WHO-EM/WRH/047/E

Strategic Directions for Accelerating the Reduction of Maternal Mortality in the Eastern Mediterranean Region

A Regional Framework

World Health Organization
Regional Office for the Eastern Mediterranean

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World Health Organization
Regional Office for the Eastern Mediterranean
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1. Introduction

The tenth revision of the International Classification of Diseases and Health-Related Conditions (ICD-10) defines maternal mortality as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes". Reduction of maternal mortality has been endorsed as a key development target by countries and is included in consensus documents emanating from several international conferences, beginning with the International Conference on Safe Motherhood held in Nairobi in 1987 and including the World Summit for Children in 1990, the International Conference on Population and Development in 1994, the Fourth World Conference on Women in 1995, the Millennium Summit in 2000 and the United Nations General Assembly Special Session on Children in 2002.

Global progress towards reducing maternal mortality has, however, been so far insufficient, despite the international efforts and commitments. Currently, more than half a million women die each year as a result of pregnancy and childbirth. Millions more become ill or are left disabled. In addition, each year, 3.3 million babies are dead at birth and another 4 million do not survive beyond the first four weeks of life. Many more are disabled because of inadequately managed pregnancies and births. The vast majority (99%) of maternal deaths take place in developing countries. As many as 300 million women, more than one quarter of all adult women now living in the developing world, suffer from short-term or long-term illness related to pregnancy and childbirth.

In the Eastern Mediterranean Region, around 53 000 women of childbearing age die every year as a result of pregnancy-related complications. In fact, the Region comes only second to the African Region with regard to the number of maternal

deaths. This problem occurs in a context where several countries in the Region suffer from lack of national policies, political instability, inadequate financial and human resources, restrictive regulations, poor socioeconomic conditions and gender-based discrimination, reduced access and utilization of safe motherhood services, including family planning, and scarcity of health-related data and information necessary to monitor and evaluate maternal health needs and the provided health services.

Most maternal deaths arise from complications during childbirth (e.g. severely obstructed labour, haemorrhage, and hypertensive complications), in the immediate postpartum period (sepsis and haemorrhage), or as a result of unsafe abortion. Factors commonly associated with these deaths include the absence of skilled health personnel during pregnancy and childbirth, lack of services able to provide emergency obstetric care and deal with the complications of unsafe abortion, and ineffective referral systems. Most of these maternal deaths are considered potentially preventable. Improved maternal health, adequate nutrition during pregnancy, appropriate management of deliveries and appropriate care of newborn babies can help avoid up to 80% of maternal deaths and up to 75% of perinatal deaths.

Current efforts in some countries of the Eastern Mediterranean Region are still insufficient to achieve the fifth Millennium Development Goal on improving maternal health. The average maternal mortality ratio in 2004 was estimated at 370 per 100 000 live births, compared to 465 per 100 000 live births in 1990. This represents only a 20% reduction in maternal deaths in the Region in this period. If the current trend in reducing maternal mortality continues in the years to come, it is expected that the maternal mortality ratio will be around 300 per 100 000 live births in the year 2015, while the target set for the Millennium Development Goals is to reduce the maternal mortality ratio by three quarters from its level in 1990 (i.e. to 116 per 100 000 live births). Strong commitment, intensive efforts and effective national policies and strategies

are now urgently required in order to translate vision into action. Such efforts and plans should target the strengthening of health systems, the expansion in the coverage of effective integrated interventions, and the recognition of the essential role of individuals, families and communities in making pregnancy safer.

This document provides a background on the current situation of maternal health in the Eastern Mediterranean Region, including underlying causes and contributing factors, and describes strategic directions aimed at accelerating the reduction of maternal mortality in the Region and moving closer to the achievement of the Millennium Development Goals. (For further information and some definitions relating to making pregnancy safer see Annex 1.)

2. Current situation of maternal health in the Region

2.1 Relation to the Millennium Development Goals

In 2000, the United Nations General Assembly adopted the United Nations Millennium Declaration, which set eight Millennium Development Goals (MDGs) to be achieved by 2015. The fifth goal addresses the need to improve maternal health and sets a target of achieving a 75% reduction in the maternal mortality ratio by 2015 from the level in 1990. For this target, two indicators have been selected to help track progress: maternal mortality ratio and proportion of births attended by skilled health personnel. This goal and its associated targets are closely linked to other MDGs and targets, including those of reducing under-five mortality (40% of which are due to neonatal causes), of halting the spread of HIV/AIDS, of controlling malaria, of promoting gender equality and empowerment of women, and of eradicating extreme poverty. It is clear, however, that the present maternal mortality levels and their reduction trends in several Member States will not enable the achievement of the fifth goal of improving maternal health; accelerated and concerted efforts are urgently needed.

2.2 Maternal mortality ratio

The average maternal mortality ratio in 2004 was estimated at 370 per 100 000 live births, compared to 465 per 100 000 live births in 1990, a reduction of only around 20%. The regional target for this period, established in 1990 by the Thirty-seventh Session of the Regional Committee for the Eastern

Mediterranean in resolution EM/RC37/R.6, had been to reduce the Regional maternal mortality ratio by 50% between 1990 and 2000.

However, there are great variations and disparities in maternal mortality levels between countries of the Region. Kuwait, Libyan Arab Jamahiriya, Oman, Qatar, Saudi Arabia and United Arab Emirates have achieved over 75% reductions compared to levels in 1990. Maternal mortality ratios in these countries range from 0 to 40 per 100 000 live births. Other countries, such as Bahrain, Egypt, Islamic Republic of Iran, Jordan, Morocco, Syrian Arab Republic and Yemen have made considerable progress in reducing maternal mortality by 50% to 75% from levels in 1990, with a wide array of maternal mortality ratios ranging between 21 and 366 per 100 000 live births. Meanwhile, the reduction in maternal mortality in Afghanistan, Djibouti, Iraq, Pakistan, Somalia and Sudan has not exceeded 30% from levels in 1990, with the maternal mortality ratio ranging from 294 per 100 000 live births in Iraq to 1600 in Afghanistan and Somalia.

2.3 Proportion of births attended by skilled health personnel

Skilled birth attendants are defined by the World Health Organization as "trained midwives, nurses, nurse-midwives or doctors who have completed a set course of study and are registered or legally licensed to practice". There are sound medical reasons why governments should invest in skilled birth attendants, especially for the time of birth. Most maternal and newborn deaths occur around the time of delivery or shortly thereafter. Some 80% of maternal deaths are due to a few direct obstetric complications (sepsis, haemorrhage, eclampsia, obstructed labour and abortion) and most could be prevented or managed if the woman had access to a skilled birth attendant with necessary back-up and support.

According to the Millennium Development Goals, 80% of all births should be assisted by skilled attendants by 2005, and

90% by 2015. However, in 2004, it was estimated that only 53.3% of births in the Eastern Mediterranean Region were attended by skilled attendants, compared to 36% in 1990, making only a 48% increase in this proportion. At the country level, less than 50% of deliveries were attended by skilled health personnel in Afghanistan, Pakistan, Somalia and Yemen. Meanwhile, this indicator ranged between 50% and 80% in Djibouti, Egypt, Iraq, Morocco and Sudan.

3. Underlying causes of maternal mortality

Community awareness about life-saving practices in pregnancy, childbirth and home care for children, literacy and female education, fertility and family formation patterns, and quality of health care delivery systems, are the main factors that contribute to the maternal health situation. There remain several barriers that hinder progress towards improving maternal health in the Region.

- Lack of national policies: in several countries of the Region, there are no clear national policies on maternal health that reflect long-term direction and ensure sustained commitment. Furthermore, policy-makers in many countries still do not have a good grasp of the MDGs, so the adoption of the Millennium Development Goals by these countries has not necessarily been translated into action to achieve them.

- Political instability: for a considerable period of time the Eastern Mediterranean Region has been devastated by manmade disasters, including wars and civil conflicts, which have tremendously affected the health of the population in some Member States. Such effects include states of emergency, depletion of resources and low prioritization of certain aspects of health.

- Limited financial resources: the current level of health expenditure, especially in the low-income countries with the highest maternal mortality in the Region, is insufficient to support strategies and actions necessary to achieve the MDGs. The problem is aggravated by the fact that there has been a decline in overall development aid in recent years. Hard economic circumstances and limited resources in the context of pressing needs and competing priorities have led to inadequate budgetary allocations for national health and

development programmes including making pregnancy safer. The current tendency to fund vertical disease-specific programmes has dramatically shifted resources from maternal and neonatal health. This tendency may lead to neglect of integrated strategies that aim both to strengthen the health system and to build capacity of the human resources that are essential to support and sustain progress towards the MDGs.

- Inadequate human resources: the low quality pre-service (basic) education and in-service training, as well as the high turnover of health providers, overburdens the health system with a continuing need to improve and update health providers' knowledge and skills. Shortage in numbers of appropriately trained personnel and poor organization at the peripheral level especially in rural and remote areas, aggravate the problem. Even when appropriately trained health care professionals are available, low salaries and poor supervisory and working conditions lead to poor performance and high turnover.

- Restrictive regulations: In some countries, laws, policies and regulations may hinder access to services, unnecessarily limit the roles of health personnel (for example, preventing midwives from performing life-saving procedures such as removal of the placenta), bar the provision of some services (such as over-the-counter provision of certain types of contraceptive), or restrict the importation of some essential drugs and technologies.

- Reduced access to safe motherhood health services: the burden of maternal morbidity and mortality is greatest in the poorest countries where health services tend to be scattered or physically inaccessible, poorly staffed, poorly resourced and equipped, and beyond the reach of the poor. Barriers that disadvantaged people face in accessing health services generally include lack of quality services, distance

from services, lack of emergency transport, lack of or poor referral services, cost of services and discriminatory treatment of users. Unfortunately, too often, improvements in public health services disproportionately benefit wealthier people.

- Reduced utilization of services: high illiteracy rates, accompanied with poor community awareness about life-saving facts and practices in pregnancy and childbirth coupled with other factors related to the availability and quality of delivered health care, result in the lack or under-utilization of existing safe motherhood services, even when these services are made accessible and affordable. This is particularly true in rural and remote areas.

- Poor availability and use of relevant data: maternal health-related data and information are still scarce in most countries of the Region, largely due to inadequate reporting. Even when available, these data are either of poor quality or their use in decision-making and planning is limited.

- Poor family planning practices: health hazards due to poor birth spacing—leading to too early, too late, too close, and too many pregnancies—are well established. If such high-risk pregnancies were prevented, it is estimated that maternal mortality could be reduced by up to 25%. Promoting family planning among married women is an effective intervention to prevent many avoidable deaths among mothers and their newborn babies.

- Poor socioeconomic conditions: poverty, illiteracy and malnutrition are among the major underlying causes of maternal mortality. The level of illiteracy among women in many countries of the Region is still unacceptably high with an average of up to 46% in the Region as a whole. Poverty alleviation, female education and eradication of illiteracy, particularly among women, are important factors in protecting and promoting maternal health.

- Gender-based discrimination: the lower social status of girls and women frequently results in poor physical and mental health, by making women more prone to gender-based violence, including female genital mutilation. Women's lack of decision-making power related to reproduction, low values placed on women's health, and negative or judgmental attitudes of family members and health care providers, compromise women's reproductive health in general and maternal health in particular.

4. Strategic directions for making pregnancy safer in the Region

4.1 Central strategic objective

The central objective of the Making Pregnancy Safer (MPS) strategy is to ensure safe pregnancy and childbirth through the availability, access and use of quality skilled care for all women and their newborns. As a priority, skilled care should be ensured at every birth. Skilled care in maternal and newborn health refers to the process by which a pregnant woman and her newborn are provided with the necessary care which must include, apart from care in normal (uncomplicated) births, timely referral and management of complications if they arise. The essential component of skilled care is the presence of a skilled attendant and other key skilled professionals supported by an appropriate environment with access to basic supplies, drugs and relevant emergency services. Skilled care should be provided within a continuum of care. This continuum extends from care and support in the home, to care by a skilled attendant throughout pregnancy, childbirth and the postnatal period, to the care needed in case of complications.

4.2 Guiding principles

The following core values and operational principles provide the basis for effective and appropriate strategic directions.

Core values

- Human rights: based on a human rights approach, the MPS strategy promotes the rights of women and neonates to life and to the highest attainable standard of health.

- Gender: the strategy aims at promoting gender equality as the basis of maternal and neonatal health programmes, by addressing the lower status of women and discrimination against women.

- Equity: the actions promoted within the strategy aspire to contribute towards decreasing the inequities in health in the Region, with priority attention to poor and underserved groups.

- Culture: the strategy aims at improving maternal health through working with women, families, communities and policy makers using a culturally sensitive approach that takes into consideration the sociocultural dimensions and specificities of the Eastern Mediterranean Region.

Operational principles

- Continuum of care: this continuum must result in the best possible care at all levels of the health system from the household to the first service level to the higher level service site, as appropriate to the needs of each woman or newborn child. Primary care should be strongly connected to a referral system in order to effectively manage life threatening complications.

- Quality of care: standards should be met in order to effectively manage routine cases as well as complications. Addressing providers' needs and community views, particularly those of women, on the quality of service provision is the key to ensuring improved quality and increased access and utilization.

- Integrated primary health care: recognizing the importance of reducing unwanted and unplanned pregnancies, the MPS strategy focuses on links with family planning services, other reproductive health services and other aspects of

primary health care, including management of malaria and HIV where applicable.

- Partnerships: partnerships between governments, civil society, professional groups, international agencies and donor groups have been shown to bring down mortality rates in a range of contexts.

- Good governance, peace and security: these elements are vital components of a sustained effort to improve the health and survival of mothers and their newborn babies, and are especially relevant to the Eastern Mediterranean Region.

4.3 Priority actions

Achieving political commitment

Achieving the objective of skilled care for all women and their newborns requires strong political will. Therefore, it is necessary to develop national maternal health policies which prioritize the interventions required to reach the population groups most in need, bring all elements of maternal health together in one policy document, reallocate resources and serve as a reference for partners to help guide their assistance to countries and achieve the MDGs. It is essential that governments of the Region develop such long-term policy commitment across a wide spectrum of stakeholders. Sustained demand for action from local political, community and religious leaders is also necessary to accelerate the momentum and to ensure continued commitment at the political and government level, which is essential for allocation of adequate resources for this problem over the long term.

Well-managed advocacy, based on solid data, to create awareness of the scale and consequences of the problems of maternal and perinatal mortality in a country must also spread beyond the experts working in the area of maternal and child health and include other stakeholders in

government, policy-makers, religious leaders, academic institutions, professional associations and nongovernmental organizations, as well as community and women's groups. International organizations, nongovernmental organizations, local groups and the local media will have a key role to play in supporting governments in their efforts to mobilize resources. Political commitment at the highest level, joint action by the concerned sectors including health, human development, education, finance, transport, and law are important for long-term sustainable action required to increase access to, and use of, quality maternal and neonatal care.

Ultimately, generating political commitment to devote a sufficient proportion of gross domestic product to expanding the availability of services is an urgent priority. Financing a system which enables the poor in a country to access care should be a key part of this. Where domestic resources are not sufficient to meet the costs, countries will require the assistance of international donors.

Promoting a favourable policy and legislative environment

It is important to develop a human resources policy that is comprehensive and that takes into consideration the country-specific context. Such a policy would serve to regulate issues such as licensing of health providers and skilled attendants and the extent to which each can perform certain procedures. Removal of unnecessary restrictions from policies and regulations in order to create a supportive framework for ensuring skilled care for all women and their newborn babies is likely to contribute significantly to improved access to services.

Promoting an effective regulatory environment needed to ensure public and private sector accountability is also key to providing high quality care for all of the population. Laws and policies may need to be reviewed and even modified in order that they facilitate universal and equitable access to reproductive health information, education and services. The

supportive environment for care of pregnant young women and girls and their newborn babies, as well as for working women should be a specific focus.

Ensuring that regulations and standards are in place is important to guarantee that the necessary medicines, equipment and supplies are available on a consistent and equitable basis and meet international quality standards. These aspects of a supporting policy environment are relevant at national, regional and local levels, and the integration of policy measures and initiatives across levels and across sectors can ensure that a supportive regulatory framework is coordinated and monitored.

Ensuring adequate financing

Sustainable financing mechanisms should be set up so that actions to strengthen the health system can yield results. Improving health financing would reduce the extent to which people have to make large out-of-pocket payments at the point of service; increase the accountability of institutions responsible for managing insurance and health care provision; improve the pooling of health fund contributions across rich and poor and raise money through administratively efficient means. Such sustainable financing mechanisms would play the greatest role in countries of the Region that suffer from poverty by offering financial protection to those who need it most.

Appropriate arrangements that provide basic insurance and social protection for all can be designed according to country contexts. Central to all financing models is the mobilization of funding sources that do not derive from out-of-pocket costs, including general and earmarked taxes, social insurance contributions, private insurance premiums, and community insurance prepayment. Emerging evidence should be monitored to assess the effectiveness of these models in increasing service utilization and putting services within reach of the poor. Health sector reforms, sector-wide approaches and the implementation of other financing mechanisms such as poverty reduction strategy papers, cost-sharing and direct

budget support should also be monitored to ensure that they benefit the poor and other marginalized groups and that they contribute to strengthening maternal and neonatal health.

Strengthening the delivery of health care services

Maternal health should be embedded into an integrated and comprehensive set of primary health care services that are intended to reach out to all parts of the population. To realize these primary health care objectives, health care for women and newborn babies should be underpinned by reproductive health programmes, such as family planning, and also strongly linked with other key primary health care components, such as the prevention and treatment of malaria, wherever necessary.

To strengthen health care delivery and create functioning systems the provision of an effective, skilled and appropriately trained workforce is fundamental. The health system requires a comprehensive human resources policy which is able to manage different workforce, issues such as shortage, drain of human resources, deployment and motivation, which strain health care service delivery in several places in the Region. The health system needs to be equipped with sufficient numbers of skilled workers to deliver essential services at each level of care. These include midwives, doctors, nurses, and specialized medical personnel as well as managers and related professionals. Existing human resources can be maximized through improved management and enhancement of skills and capabilities. One way to approach the latter would be for Member States to introduce adapted WHO maternal health-related guidelines into the formal teaching curricula of medical and paramedical schools, both to improve the quality of teaching and to ensure sustainability of the effective interventions. The supply of skilled personnel can be expanded by training and recruiting new staff and by working with the education sector to ensure that there is an adequate supply of new entrants. Skilled attendants will need to be deployed in areas where they are most needed, for example

remote areas where women currently have no access to skilled care. The continuum of care also requires a functioning referral system for the management of pregnancy-related complications in an emergency.

Ensuring the functioning of enabling environments in which skilled workers can provide care effectively is an essential part of health system strengthening. In order for women and their newborn babies to access skilled care at any time, especially in an emergency and at times of conflict, the equipment, drugs and supplies necessary must be in place within a well-managed system. Planning the systems requires the establishment of an essential package of evidence-based interventions including the provision of skilled care during pregnancy, birth and postpartum and for the newborn child, as well as family planning services, post-abortion care and, where legal, abortion services. To ensure quality of services, evidence-based standards can be established and implemented for benchmarking care. Those responsible for decentralized planning associated with health sector reform need to give special attention to enabling system-wide adoption of good practices.

Empowering women, families and communities

A number of strategies are required to work effectively with women, their families and communities to strengthen their capacities to provide appropriate care in the home; to make healthy decisions and to act upon those decisions, including the decision to seek care at other levels of the continuum when needed; and to assume their important role as partners in improving maternal and newborn health. The strategies of education, community action, partnerships, institutional strengthening and local advocacy have been identified, as have key interventions to contribute to the empowerment of women, families and communities to improve and increase their control over maternal and newborn health, as well as to increase access and use of quality health services. Selected areas of intervention and strategies will ultimately depend upon the local situation, context and resources available.

Raising community awareness about life-saving practices in maternal and neonatal health through community-based messages can take several forms. For example, educating women and their families about the risks they may encounter in pregnancy and childbirth and about the appropriate actions to be taken should danger signals be identified, early identification of mothers and newborn babies with complications and their prompt referral to appropriate medical care, and effective motivation of women and their families to agree to these referrals, can all drastically improve maternal and neonatal health.

In order to develop these capacities, health education interventions and linkages with the education sector should be improved. Effective participatory processes and interventions for working with women, their families and communities for improved health can be identified and implemented. Partnerships between health service delivery and the community should be developed to respond to maternal and neonatal health needs, and to increase use of care. These will be facilitated by improved health planning processes that include women and community groups and other important stakeholders and by establishing quality improvement mechanisms that take account of women and community perspectives. Finally, health service capacities to interact with the community should be developed, including health workers' intercultural and interpersonal competencies, as should community group capacities for working with health services.

Strengthening monitoring and evaluation for better decision-making

Effective monitoring and evaluation is essential to programme and service improvements. Tracking progress is also a potent tool for advocacy and can galvanise political commitment for improving maternal and neonatal health and survival. Improved monitoring of maternal and neonatal deaths is a priority, especially in Member States where vital registration is incomplete. Approaches should be tailored to country

contexts, but the application of facility audits, special surveys for women of reproductive age, verbal autopsies and even special questions administered through the census have all been and can be used successfully. However, the eventual aim should be the strengthening of vital registration and improvements in country health management information systems. These systems can be effectively tied into maternity registers within facilities and can be the basis for effective and responsive decision-making at all levels. This would help recognize epidemiological patterns and maternal morbidity and mortality trends, in order to identify appropriate interventions that address real needs in the community.

The tracking of process indicators, particularly in relation to utilization and quality of services and the coverage by skilled attendants at birth, is also important for policy. Programmes should be evaluated and results disseminated, especially where accelerated efforts are being applied to improve health, so that more strategic lessons can be learnt for the future. Particular efforts should be made to use existing data sources to the full, as well as to maximize ongoing data collection exercises. This implies the development of statistical expertise at all levels, and the regular dissemination of indicators, analyses and assessments of data quality surrounding maternal and neonatal health, survival and care. Recent progress in the estimation of wealth status should also be applied as widely as possible to facilitate the tracking of improvements among poor and other subgroups, where data allows.

5. Implementation framework

Implementing the priority actions described in section 4.3 will depend on country contexts. The following key issues for implementation are intended as a guide for prioritizing strategic elements in countries.

5.1 Building on existing country efforts and maintaining gains

It is vital to build on existing country efforts and strengthen the processes, structures and systems for planning, implementing and evaluating the national safe motherhood programme. Hard fought gains should be maintained, and country processes respected. It is evident that it may not be possible to implement all activities in the strategy simultaneously, or in the same way throughout a country. The priority actions can be introduced and scaled up at different rates and in alternative ways based on local needs and available resources. The plan of action must allow for local decision-making, prioritizing and adaptations to meet the particular needs of a district or region. The following steps can be followed as part of the process.

- Review the focus, strengths and weaknesses of current efforts to make pregnancy and childbirth safer, in terms of both coverage and quality of skilled care, gaps and barriers to access and use, and the strengths and weaknesses of the different levels of the continuum of care, and then develop and implement plans to address these;

- Review the national plan of action and estimate funds required, based on national policies and needs assessment

and focus on strengthening the health system, with clear prioritization of activities;

- Fundamental activities will include increasing training capacities at national and local levels, improving planning, programming and management capacities at district and other levels, and revising regulations and guidelines related to health personnel, their status and deployment.

5.2 Partnerships—a participatory approach

Strong political commitment and strategic partnerships at all levels are crucial for gaining the necessary intersectoral collaboration. All stakeholders at both national and local levels, including public and private providers, all related programmes and representatives from women's and community groups, should be actively involved from a very early stage in identifying priorities, assessing needs, developing, implementing, monitoring and evaluating maternal and newborn health programmes and plans. The involvement of other ministries, such as those dealing with education, finance, transportation, social welfare and women's affairs etc., is critical. In addition, working closely with nongovernmental organizations and the private sector in a systematic and regulated manner would allow the tapping of resources, be it financial, human, or logistic, and strengthen and regulate the participation of two sectors that are increasingly playing a significant role in shaping the health of the populations of the Region. Collaborative efforts with other relevant public health programmes and initiatives should be systematically addressed and established.

5.3 Strong programme management and planning

A high level national multidisciplinary taskforce or committee, with the responsibility to take action and influence policy change, as well as to coordinate and oversee all

partners' efforts, is required. Actions taken by such a taskforce should be underpinned by the strongest available evidence. Efforts should be focused on identifying the components which need strengthening in the health system for building the continuum of care. Evidence-based interventions should be promoted and national standards for the essential package should be established or revised, with clear lines of accountability and reporting and monitoring of progress.

6. Supporting policy development and implementation: Regional Committee resolutions

Since the Nairobi Conference in 1987, the Regional Office has adopted the Safe Motherhood Initiative as a priority strategy to protect and promote maternal health in countries of the Region. The Regional Office has, subsequently, advocated the principles and necessary interventions for the implementation of the Strategy in the Region. In 1988, the Regional Committee for the Eastern Mediterranean discussed and "noted with concern the high levels of maternal and infant deaths in some countries of the Region", and adopted resolution EM/RC35/R.9 "Maternal and infant mortality in the Eastern Mediterranean Region—socioeconomic implications and urgent need for control". In 1990, the Regional Committee adopted resolution EM/RC37/R.6, in which all countries of the Region were requested to aim at reducing maternal mortality by 50% by the year 2000 and to adopt all possible measures to achieve this target. Two approaches were determined in this resolution to improve maternal health, namely, securing the availability of at least one trained birth attendant in every village and urban quarter, and reinforcing the technical support provided to Member States to achieve the goals of safe motherhood.

During the 1990s the Regional Office placed the Safe Motherhood Initiative and its subsequent programmes and activities high on the ladder of priorities among reproductive health programmes. Subsequently, significant achievements were made and maternal health care delivery indicators were significantly improved. However, the progress in some countries was relatively slow and maternal health indicators continued not to meet global targets.

The launch of WHO's Making Pregnancy Safer (MPS) Initiative in 2000 was a significant step towards reducing maternal and neonatal ill health in Member States. The Initiative was first applied in Sudan; since then, 11 more countries have embarked on the necessary steps to implement the strategy in collaboration with the Regional Office. These countries are Afghanistan, Djibouti, Islamic Republic of Iran, Iraq, Morocco, Pakistan, Qatar, Somalia, Syrian Arab Republic, Tunisia and the Republic of Yemen. Special attention has been given to countries with high levels of maternal death.

In October 2004, noting with concern the high levels of maternal and child mortality in some countries of the Region which prevent the achievement of the Millennium Development Goals, and impede the human and socioeconomic development of those countries, the Fifty-first Session of the Regional Committee for the Eastern Mediterranean passed Resolution EM/RC51/R.4 (Annex 2), which focused on moving towards achieving the MDGs through investing in maternal and child health. The Resolution urged Member States to re-examine their existing national policies and strategies; to expand upon achievements made and build on them; to strengthen national surveillance systems and adopt evidence-based interventions; to establish national maternal mortality committees to review and monitor maternal deaths; and to incorporate maternal health approaches into formal teaching curricula of medical and paramedical schools. In addition, the Resolution called upon the Regional Office to support further the scaling up of effective interventions; to assist Member States to conduct in-depth assessment of maternal mortality; and to report periodically to the Regional Committee on the progress in maternal and child health.

7. Conclusion

Too many women in the Region are suffering and dying due to pregnancy related causes. Most of these deaths are potentially preventable. We now know what can be done to prevent these deaths. Tens of thousands of mothers in the Eastern Mediterranean Region could be saved using the knowledge and experience we have today. The challenge is to transform knowledge and experience into action. This requires the commitment of Member States, who have a unique opportunity to accelerate reduction of maternal mortality at this time, with support from WHO and other concerned partners. What remains is for us to amalgamate our efforts and join forces in coordinated action to decrease maternal mortality and make the achievement of the Millennium Development Goals a reality.

Annex 1

Fact sheet on making pregnancy safer in the Eastern Mediterranean Region, 2004

Indicator	Rate
1. Pregnant women attended, at least once during pregnancy, by trained personnel (excluding trained or untrained traditional birth attendants) for reasons relating to pregnancy.	60.3%
2. Deliveries attended by trained personnel (excluding trained or untrained traditional birth attendants): skilled birth attendants are defined by the World Health Organization as "trained midwives, nurses, nurse–midwives or doctors who have completed a set course of study and are registered or legally licensed to practice".	53.3%
3. Proportion of caesarean sections of all deliveries: number of caesarean sections per 100 deliveries conducted in health institutions run by the public, private and nongovernmental sectors.	17.4%
4. Married women of reproductive age (15-49) who are using a contraceptive method.	40.5%
5. Pregnant women with anaemia (screened during pregnancy for haemoglobin concentration) with haemoglobin concentration of less than 110 g/l.	40.9%
6. Total fertility rate: total number of children a woman would have by the end of her reproductive period if she experienced the currently prevailing age-specific fertility rates throughout her childbearing life.	4.0
7. Maternal mortality ratio: number of maternal deaths per 100 000 live births	370
8. Neonatal mortality rate: number of deaths, of live born infants, occurring during the period, which commences at birth and ends 28 completed days after birth per 1000 live births.	32.7
9. Percentage of low birth weight: live births that weigh less than 2500 g.	18.7%

Annex 2

Moving towards the Millennium Development Goals: investing in maternal and child health (EM/RC51/R.4)

The Regional Committee,

Having discussed the technical paper on Moving towards the Millennium Development Goals: investing in maternal and child health;

Recalling World Health Assembly resolution WHA 55.19, WHO's contribution to achievement of the development goals of the United Nations Millennium Declaration, which recognized that "maternal, child and adolescent health and development have a major impact on socioeconomic development" and which urged Member States to advocate them as public health priorities, and WHA 57.12, Reproductive health: draft strategy to accelerate progress towards the attainment of international development goals and targets;

Recalling its resolutions EM/RC35/R.9, Maternal and infant mortality in the Eastern Mediterranean Region: socioeconomic implications and urgent need for control, EM/RC37/R.6, which requested Member States to aim at reducing maternal mortality by 50% by the year 2000, and EM/RC5O/R.14, Healthy environments for children, which urged Member States to adopt national child health policies and integrated approaches to healthy environments for children;

Firmly convinced that mothers and children are the future of development of countries in the region, and that, therefore, investing in maternal and child health should remain a priority;

Noting with concern the high levels of maternal and child mortality in some countries of the Region which prevent the achievement of the Millennium Development Goals, and impede the human and socioeconomic development of those countries;

1. COMMENDS the steps already taken by the Regional Director to assist Member States in implementing effective maternal and child health interventions in the Eastern Mediterranean Region;

2. URGES Member States who have not already achieved the targets set by the Millennium Development Goals for improvement of maternal and child health care to:
   - 2.1 Develop national child and maternal health policy documents and strategies necessary to achieve the Millennium Development Goals;
   - 2.2 Expand upon the achievements already made by the Member States in implementing the effective interventions of Integrated Management of Child Health (IMCI) and Making Pregnancy Safer (MPS) and ensuring the availability of one skilled birth attendant/midwife per village;
   - 2.3 Strengthen existing national surveillance systems to identify mortality and morbidity trends in children and mothers and adopt evidence-based interventions, including community-based interventions;
   - 2.4 Establish a national maternal mortality committee to review and monitor maternal deaths in the country;
   - 2.5 Incorporate public health approaches related to maternal and child health into the

formal teaching curricula of medical and paramedical schools.

3. REQUESTS the Regional Director to:
   - 3.1 Support further the scaling up of effective interventions; in order to improve maternal and child health in the Eastern Mediterranean Region and assist the Member States to achieve the Millennium Development Goals;
   - 3.2 Assist Member States to conduct in-depth assessment of maternal mortality;
   - 3.3 Conduct a regional expert consultation to advise on introduction of new vaccines;
   - 3.4 Report periodically to the Regional Committee on progress in moving towards the Millennium Development Goals relating to maternal and child health.

Annex 3

Further reading

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