehensive abortion care and medical abortion; the medications for medical abortions (mifepristone and misoprostol) were registered in 2004 on the national list of essential medicines and can be accessed in pharmacies with a prescription. In order to ensure monitoring and evaluation, the data collection system has been revised, and indicators on the quality of services have been introduced.

22 Sexual and Reproductive Health and Human Rights in Moldova: Implementation of the WHO Tool on Sexual and Reproductive Health and Human Rights. Moldova, Ministry of Health, in publication. The information in this section was taken from this source, unless otherwise referenced.
India

From 1990 to 2008 India achieved a 59% drop in MMR, moving from 570 per 100,000 live births in 1990 to 230 per 100,000 live births in 2008, with 63,000 maternal deaths per year and a lifetime risk of maternal death of one in 140. One state in particular, Tamil Nadu in southern India, has made significant progress towards MDG 5. MMR dropped from 450 in 1980 to 111 in 2006. According to the National Family Health Survey 2005-2006, in the state of Tamil Nadu, 90% of births took place in institutions and over 96% of mothers had at least three antenatal care visits during their last pregnancy. The total fertility rate declined from 3.9 in 1971 to 1.7 in 2006. Improved literacy; reduced incidence of early marriage, early pregnancy and frequent pregnancies and increased public awareness of family planning and good nutrition are also reported. The key factors behind the advances were related to social reform, political commitment to improve maternal and newborn health and establish women-centred health policies.

In order to reduce maternal mortality in Tamil Nadu a three-pronged strategy was embraced: prevention and termination of unwanted pregnancies; accessible high-quality antenatal care and institutional childbirth, with routine essential obstetric care and emergency obstetric first aid care at the primary level; and accessible, high-quality emergency obstetric care at the first referral level.

Efforts have been made to ensure access to permanent and temporary methods of family planning. Access to safe abortion services was addressed by raising awareness of the availability of services, training health workers in counselling and in safe abortion methods, and monitoring related activities.

To improve the quality of maternity care, the Government simultaneously addressed issues of infrastructure strengthening, availability of supplies, drugs and equipment, and rationalized allocation of human resources and upgrading of health workers' skills.

Delays in reaching care in case of complications were tackled with the provision of emergency transportation. In 2008, Emergency Management Research Institute (EMRI), a public private partnership initiative started providing free transportation. Currently for every 100,000 persons, there is one emergency ambulance available, with a 24 hours/7 days call centre to receive calls.

WHO. Safer Pregnancy in Tamil Nadu: from vision to reality. New Delhi, World Health Organization Regional Office for South-East Asia, 2009. The information in this section was taken from this source, unless otherwise referenced.


Compulsory reporting of maternal deaths and audits were introduced. In response to the findings of the audits, a "24x7" model was introduced whereby there is 24-hour / 7 days availability of nurses trained in obstetric and newborn care, two sanitary workers, and a driver to transport labour cases to a larger centre at the first signs of life threatening complications. The intervention resulted in more women seeking care in a timely matter thus reducing the load on both the referral levels of care. 

Quality of services from the perspective of women and communities has also been addressed. Several programmes have been started to make institutions friendlier and to create a more welcoming environment. "Maternity picnics" were arranged to provide the women with a tour of the facility; a birth companionship programme was developed to encourage women to have support with them during labour and childbirth; and to integrate tradition and culture into service provision primary, health centres held Valaikkappu ceremonies (where bangles are given to pregnant women), which are traditionally hosted in the woman’s home by friends and family.

Recognizing the importance of participation, the government of Tamil Nadu has established village health committees in all health sub-centres, which brought together community leaders and village officials to participate in the planning and implementation of health programmes. These committees also play a role in health education efforts. Health volunteers were engaged in the tribal areas to provide information on healthy practices and available health services and treatment of minor ailments.

A range of activities have been undertaken to address some gender-based beliefs which contribute to poor health among women. Kalaipayyam, a form of street theatre, has been used to explore issues of dowry, violence against women, early marriage, maternal health and mortality, and gender equality in decision-making. A second example is a training programme to sensitize local government officials to gender and health related issues, emphasizing their role in improving community health and welfare.

Conclusion

Progress has been made in maternal mortality reduction. Several countries have achieved reductions embracing measures which: ensure universal access to care; address inequities and the needs of the poor and marginalized; improve the quality of services; improve information, monitoring and/or accountability; involve communities; and ensure coordinated donor support. Despite the advances, each of these examples notes the scope for further improvement. There is still much to be done as global progress remains markedly inconsistent, with mortality rates even increasing in some countries. But these country examples show that MDG 5 can be reached if commitment is sustained. The UN Secretary-General's Global Strategy for Women's and Children's Health is an important step towards achieving improved maternal health. Success relies however on

stakeholders to make and act upon their commitments to enhance financing, strengthen policies and improve service delivery, and to ensure that these actions are firmly grounded in principles of human rights and equity.