

BETTER OFF DEAD?

A report on maternal morbidity
from the UK All Party Parliamentary
Group on Population, Development
and Reproductive Health

May 2009





Rehabilitation Unit, Addis Ababa Fistula Hospital, Ethiopia
– MPs Study Tour, February 2009



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Foreword

Christine McCafferty MP
Chair
The UK All Party Parliamentary Group on
Population, Development and Reproductive Health



The UK All Party Parliamentary Group on Population, Development and Reproductive Health held Hearings into Maternal Morbidity on 8th – 9th December 2008, in response to members' quest for information, on this often neglected subject.

Currently, there is no global definition of Maternal Morbidity, but millions of women and young girls suffer injury and disability. They live in shame and isolation, frequently abandoned by their husbands and excluded from economic and social lives, as a direct result of pregnancy and childbirth.

Some of the most devastating injuries discussed in the report include obstetric fistula, prolapsed uterus, infertility and depression – all easily preventable, at a very low cost.

I recently visited the Addis Ababa Fistula Hospital, in Ethiopia, to see the wonderful work being done to restore the health and dignity of thousands of women. Words cannot express the trauma and distress I witnessed.

Young girls curled up in the foetal position, doubly incontinent and unable to walk, due to obstetric fistula. It is a moral outrage that millions of women are allowed to suffer like this, in the 21st century. Political leaders must speak out to prevent further tragedy.

Concerted action is needed to improve Sexual and Reproductive Health and Rights legislation and adequately fund appropriate policies.

Ministers of Finance around the world must understand that investing in women's health, makes social and economic sense.

Professional colleges have an enormous task ensuring improvements in the quality of obstetric care for all women, but especially for young girls.

They also need to ensure that sufficient health workers are trained to cope with the increased demand.

I believe that Traditional Birth Attendants have a role to play in the communities they serve. They should be trained to administer simple life saving drugs, including family planning, emergency contraceptives, misoprostol and antibiotics.

Health systems must be strengthened, in order to improve women's lives and achieve the promises of the Millennium Development Goals (MDGs); in particular, MDG5 to improve Maternal Health. A range of family planning, including emergency contraceptives, skilled birth attendants and obstetric emergency care, must be accessible, affordable, appropriate and acceptable to all, irrespective of age, community or country.

2009 is the 15th anniversary of International Conference on Population and Development Programme of Action; women, children and their families cannot wait any longer for the promises made 15 years ago by 179 leaders around the world.

It's time for politicians to stand up and be counted.

In that context, I particularly want to express my appreciation to Baroness Tonge for her inspiration behind the Hearings; questioning whether women who die during pregnancy or childbirth are often better off, than the many women who survive, but suffer in silence.

Chris McCafferty

Executive Summary

The UK All Party Parliamentary Group on Population, Development and Reproductive Health would like to introduce you to a little known, little researched, and little understood topic: maternal morbidity. The definition is disputed, but the term roughly means women's illnesses and injuries related to pregnancy and childbirth. It leaves 10 – 20 million women and girls every year with long-term physical, psychological, social and economic problems (RCM written evidence). Many women are abandoned, ostracised and alone. The grim series of complications include:

Obstetric fistula, perineal damage, prolapsed uterus, stress incontinence, puerperal infection and sepsis, haemorrhage, hypertensive disorder (pre-eclampsia) and fits, anaemia, infertility and ectopic pregnancy, depression and suicide.

Maternal morbidity has root causes in gender inequality and violence, poor access to education (especially for girls), early marriage, adolescent pregnancy, poor access to comprehensive quality sexual and reproductive health services and other social and economical determinants.

Among the many structural problems in maternal health, the lack of health workers and drugs and supplies, economic inequity, remote populations, the low status of women and a lack of political will or ideologically driven policies are particularly important.

While there has been some progress in the health-related Millennium Development Goals (MDGs), MDG 5 to improve maternal health has shown the least progress. Maternal health is inextricably linked to development, poverty reduction and social inclusion. Investing in maternal health has wide social and general health benefits and makes economic sense.

Maternal morbidity can be effectively reduced by addressing the above determinants and by ensuring universal access to family planning and safe abortion, skilled attendance at birth, and basic and comprehensive emergency obstetric care. It has been proven that there are ways to mobilise women and community groups to help themselves to protect households from the devastating effects of an unwanted pregnancy, or a difficult and complicated delivery.

The UK All Party Parliamentary Group on Population, Development and Reproductive Health makes the following recommendations:

- **Increase Political Will** to ensure sufficient resources for maternal health including family planning, safe abortion, menstrual regulation and a clean and safe delivery (with more research, especially cost-benefit analysis on maternal health, to engage policy-makers, including Finance Ministers);
- **Increase Resources to Sexual and Reproductive Health and Rights (SRHR)** to 10 per cent of Official Development Aid (ODA) as recommended at successive International Parliamentarians' conferences (Ref 1), with attention to supporting country plans that include MDG target 5.B: "achieving universal access to reproductive health by 2015";
- **Encourage Equitable Health Care** by removing financial barriers and improving access to services by empowering women particularly through community groups;
- **Work in Partnership** with the United Nations and the United Kingdom and International Royal Colleges for expansion and registration of health workers with appropriate 'task shifts', improve codes of practice, standards, guidelines, protocol and improve maternal health data collection;
- **Improve SRHR Legislation and Policies** world-wide with specific reference to legislating against child marriage and female genital mutilation, decriminalising abortion, preventing legislation that criminalises transmission of HIV and ensuring comprehensive linked SRHR and HIV/AIDS policies and strategies;
- **Make Governments Accountable** by publishing country league tables on maternal health.

***"Men between the ages of 15 and 44 face no single threat to their health and lives that is comparable to maternal death and disability"**
(CRR Written Evidence).*

Background and Acknowledgements

Baroness Tonge
Hearings Chair and Treasurer
**The UK All Party Parliamentary Group on Population,
Development and Reproductive Health**



“We always hear the Millennium Development Goals emphasis on maternal mortality, but I do not think this covers the whole problem, especially nowadays when we talk of billions and trillions... you say ‘around half a million women die every year in childbirth’. We have to add to that, that millions of women are permanently disabled and have their lives ruined by childbirth every year – some of them might even be better off dead! This inquiry is to strengthen the argument for women’s reproductive health. We are hoping to champion the cause of women’s health worldwide”

The UK All Party Parliamentary Group on Population, Development and Reproductive Health (the Group) warmly thanks hearing committee and panel members, Chair of the Group Christine McCafferty MP, and members of the Group Lord Rea, John Bercow MP, Sandra Gidley MP, Lord Patel, Baroness Flather, Baroness Thomas and Baroness Northover.

In addition, thanks are extended to NGO representatives on the hearing committee Jennifer Woodside (IPPF), Anne Quesney (MSI), Ros Davies (WCF), Amy Kesterton (Interact Worldwide) and Belinda Atim Tima (ICW) for their support, commitment and work on the Parliamentary Hearings and Report.


Special thanks also go to the experts from Professional Organisations, Non Governmental Organisations, Ministries of Health, Academic Institutions, Banks, United Nations Organisations, Foundations and Governments who all provided written and oral evidence to the Hearings.

Expert witnesses included:

- Dr John Kelly, Obstetrician;
- Dr Tony Falconer, Vice President and Dr Nynke van der Broek, Director International Office, Liverpool, RCOG;
- Frances Day-Stirk, Director of Learning, Research and Practice Development, RCM;
- Dr Gill Greer, Director General, IPPF;
- Rosey McDonald, Programme Officer, Women and Children First (UK);
- Getachew Bekele, Senior Advisor to MSI Global Partnership, MSI;
- Gilda Sedgh, Senior Research Associate, Guttmacher Institute;
- Alec Cumming, Chief Executive Officer, Impact;
- Amy Ong Tsui, Director and Professor, John Hopkins SPH, Bill and Melinda Gates Institute for Population and Development;
- Ian Anderson, Advisor, Principle Economist, Health Services Delivery, Regional and Sustainable Development and Mr Bruce Purdue, Head of the Results Management Unit, Strategy and Policy Department, Asian Development Bank;
- Veronique Filippi, Senior Lecturer, LSHTM;
- Karen Newman, Coordinator, PSN;
- Dr Maliha Rashid, Bangladesh MoH representative;
- Binjwala Shrestha, Nepal and Brigid McConville, Director, WRA;
- Naana Otoo-Oyortey, Executive Director, FORWARD;
- Max Lawson, Head of Development Finance and Public Services Team, Oxfam;
- John Nduba, Director for Reproductive and Child Health, Nairobi, AMREF;
- Dr Hedia Belhadj, Executive Coordinator, Global Health, UNFPA;
- Mr Ian Pett, Chief of the Health Systems and Strategic Planning Unit of the Health Section, UNICEF;
- Mary Ellen Stanton, Senior Advisor for Maternal Health, USAID;
- Malcolm McNeil, Head of AIDS and Reproductive Health Team, John Worley, Head of Profession/Health, and Sandra MacDonagh, Health Advisor/Reproductive and Sexual Health, DfID.

The Group also thanks Carol Bradford for editing the Hearing Report, W.B. Gurney & Sons LLP staff for transcribing the Hearings, Yumi Kohsaka for design and Kari Mawhood for providing administrative and logistical support at the Hearings.

A thank you also goes to Ann Mette Kjaerby for her professional and technical knowledge and organisational skills.



Section 1

Introduction

The UK All Party Parliamentary Group on Population, Development and Reproductive Health (the Group) would like to introduce you to a little known, little researched, and little understood topic with a name that is even hard to understand: maternal morbidity. The definition is disputed, but the term roughly means women's illnesses and injuries related to pregnancy and childbirth. In trying to bring safer motherhood to the world's attention, the concept of maternal mortality has been emphasised. While mortality or deaths are more straightforward to measure, they are only the tip of the iceberg. It is estimated that for every maternal death, there are 20 women who suffer long-term illnesses and disabilities related to an unwanted pregnancy or recent childbirth (Commonwealth Secretariat written evidence). Illnesses related to pregnancy and childbirth are frequent, under-reported, often devastating to the woman and a serious economic drain on families and society. They leave many women abandoned, ostracised and alone.

This report brings together expert testimony on the often overlooked subject of maternal morbidity. It attempts to define it, quantify it (estimates vary from source to source, as will be noted in the report), and goes into detail on some of the many problems women suffer connected with pregnancy and childbirth. The report discusses some of the structural reasons for these problems, offers solutions and concludes with the Group's recommendations for improving women's reproductive health.

It is important to note that it was not until the late 1930s with the introduction of antibiotics, safe blood transfusions for haemorrhage and improved surgical techniques for caesarean section, that the women of the UK saw an improvement in survival and morbidity. Mothers of today's grannies were dying of puerperal fever and suffering the long-term effects of pregnancy and childbirth, including obstetric fistula and uterine prolapses. Instruments such as hooks and primitive forceps were being used to drag babies out of exhausted mothers who suffered devastating consequences. Women in other European countries, including Sweden, saw improvements a bit earlier around 1900 with the number of births attended by 'professional' midwives increasing, coupled with strong political will to tackle the problem (Refs 2, 3 and 4).

Improving women's health usually requires an integrated approach. Political will, education, healthcare systems and medical advances, have transformed lives and enabled women to contribute equally and fully to the family and economy, which benefits the whole nation. It is our duty to help women throughout the world to do the same and the Group hopes, that this report will be a catalyst for political commitment and improvements in women's reproductive health world-wide.

Section 2

Maternal Morbidity

Definition

There is no universally agreed definition for maternal morbidity, although the World Health Organization (WHO) is working on producing one.

A few working definitions are included here:

- Morbidity in a woman who has been pregnant (regardless of the site or duration of the pregnancy) from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (Ref 5);
- Any departure, subjective or objective, from a state of physiological or psychological well-being during pregnancy, childbirth and the post-partum period (WCF written evidence); and
- Maternal morbidity is defined as morbidities that occur during pregnancy or childbirth or within 42 days after giving birth. They can be acute, or chronic, lasting for months or even years. Many of these are conditions that may cause difficulty in pregnancy, and aggravate existing morbidities, which can lead to more severe consequences for women (AMREF written evidence).

As the international community has no agreed definition, it is not surprising that there are very little and varying data on maternal morbidity.

Below are a few of the reasons why maternal morbidity is difficult to measure:

- Some morbidities are recognised or acknowledged as an illness and others not, some are discomforting while others are seriously disabling;
- It can be acute or chronic;
- Perceptions of illness vary between cultures;
- Surveys cannot always capture it, as medical diagnosis is often required; and
- Women are often shy to speak of such personal matters, so it is not reported.

Global Burden

As there are few data illustrating the size of the problem, we use estimates which show that for every woman that dies, there are at least 20 more women who suffer from injuries, infection and disabilities relating to pregnancy and birth (Maternity Worldwide written evidence). When estimating the global burden of maternal morbidity, most researchers focus on severe, acute maternal morbidity and estimates range from 0.8 to 8.2 per cent of pregnant women who experience them (UNFPA written evidence).

Maternal morbidity consists of a grim series of complications, most of which can easily be prevented or treated, including:

Obstetric fistula, perineal damage, prolapsed uterus, stress incontinence, puerperal infection and sepsis, haemorrhage, hypertensive disorder (pre-eclampsia) and fits, anaemia, infertility and ectopic pregnancy, depression and suicide.

“Pregnancy poses profound risks for women: one woman dies every minute from causes related to pregnancy and childbirth. Men between the ages of 15 and 44 face no single threat to their health and lives that is comparable to maternal death and disability” (CRR written evidence).

Estimates of Maternal Morbidity

- Of the 120 million women who give birth every year, half experience a complication and 20 million develop disabilities.
- 18 million unsafe abortions occur every year in less developed countries.
- 2 million women suffer from obstetric fistula, mostly in Africa and the Indian subcontinent.

Source: Impact written evidence

Section 3

Some Maternal Health Problems (by condition)

There are many maternal health problems that can affect a woman without adequate care and she is likely, in fact, to suffer several of these at a given time and over her lifetime. Here follows a brief overview of some of the major causes of maternal morbidity.





Obstetric Fistula



Definition: Fistula is a direct complication of prolonged obstructed labour when women and particularly young girls are not monitored in labour by a skilled birth attendant. A hole develops in the wall between a woman's vagina and her bladder or rectum, or both, leading to incontinence and other complications. Traumatic fistula is the result of violent rape.

Seriousness of the problem: Fistula leads to incontinence and other complications such as nerve damage and infection. As the woman is often leaking urine and faeces, she may be ostracised by her community and family and forced to live in isolation. In the case of traumatic fistula, the situation is worse because of the stigma of rape. In addition, women with fistula can develop other complications including prolapsed uterus, infertility, infection, kidney disease and spontaneous abortion. Obstetric fistula is not seen in countries with good maternal care. Finally in countries where Female Genital Mutilation (FGM) is practised, fistula can be even more severe as FGM can further confound the problem.

Traumatic fistula: Traumatic fistula is an abnormal opening between the reproductive tract of a woman or girl caused by sexual violence. These nearly always happen in conflict or post-conflict settings. Trauma like this is caused by violent rape or the forced insertion of foreign objects (such as guns) into the vagina. The combination of rape and incontinence sadly mean that many of these women are ostracised by their families and communities (Columbia University written evidence). While traumatic fistula is not a true maternal morbidity, unless it happens during pregnancy, the consequent difficulties for the woman's reproductive and maternal health will be the same.

Incidence: At least 2 million women around the world suffer from fistula with between 50,000 and 100,000 new cases emerging each year (Ref 6). Young girls are at particular risk of developing fistulas, as their bodies are not fully developed and the foetal head cannot pass through their small pelvis’.

Case Study:

“Achuwache was married at 15 and soon afterwards had a difficult pregnancy and prolonged labour. The long labour caused a fistula — a hole between the vagina and the bladder, which caused incontinence. “After twelve days labour, I went to the health centre. They couldn’t do anything. They said take her to Gonder (six hours away) and that was it. So they took me back home. They thought they were taking my corpse home but when it is not your time, it is not your time. I survived and had the baby at home. It was dead. Then I had this problem. I got damaged. As far as my family was concerned, I didn’t exist, but here I am, alive. My husband divorced me straight away before the year was out. People only like you when you’re healthy.” It was six years before Achuwache heard that her problem could be cured and underwent a successful operation to repair her fistula” (SafeHands written evidence).

Prevention: Preventing child marriages and teenage pregnancies will reduce the incidence of fistula. As will sufficient skilled birth attendance, available 24 hours a day, trained to interpret a partogram and refer women to Emergency Obstetric Care (EmOC) for interventions, including a caesarean section (the partogram is a chart where the wellbeing of the mother and foetus and the progress of labour is recorded). A solution to the problem of inadequate health staff is also to train more to provide EmOC services, including mid-level providers. Furthermore, surgical intervention to treat fistula is nearly always successful in less serious cases and 60 per cent successful in more serious cases – with a cost of about £160 per woman (Columbia University written evidence). Unfortunately, this is prohibitively expensive for most women and health systems.

“There is huge stigma attached to fistula and women are often divorced by their husbands and completely rejected by their communities. It is not a problem that can be hidden -- because of the smell” (WRA written evidence).

Prolapsed Uterus



Definition: Weakening of or damage to a woman's pelvic musculature to the extent that it can no longer support the uterus. It is sometimes referred to as 'fallen womb'.

Seriousness of the problem: In first degree prolapse, the cervix descends into the vaginal opening; in the second degree, the cervix descends into the vulva; in third degree prolapse, the cervix and often the uterus descends beyond the vulva and often outside the body entirely. Internal tissues, when outside the body, can become dry and cracked leading eventually to infection. Women with prolapses are in considerable discomfort and pain. They may have urinary problems including stress incontinence and even simple daily activities like sitting, standing, walking, and lifting become impossible. In addition, uterine prolapse can have negative consequences for a woman's family, social life, ability to work and her dignity. She can also suffer stigma and discrimination as a severe prolapse is almost impossible to hide.

Incidence: Two to 20 per cent of women of reproductive age suffer from prolapsed uterus (Columbia University written evidence). Urinary stress incontinence is not only common with prolapsed uterus but common following any childbirth, with or without complications. In many societies stress incontinence is perceived as an inevitable consequence of motherhood, including in the developed world, where it is estimated that half of pregnant women suffer from it and one in three women suffer from it post delivery (Ref 7).

Case Study:

“In Himachel Pradesh, India, there was a woman who had taken two days to get to a clinic. She had a breech baby and an obstructed labour, with the legs emerging first. The Traditional Birth Attendant had pulled the uterus out and chopped off the baby’s limbs. The prolapsed uterus with the baby’s head still stuck in had to be put back inside the woman for the doctor to do a dilatation and curettage” (WRA written evidence).

Reports from the field:

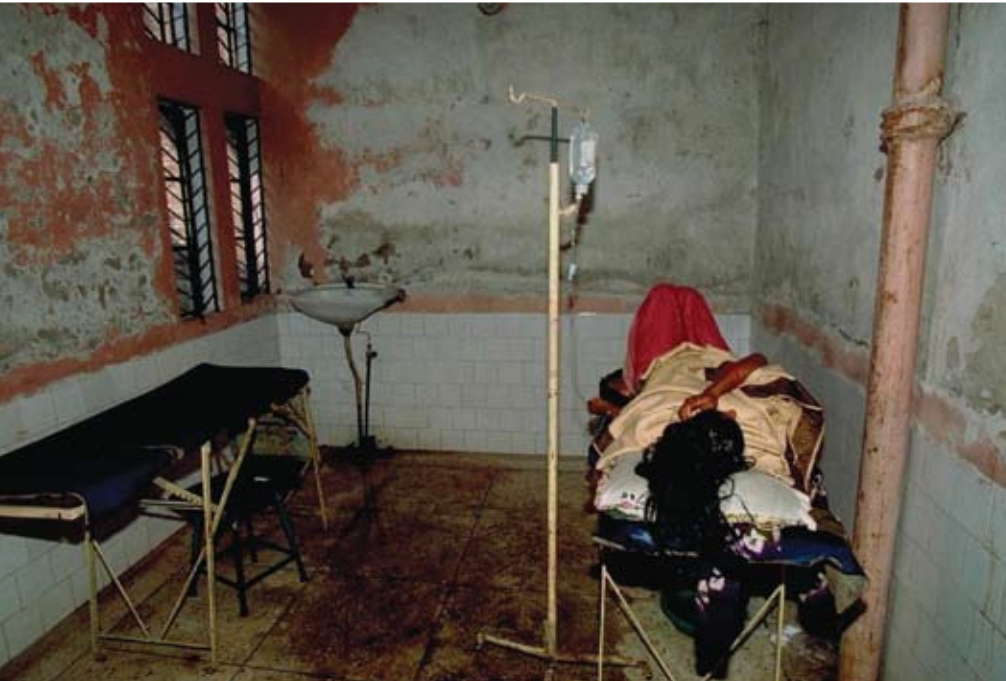
“As many as 600,000 to one million women in Nepal suffer from a prolapsed uterus; recent studies have shown that the prevalence of prolapsed uterus ranges from 10 to 40 per cent” (Columbia University written evidence).

“Heavy work during and immediately after pregnancy are major risk factors. Women are able to push their uterus back inside themselves when they are lying down, so their husbands continue to have sex with them and they continue to have babies. When they are pregnant, the uterus expands so that it doesn’t prolapse. When they are not pregnant, they put things like rocks inside themselves to try to stop the prolapse” (WRA written evidence).

Prevention: Informing and empowering women to use family planning, will avoid pregnancies too early, too often and too close together, which increase the chances of a prolapsed uterus. Discontinuing obstetric malpractice, including applying abdominal pressure during labour, and discouraging heavy and strenuous work soon after childbirth are equally important. Health systems must be strengthened with registered health workers who have codes of practice, standards, protocols and guidelines to guarantee quality of care and prevent malpractice. Severe cases of prolapse can only be treated by surgery at a cost of approximately £110, a sum well beyond the means of poor women (Columbia University written evidence). Pelvic floor exercises during pregnancy and post delivery can minimise urinary stress incontinence. Surgery for urinary stress incontinence may relieve the symptoms for some women.

“Women in Nepal have to carry heavy loads — soon after labour — and they also live and work in smoky kitchens where the chronic coughing makes things worse. This is often thought of as a problem of older women, but we have found women as young as 16 and 17, just married, with prolapse. And they can never tell anyone about it; the shame and embarrassment is too much”
(WRA written evidence).

Unsafe Abortion



Definition: An abortion is unsafe when it is carried out either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both, and can lead to haemorrhage, infection, or poisoning from substances used to induce abortion (Ref 8).

Seriousness of the problem: Complications from unsafe abortion account for the largest proportion of hospital admissions for gynaecological services in the world. Five million women each year are admitted to hospital for treatment of unsafe abortion complications, including trauma to the vagina, uterus and abdominal organs, reproductive tract infections, shock, and infertility (Guttmacher Institute written evidence). This means that roughly one in four women who undergo unsafe abortion are admitted to hospital. Access to safe abortion is inequitable and poverty seems to play a large role in women's access to safe abortion care. Virtually all unsafe abortions in 2003 occurred in developing countries (Guttmacher Institute written evidence). Finally, WHO estimate that about 24 million women are currently infertile because of an unsafe abortion (Ipas written evidence).

Direct costs of treating unsafe abortion complications burden health care systems, and indirect costs also drain struggling economies.

Incidence: There are 18-20 million abortions carried out illegally per year and almost 60 per cent of all unsafe abortions in Africa are among young women under the age of 25. Over 68,000 women die from complications of unsafe abortion each year (Ref 9).

Case Study:

“I will never forget one night when one of my friends came. She was haemorrhaging and it wouldn’t stop. I told her that we would go to the hospital, but she didn’t want to because they would give us trouble. She kept fainting and I took her to the hospital. When we got there the doctors treated us very badly. They didn’t take care of her even though they knew she was dying” (MSI written evidence).

Report from the field:

“We have conducted 800 face to face investigations of maternal mortality in Orissa state, [India] this year. We have found that unsafe abortion by village quacks leads to infection and future complications for many women. The local practice is to take very hard, sharp sticks from trees in the forest and soak them in a toxic ‘milk’ – gathered from leaves – for 48 hours. These are inserted into the woman through the birth canal. I talked to a gynaecologist who told me that he treated one woman who had ten of these sticks inside her. She was in her 7th month of pregnancy and the sticks were poking into the head and body of the foetus” (WRA written evidence).

Prevention: Improve sex and relationships education and provide family planning for women, men and young people, including for women post-abortion and post delivery. Improve access to emergency contraception and menstrual regulation and make safe abortion available through legislation and by training providers about safe abortion practice and ensuring the availability of appropriate equipment and supplies (e.g. manual vacuum aspiration or medical abortion drugs including mifepristone and misoprostol). The availability of misoprostol seems to be reducing the incidence and severity of unsafe abortion complications in Latin America (Ipas written evidence). It is also worth noting that abortion is safer when performed earlier in pregnancy and that carrying a pregnancy to term carries greater health risks to a woman than having a safe abortion, early in pregnancy.

“Worldwide, the women most at risk of suffering serious complications or dying from unsafe abortion share several characteristics: they overwhelmingly live in countries with restrictive abortion laws, they are poor, they reside in rural areas, and they are young” (Ipas written evidence).

“Women have abortions just as frequently where abortion is legally restricted as where it is broadly permitted by law, but the health consequences are vastly different” (Ipas written evidence).

Haemorrhage



Definition: Primary post partum haemorrhage (PPH) is loss of blood estimated to be 500ml or more, from the genital tract, within 24 hours of delivery. This is the commonest obstetric haemorrhage. Secondary PPH is defined as abnormal bleeding from the genital tract, from 24 hours after delivery until 6 weeks post-partum (DfID written evidence).

Seriousness of the problem: PPH remains one of the most serious maternal health problems – causing up to one-third of all maternal deaths. 88 per cent of deaths happen within four hours of delivery, so skilled birth attendance and timely transfer to emergency obstetric care is paramount. Symptoms of haemorrhage include dizziness, tiredness, breathlessness, shock and even heart failure. Many women are unable to stand up or care for their newborn child because of it. Anaemia before haemorrhage exacerbates the problem and increases the risk of death from PPH.

Incidence: 150,000 women die annually from PPH (DfID written evidence).

Case studies:

“An Indonesian woman needed a blood transfusion when she was admitted to hospital with a retained placenta and haemorrhage. The hospital had no blood supplies. The woman’s father travelled to another hospital to obtain blood. More delay was experienced when he found out he had to pay for the blood. He managed to return to his daughter’s hospital with the blood after eight hours. By this time, his daughter had become so weak that blood could not be given and she passed away with the placenta undelivered” (Immpact written evidence).

”I didn’t think I would survive. Since there was no more blood my whole body hurt, I was very nauseated, and to add to this, when they came to examine me, they didn’t even say they were going to prescribe something. They only told me to wait, and they talked amongst each other and since I don’t understand French, those who came to see me looked at me like that and said, ‘there is no blood’. They looked at my whole body and they walked past and they didn’t say anything...and that’s what made me feel despair!” (LSHTM written evidence).

Prevention: All women should give birth with a skilled birth attendant who knows how to prevent post partum haemorrhage and conduct an active management of the third stage of labour with oxytocin and other drugs to minimise bleeding. Low cost misoprostol should also be made available to Traditional Birth Attendants (TBAs) and mid-level health workers in a wide range of health facilities and especially in the community to control bleeding.

“Low-cost, evidence-based interventions to reduce the incidence of PPH exist, are being implemented in numerous countries, and must be taken to scale globally”
(Jhpiego written evidence).

Infections (including STIs and HIV/AIDS)



Definition: Infection is the invasion by microorganisms, which can produce tissue injury and progress to disease. Infections include a broad range of problems from urinary tract infections to Sexually Transmitted Infections (STIs) such as chlamydia, syphilis, gonorrhoea, genital herpes, HIV and AIDS to puerperal sepsis. Puerperal sepsis is any bacterial infection of the genital tract, which occurs after the birth of a baby. Symptoms usually include fever, abdominal pain, bleeding and discharge.

Seriousness of the problem: If the infection does not kill the mother, sepsis can cause long-term health problems such as discomfort, scarring, pelvic inflammatory disease and infertility. Pregnancy alone increases a woman's risk of a urinary tract infection. Births and abortions with unskilled providers using unhygienic, improper procedures and non-sterile equipment can cause infections. There is a lack of awareness of STIs in many developing countries and the vast majority of infections go undetected, which can lead to infertility, ectopic pregnancies, chronic illness and death. Pregnant HIV positive women may actually see the progression of the disease worsen during their pregnancies, although research is ongoing on this.

Incidence: 15 per cent of maternal deaths are the result of infections. It is estimated that annually about two million women with syphilis become pregnant in sub-Saharan Africa. Approximately 15 per cent of the babies born to women in a study in Bolivia had congenital syphilis (WHO written evidence). Syphilis can cause insanity and death in the adult and congenital syphilis in the newborn, with blindness, deafness and brain damage.

Case study:

“Djeneba is from the village of Sanankoroba in Mali. She has been married for four years and is the third wife of Batary Diakite. His other wives between them have 17 children, but Djeneba has none. At first Batary thought she was a bad wife because she didn’t want to have sex. Then he realised that she felt great pain during intercourse and he took her to a doctor. She was diagnosed with blocked fallopian tubes, following chronic and untreated infection. She had suffered excision (FGM) as a girl, which may have caused the onset of the infection. “I am very sorry for her,” said Batary. “When my other wives play with their children, she goes inside the house to cry. I can’t afford treatment for her. Just one baby would make her happy, but it’s unlikely to happen” (WRA written evidence).

Prevention: Prevention of infection in the first place is important. Women must be offered ante-natal urine, STI and HIV/AIDS screening and treatment. Testing for syphilis no longer requires a laboratory test, but the new diagnostic tests, while easy and accurate, are expensive and not always available. Pregnant women must not be deterred from voluntary counselling and testing, as prompt treatment of infections often has immediate positive consequences. Legislation that criminalises transmission of HIV is of great concern.

The prevention of mother to child HIV/AIDS transmission strategy includes: primary prevention of HIV (stopping women from becoming HIV positive in the first place); prevention of unintended pregnancies among women living with HIV; prevention of vertical transmission through safe delivery, antiretroviral drugs and safer infant feeding; and treatment, care and support for women living with HIV and their families (Ref 10).

Women with HIV have the same reproductive rights as all women, including a satisfying and safe sex life, the capacity to have children and, freedom to decide if, when and how often to do so (ICW written evidence).

Medical interventions in labour and at delivery must be minimised and sterile equipment used for invasive procedures. Women must also be followed up post-natally and advised to seek care if infection and fever occur. If an infection is detected it is easily treated with antibiotics. Antibiotics played a major role in reducing maternal death in the developed world in the 1930s with a 40 per cent decline in maternal mortality (Advocacy International written evidence). Ensuring that the correct antibiotics are available and affordable when they are needed in developing countries is crucial.

“A retained placenta—or part of it—is a foreign body and is a killer. It can cause not only bleeding but toxæmia of the blood” (WRA written evidence).

Pre-eclampsia and Eclampsia



Definition: Pre-eclampsia (pregnancy-induced hypertensive disorder) with a set of symptoms including high blood pressure, protein in the urine, swelling, visual disturbances, headaches and abdominal pain can lead to convulsions (eclampsia), which in turn can lead to liver damage, kidney failure and death of both mother and baby. The causes are not well understood.

Seriousness of the problem: Eclampsia can be life threatening for both mother and baby. It often means a lack of productivity, pre-term delivery and a pre-term and low-birth weight baby at high cost to the family. There may be little warning when a woman develops eclampsia and the problem can become very serious, quickly, during pregnancy, delivery or after birth.

Incidence: 63,000 maternal deaths in the world every year are the result of pre-eclampsia, totalling 12 per cent of all maternal deaths (RCM written evidence). There are little data on the incidence of morbidity caused by pre-eclampsia.

Case studies:

“An unmarried woman from Burkina Faso who developed eclampsia during her first delivery explained how the money to pay for her care was obtained: My father asked for part of it at the mosque, and my mother also asked for some and then we added our 5,000 F (saving)...We haven't reimbursed them... my mother got 1000 F from one person and 1000 for another, 1500 from yet another. We had a bit of maize that we sold. I had three cloths and I sold these and added it all and had 15,000 F which we went to give to the hospital” (Immpact written evidence).

“Salimata's first pregnancy had gone well, but the baby had died in infancy, after which her first husband left her. A few years later, she considered herself lucky to be betrothed to Yacouba, a farmer. The wedding was postponed when Salimata fell pregnant. When she developed fever and started vomiting in the eight month of her pregnancy, Yacouba took her on a bicycle to the nearby health centre. By the time they arrived she had started convulsing, a symptom of eclampsia. She responded to treatment and survived. Her baby was stillborn. Yacouba was helped by people in the village to meet the cost of care, although he was also forced to borrow money and sell one of his farm animals. He was extremely grateful that Salimata had survived, but worried about the future as Salimata continued to need medication for high blood pressure” (LSHTM written evidence).

Prevention: Blood pressure must be monitored during pregnancy, in labour and post-natally and professional health workers must refer women to a health centre or hospital for care, treatment and possible delivery if symptomatic. Life saving drugs must be available for the management of pre-eclampsia, especially magnesium sulphate, which is cheaper than table salt. The effect of magnesium sulphate in the prevention of eclampsia is unclear but probably multi-factorial. Lack of commercial interest may be one of the reasons that magnesium sulphate, whilst cheap, is only available on half of countries' essential drugs lists.

“The Eclampsia Trial Collaborative Group in 1995 produced compelling evidence for the use of magnesium sulphate (MgSo₄) in management of eclampsia and it has been used both in the UK and USA for decades. In spite of the evidence and its low cost, few countries have included magnesium sulphate on their essential drug lists or provided the training necessary for its proper use. As a result, magnesium sulphate is under-used and more lives could be saved and related morbidity reduced” (DfID written evidence).

Anaemia – Malnutrition (also Malaria)



Definition: Anaemia is a condition that occurs when there is a reduced number of red blood cells or concentration of haemoglobin. The most common form is iron-deficiency anaemia, where the body lacks enough iron to keep the red blood cells functioning properly. Malaria also causes anaemia and is activated by parasites transmitted through the bite of an infected mosquito. In one of life's great injustices, pregnancy reduces a woman's immunity to malaria—making her more likely to become infected and anaemic. Malnutrition develops when the body lacks the vitamins, minerals, and other nutrients it needs to maintain healthy tissues and organ function.

Seriousness of the problem: Anaemic women suffer from chronic fatigue and are more likely to die if they haemorrhage and have a higher risk of delivering prematurely, having a low birth-weight baby or bearing a stillborn baby. Anaemic women also have an increased risk of puerperal infection.

Incidence: World-wide, 42 per cent of pregnant women are anaemic (Ref 11). It disproportionately affects women living in the developing world. Malaria, malnutrition and worms are three of the factors that contribute to this high prevalence. Anaemia increases the risk of death from haemorrhage and causes over 13 per cent of maternal death in Asia and four per cent in Africa (DfID written evidence). In sub-Saharan Africa, malaria is estimated to cause up to 400,000 cases of severe maternal anaemia and an estimated 10,000 deaths per year (Malaria Consortium written evidence). Serious maternal under-nutrition is common in sub-Saharan Africa, South Asia and South-East Asia and is critical in Bangladesh, Eritrea and India (UNICEF written evidence).

Case studies:

“Amena, aged 26, was pregnant at 30 weeks with her fourth baby. She had no knowledge of good nutrition in pregnancy, and her babies had been born closely together. She had never seen a health professional or received ante-natal care before as her husband and mother-in-law told her she should give birth at home with the local attendant. But when Amena began to feel dizzy and weak, with blurred vision, headaches and restlessness, they agreed she could go to the health clinic. Tests found that she was very anaemic, with a haemoglobin level of 6 (about half of what it should be for a healthy pregnancy). Amena was told of the risks to her own life, and also that her baby could suffer low birth weight as a result of anaemia. The clinic gave her iron tablets and advised a blood transfusion, but it will be difficult for Amena’s family to buy the blood and/or pay for the transfusion” (WRA written evidence).

“In Bangladesh, while a woman is in labour, doctors routinely keep a donor (usually a family member) nearby and ready to give blood as an estimated half of women are anaemic. The implications of anaemia for women are huge in Bangladesh. Women suffer from chronic weakness and don’t have the energy to give birth—often leading to prolonged labour, which (without skilled care) can be fatal. Anaemia is dangerous for the baby too as a cause of low birth weight and prematurity” (WRA written evidence).

Prevention: Improving the diets of young girls and women, giving supplements of iron and folic acid and some vitamins and de-worming are all ways that anaemic and malnourished women and mothers can be strengthened. Increased treatment of malaria during pregnancy is very important and the WHO found that in 18 African countries, only 27 per cent of pregnant women slept under an insecticide treated net. Studies have shown that women who sleep under insecticide-treated nets for their first four pregnancies give birth to 25 per cent fewer underweight or premature infants (Malaria consortium written evidence). An additional treatment involves intermittent preventive treatment in the form of two doses of long-acting anti-malarial drugs given to women during ante-natal care.

“If you are not anaemic, you can bleed for two hours and survive. If you are anaemic, you will die after one hour” (WRA written evidence).

Mental Health Disorders



Definition: Mental health disorders before, during and after birth take many forms and there is a lack of consensus about how to define them.

Current thinking would categorise them into the following four areas:

- baby blues • moderate to severe depression
- anxiety disorders • post-natal psychosis.

Women across many cultures experience transient periods of low mood during pregnancy or after a baby's birth including feelings of loneliness, increased anxiety and unhappiness. Most women find these feelings are fleeting, but for a small minority, the problems are much more serious and may amount to a clinically diagnosable mental disorder (National Childbirth Trust written evidence).

Seriousness of the problem: Many women who develop depression are coping with many other complications in their lives such as poverty, a lack of social support, abusive partners, or bereavement. Even in the UK where maternal deaths are infrequent, 17 per cent of all maternal deaths are due to psychiatric causes. Women with a history of mental illness are more likely to suffer serious post-natal mental illness than other women. In addition, other maternal morbidities can, not surprisingly, have a negative effect on mental health.

The mental health of new mothers can adversely affect their ability to breast-feed and children of depressed mothers are more likely to suffer from stunting (UNICEF written evidence). Currently, little understanding of the problem or support is available and research shows that as few as five per cent of women in the developing world with mental health disorders, arising from pregnancy, receive any support (RCM written evidence).

Incidence: There are very little data on mental health disorders in the developing world. However some research suggests the problem is as prevalent in the developing world as in the developed world. The prevalence of peri-natal depression is 20 to 30 per cent in developing countries and suicide is a leading cause of pregnancy-related death (UNFPA written evidence).

Case study:

“Bindu, aged 18 from Nepal was married against her will to an older man who promised her middle class family that he would support her further education. But her new husband and in-laws physically and verbally abused and tormented her, demanding money from her parents’ family. After three months of marriage she became pregnant, and when her parents did not give money to her husband, Bindu was kept in isolation, treated as a slave and deprived of food throughout her pregnancy. After her baby was born, she started to show signs of mental instability. When her mother came to know about her situation, Bindu was immediately brought to a hospital in Kathmandu. Now, she is improving with psychiatric treatment, but is violent towards her own and her husband’s family and is extremely anxious about the wellbeing of her baby daughter” (WRA written evidence).

Prevention: Research has identified critical risk factors such as partner and social support, the experience of motherhood and infant temperament (UNICEF written evidence). WHO is currently developing guidance notes on the integration of mental health and psycho-social support in Sexual and Reproductive Health and Rights (SRHR) programmes. Post-natal depression can be detected using a short screening questionnaire and antidepressants and psychological treatment can be effective. A study in Pakistan saw good results from a cognitive behaviour intervention (LSHTM written evidence). The United States Agency for International Development (USAID) is currently supporting a study in Bangladesh, which may shed some light on the problem and some cost-effective interventions (USAID written evidence).

“In Bangladesh, post-natal depression is really ignored. You are supposed to be happy to give birth and start working the next day” (WRA written evidence).

“Above all, the new evidence we have reviewed emphatically shows that maternal mental health is a critical, and previously ignored, factor in the association between social adversity and infant failure to thrive in low income countries” (LSHTM written evidence).

Section 4

Structural Problems in Maternal Health

A strong health system with adequate and appropriately trained health workers, accessible and affordable to all, will bring maternal morbidity and mortality in the developing world to the low levels found in the developed world. This involves managing the inequities found in the health system (being able to provide services for free so that even the poorest can afford them) and having the political will with funding to deal with these seemingly intractable problems. Among the many structural problems in maternal health, the lack of health workers and drugs and supplies, economic inequity, remote populations, the low status of women and a lack of political will and ideologically driven policies are briefly touched on here.

Lack of political will

There is a critical lack of political will, essential to tackling any of the structural, financial and legislative issues to do with maternal morbidity and mortality and this is reflected strongly in this report's recommendations. Governments must take seriously their responsibility to decrease morbidity from maternal related causes, including unsafe abortion. Non-evidence based policies and ideologically driven policies and programmes cause harm to existing and developing health systems. The Catholic Church's anti condom, emergency contraception and safe abortion agenda is to the detriment of women's health. As the Group highlighted in the 2004 'Missing Link' Hearing Report, there is a need for integrated SRHR, HIV and other health related policies and services (Ref 12). Several donor governments are showing leadership in this area and there are governments in the developing world that are prioritising health system strengthening including for maternal and sexual and reproductive health, but progress has been slow since the first Safe Motherhood Conference in Nairobi in 1987. Women, children and their families cannot wait.

“DFID recognises that the need for greater political will and resource mobilisation by both national governments and donor partners has never been greater”
(DfID written evidence).

“The percentage of domestic resources allocated to health generally and to reproductive health in particular is the best testimony of political will”
(UNFPA written evidence).

Lack of health workers, particularly midwives

Skilled birth attendance and emergency obstetric care cannot be delivered without adequate numbers of staff. These staff also have to be distributed properly and be appropriately trained, posted, and retained (Columbia University written evidence). In many developing countries, there is a real shortage of trained healthcare providers. In addition, it is easier to maintain health workers in urban areas than in rural ones, leaving much of the population with inadequate maternal health care. In some countries, the requirements for entry to midwifery training are too high, making it a barrier for suitable people to access training. Often women who train then migrate for better salaries to the cities or abroad. Recruiting from local areas has brought about some changes in health workers returning to serve their communities.

Lack of drugs and unreliable supplies

Family planning and drugs – especially misoprostol, iron and folic acid, magnesium sulphate, and various antibiotics – are cheap and many have long shelf lives. But providers' lack of knowledge, out-of-date clinical guidelines and protocols, and poor drug supply systems, mean that these drugs are often not available, particularly in rural areas. Furthermore, some countries do not have these drugs on their essential drugs list and many clinics lack supplies. The stakes are high and a strong case exists for improving supplies. There is no lack of potential demand, as the Group highlighted in the 2007 "Return of the Population Growth Factor: Its impact upon the MDGs" Hearing Report (Ref 13).

Economic inequity

Maternal morbidity causes poor families to become poorer (Immpact written evidence). Catastrophic payments for maternal health care and treatment are so high that they take up a large share of household income. The consequences for the poorest groups are particularly devastating, often plunging families into debt, from which it is difficult to recover. In Nepal, one in eight incurred extremely high health expenditures, estimated to increase poverty by 25 per cent among those seeking care (LSHTM written evidence).

"In Burkina Faso, delivery costs are estimated to constitute 43 per cent of the per capita income in the poorest households and as much as 138 per cent for a caesarean section" (Immpact written evidence).

Difficult groups to reach

Women often give birth at home, and are far from primary health care facilities, particularly if they live in rural areas. Ideally health facilities should be near women's homes, have skilled attendance, and be open 24 hours a day. In practice, this is rarely the case as developing country health systems need further strengthening. As a result, women are often in life-threatening situations with only their immediate family (and perhaps a traditional birth attendant) to make crucial life-saving judgements. Once the decision is made to take a woman to a health facility, the transportation to safely get her there is a further problem. Transport for a woman in labour is often expensive or simply unavailable or too late (see box on Three Delays to Safe Delivery Model). Reaching young people with sex and relationships education and family planning to prevent unwanted pregnancies is also a challenge in most communities.

Three Delays to Safe Delivery Model

Delay 1: Determining that the woman in childbirth needs urgent medical attention

Delay 2: Transport to medical facility

Delay 3: The woman receiving adequate medical attention when she arrives at healthcare facility

Source: Maternity Worldwide written evidence

Low status of women

Underlying the low levels of priority given to maternal morbidity, is a failure to assure women's status and rights. Women's lack of power, poor access to information and care, restricted mobility, low political priority, heavy physical workloads and early marriage are part of a package of neglect that pervades all levels of society. In many settings, this means challenging the cultural and political norms, as well as the legal frameworks that limit women's ability to make informed choices and take control of their reproductive lives (AMREF written evidence).

*“This lack of information is compounded by the stigma and shame surrounding such issues as unsafe abortion, fistula, uterine prolapse, and STIs; women simply can’t and don’t talk openly about these things – if at all”
(WRA written evidence).*



Section 5

Why Invest in Maternal Health?

Maternal health is inextricably linked to development, poverty reduction, rights and social inclusiveness. Investing in maternal health has wide social, and general health benefits and we know what to do.

It makes economic sense. Avoiding a problem that will cost a health system considerable money to treat, makes good economic sense. Many hospitals, for example, devote a large share of their gynaecological beds to care for women presenting with incomplete abortions (probably performed by illegal providers). A safe abortion means that the woman is unlikely to present at hospital. A study in Mexico found that the cost of providing a safe abortion was in the range of \$50 to \$100 while treating a woman with complications of abortion ranged from \$600 to \$2,100 (Bixby written evidence). Another study across several Latin American countries estimated the cost to the state of preventing one unwanted pregnancy through contraception at \$133 but also estimated the savings from services prevented at \$1600 (MSI written evidence). It is estimated that an investment of approximately £500,000 on family planning would avert 26,338 unwanted pregnancies, prevent 14,789 induced abortions and prevent 30 maternal and 380 infant deaths (DfID written evidence).

USAID has said that maternal and newborn mortality accounts for \$15 billion per year in lost productivity across the world. Furthermore the World Bank has shown that for every dollar Thailand invested in HIV/AIDS prevention, they saved \$43 worth of treatment costs in the subsequent decade (ADB oral evidence).

Prevention and cost effective interventions should be particularly high on the agenda with the global financial downturn, as international and national funding is likely to fall and at household level, less money will be available, including for health.

If unmet need for family planning were met world-wide, the following could have been avoided:

- 52 million unintended pregnancies (one-fourth of all pregnancies);
- 23 million unintended births (72 per cent of all unintended births);
- 22 million induced abortions (64 per cent of all induced abortions);
- 7 million spontaneous abortions;
- 1.4 million infant deaths; and
- 142,000 maternal deaths (53,000 from unsafe abortion and 89,000 from other causes).

Source: UNFPA written evidence

Family Planning and Economic Growth – The Demographic Window

There is solid evidence, based on two generations of experience and research, that there is a “population effect” on economic growth.

Developing countries with lower fertility and slower population growth have seen higher productivity, more savings and more productive investment. They have registered faster economic growth, investments in health (including reproductive health) and education, and reducing gender inequality, have contributed to this effect. These investments attack poverty directly by empowering individuals, especially women.

Given a real choice, poor people in developing countries have smaller families than their parents did. This downturn in fertility at the “micro” level translates within a generation into potential economic growth at the “macro” level, in the form of a large group of working-age people supporting relatively fewer older and younger dependants.

This demographic window opens only once. Several countries in East Asia and a few others have taken advantage of it.

Source: Ref 14

The medical benefits of Sexual and Reproductive Health interventions in*DALY's:

SRHR problems account for 18 per cent of the total burden of disease and 32 per cent of the burden among women of reproductive age (15-44). Women who suffer are less productive and maternal morbidity erodes precious human capital.

- Maternal conditions (haemorrhage or sepsis, obstructed labour, pre-eclampsia and eclampsia and unsafe abortion) account for two per cent of all DALYs* lost (13 per cent of all DALYs lost among reproductive-aged women);
- Peri-natal conditions (low birth weight, birth asphyxia and birth trauma) account for seven per cent of all DALYs lost;
- HIV/AIDS accounts for six per cent (14 per cent among women aged 15-44);
- Other SRH conditions account for three per cent (five per cent among reproductive-aged women).

**The medical benefits of health interventions are often expressed in Disability-Adjusted Life Years or DALYs, a measure developed by the Global Burden of Disease project and widely used to evaluate potential health interventions.*

Source: Ref 15

Inequity of maternal health. One-third of the burden of disease experienced by women globally is the result of reproductive ill-health. Maternal health is one of the starkest inequities between the developed and developing world (Columbia University written evidence). In the developing world as a whole, a woman has a one in 76 lifetime risk of maternal death, compared with a probability of just one in 8,000 for women in the developed world. By way of comparison, the lifetime risk of maternal death ranges from just one in 47,600 for a mother in Ireland, to one in every seven in Niger, the country with the highest lifetime risk of maternal death (Ref 16).

Human development. Good maternal health and gender equity are fundamental to human development. A healthy mother can nurture her children and give them a better start in life and she can play her part in maintaining a strong family that will be able to care for its members. The benefits of good maternal health cascade down through the generations (RCM written evidence). On the negative side, women may face long-term physical, psychological, social and economic consequences. The chronic ill-health of a mother puts surviving children, who depend on their mother for food, care and emotional support, at great risk.

Deaths and morbidities are preventable. The majority of maternal death and disability is easily preventable at a low cost (CRR written evidence). Investing in health systems and offering good quality care to women will save lives and prevent morbidities. The quality of care often influences the outcome of interventions and also the women's decision of whether or not to seek care. Often the quality of care provided in the community and in facilities is unacceptably poor and results in aggravation of complications, long-term morbidity and death (Immpact written evidence).

Women's rights to life and health. Because governments have the capacity to improve and save women's lives, their failure to do so, is an abdication of their duty to ensure women's enjoyment of the rights to life and health (CRR written evidence). "Health care is not only a service provided to individuals, but also a basic human right. As such, donors must support national governments in their progressive realisation of this right, which includes involving civil society organisations and ensuring that women have access to good quality pregnancy-related care" (Columbia University written evidence). FGM and other sexual violence must be outlawed to improve women's health, with attention to effective implementation, as the Group highlighted in the 2000 Hearing Report on FGM (Ref 17). FGM is illegal in many countries, however few prosecutions have taken place. In the UK there have been no FGM prosecutions to date, despite it being illegal for years.

Section 6

Maternal Health Solutions

It is 15 years since the International Conference on Population and Development (ICPD) in Cairo, where 179 countries agreed that SRHR and population and development are inextricably linked, but MDG5 on Maternal Health is still seeing the least progress of all the MDGs. Maternal morbidity and mortality can be effectively reduced with the provision of universal access to family planning and safe abortion services, appropriately trained and skilled attendance at birth, and affordable basic and comprehensive emergency obstetric care, with an enabling policy environment and political will.



Leadership and strengthening health systems

Strengthening health systems at all levels, is one of the most important things to do to improve maternal health and save lives. Equitable distribution of health workers and access to basic and emergency obstetric services is crucial. Upgrading facilities and ensuring they are accessible, affordable, appropriate and acceptable with trained staff, essential drugs, supplies and equipment is a long and arduous process, but there are no shortcuts.

Effective maternal health legislation and policies must be informed by evidence and be translated into action with sufficient funding and strong political will.

“Maternal mortality [and morbidity] data are a very sensitive surrogate for the overall status of healthcare systems since pregnant women survive where safe clean round-the-clock surgical facilities are staffed with well trained personnel and supplied with ample [equipment and supplies]. If new mothers thrive it means that the health care system is working... and the opposite is true. When doctors and nurses leave a health system, the first death marker to skyrocket is the number of women who die in childbirth” (ADB written evidence).

Basic Emergency Obstetric Care Centre should provide the following six services:

1. Antibiotics for infections
2. Anticonvulsants for pre-eclampsia/eclampsia
3. Oxytocins for post partum haemorrhage
4. Assisted vaginal delivery (vacuum extraction)
5. Manual removal of placenta
6. Removal of retained products of conception (MVA)

Comprehensive Emergency Obstetric Care Services should provide all the above six services along with the following 24-hour services throughout the year:

1. Availability of blood and blood transfusion facility
2. Facility for caesarean section for delivery of foetus in emergencies

Source: WCF written evidence

“A functioning and effective health system should be the foundation of all initiatives to prevent maternal morbidity and mortality” (Nuffield written evidence).

Using mid-level providers and TBAs

One solution to the problem of a shortage of health care workers is to train and broaden the duties of mid-level providers. Mid-level workers are health care providers who have received less training and have a more restricted scope of practice than professionals who, in contrast to community or lay health workers, do have a formal certificate and accreditation through their countries' licensing bodies. By expanding mid-level workers' capacity and authority to do more, services can be expanded further. This strategy has been very successful in Mozambique, Tanzania, and Malawi. In Mozambique, for example, surgical technicians perform more than half of the major obstetric operations in the country, with outcomes comparable to physicians. National governments and policy-making bodies, along with implementing organisations and donors, need to examine and change policies, allowing and supporting mid-level health providers to carry out life-saving skills. Interestingly, WHO has already published 'task shifting' guidelines for HIV/AIDS, which could be replicated for maternal health and general health workers (MSI written evidence).

TBAs are traditional, independent of the health system, non-formally trained, community based providers of care during pregnancy, child birth and the post-natal period. TBAs' knowledge and skills vary from country to country and community to community and their role in the provision of care is controversial in the maternal health community. When properly trained with life saving skills, TBAs can provide family planning, administer life saving drugs, including misoprostol for post partum haemorrhage and antibiotics for puerperal infections, and refer women to clinics for obstetric care. In many low income settings, this cadre might be all the maternal care available and it could, in some settings, improve maternal health.

“Maternal deaths and morbidity can be prevented. Health professionals know what to do to prevent women from dying, and the technologies involved are relatively simple” (DfID written evidence).

Ensuring essential drugs and supplies are available

A third of the world's population do not have access to essential medicines (Ref 18) and the largest generation of youth in human history has entered the reproductive age group. When it comes to reducing maternal morbidity and mortality, the global health community knows what to do, but few of the essential medical supplies listed below are available:

- Family planning services at every opportunity;
- Iron, anti-malarials and worm medication for pregnant women with anaemia;
- Oxytocins including misoprostol to prevent post partum haemorrhage, treat incomplete abortion, and perform therapeutic abortions;
- Antibiotics for infections;
- Antihypertensive and anticonvulsant drugs including magnesium sulphate to prevent and treat pre-eclampsia and eclampsia;
- Anaesthetics for minor and major operations including caesarean sections;
- Other vaccines and drugs for specific infections and diseases including drugs to prevent mother-to-child transmission of HIV/AIDS, allergies, blood disorders and diabetes;
- Equipment and supplies including blood pressure machine, suction cup, forceps, Manual Vacuum Aspiration (MVA) equipment and bloods.

All of these supplies are inexpensive and many of the drugs have long shelf lives, but government commitment needs to be secured to make these lifesaving commodities and supplies available to all populations, including the most vulnerable. In addition, guidelines and policies need to be set enabling these life saving medications to be administered safely by the widest possible healthcare staff.

Misoprostol use in Obstetrics and Gynaecology

Varying doses of misoprostol can be used to treat the following:

- Prevention of post partum haemorrhage
- Induction of labour with a live foetus
- Termination of pregnancy with intra uterine foetal death
- Missed abortion
- Therapeutic abortion
- Incomplete abortion

Source: Latin American Federation OB/GYN Societies

Avoid unwanted pregnancies

Current data show that 41 per cent of all pregnancies are unwanted and 22 per cent of total pregnancies will be terminated (RCOG written evidence). Ensuring that women have access to good family planning programmes, menstrual regulation and access to safe abortion as a back-up, is clearly an important and attainable strategy. In every legal context the health system could do more to prevent unintended and unwanted pregnancies and unsafe abortion. This would include:

- Increasing access to family planning, particularly a mix of modern contraceptives, emergency contraception and menstrual regulation;
- Promoting safer abortion techniques such as manual vacuum aspiration and medical abortion;
- Ensuring that health-care providers know how to perform safe abortions;
- Making sure that women know where to go to obtain safe care; and
- Ensuring that post-abortion care includes family planning counselling and services to break the cycle of unwanted pregnancies and abortion.

Source: Ipas written evidence

Community mobilisation and empowerment of women

Community mobilisation programmes carry out activities that aid communities to make sustained improvements to the health of individuals within them. Community mobilisation can make deep and lasting improvements to the health and well-being of community members through increasing their knowledge and enabling them to identify and address important health care needs. When problems occur during pregnancy, labour or the post-natal period, decisions on what to do, are often based on advice from family members, neighbours or traditional healers. In addition, the pregnant woman is often too shy to speak out because pregnancy is seen to be an unclean or shameful occurrence, and pain is thought to be normal, so she does not ask anyone for help.

In many developing countries, women do not see or have regular contact with other community members or health care professionals, nor do they have an opportunity to voice their opinions. Women's groups can provide opportunities to bring women together to discuss key issues affecting them, particularly during pregnancy and childbirth, and empower women and the wider community to improve health seeking behaviour. Women's groups are a key component for community mobilisation enabling women to develop their own knowledge of maternal and child health issues. There is now an increasing body of evidence on how to set up, encourage and inform these groups. They can then use their newly found knowledge to educate others and to challenge existing power structures. Therefore, it is not only the pregnant women that need to understand the best form of care but also the wider community (WCF written evidence).

The Declaration of Alma-Ata adopted in 1978 was the first international declaration underlining the importance of primary health care. The primary health care approach has since then been accepted as the key to achieving the goal of "Health for All": "The people have the right and duty to participate individually and collectively in the planning and implementation of their health care" (WCF written evidence).

"This is why civil society groups which speak about these issues are so important. They not only inform women about the reasons behind the secret health problems with which they are privately struggling, but they also provide solidarity to enable women to come out and share their experiences—often for the first time—and so to seek treatment if or where that is available" (WRA written evidence).

Mechanisms to protect households from social and economic consequences

Studies have found that many women suffer psychological distress, especially those women who did not give birth to a live infant. In many cases, these women felt responsible for how expensive their health care had been around delivery and they felt they could be blamed by their families for their worsened economic situation (Impact written evidence). It is very important that there are ways to protect these women, their families and communities from this devastating impact. Conditional cash transfer programmes, to increase the use of maternity services, are rising in popularity in some countries, particularly in South Asia. Women are 'paid', for example, to give birth in public health facilities. Ways to protect individual households from devastating economic consequences of out-of-pocket payments are built in the design of the programmes. These programmes are relatively new and are being monitored closely for indications of success. It is important that health care provider incentives are built into the design of the programmes.

The advantages of voucher schemes include:

- Vouchers can be targeted at specific groups.
- The infrastructure and capacity of private sector can be availed to the poor, offering a cost-effective alternative to building new public-sector facilities.
- Standards of care can increase.
- Women are empowered to choose their provider.
- Donor funding can increase service delivery – no payment for non-performance.

Source: MSI written evidence

Section 7

Country and Community Success Stories

From the evidence obtained and studies provided by expert witnesses the experience of developed as well as developing countries show that improving maternal health requires an integrated approach. The following countries were referenced as having successfully improved maternal health: Sri Lanka, Malaysia, Honduras, Egypt, China, Bolivia, Indonesia and Jamaica. Below, information is drawn from some of these countries and other community success stories.

Leadership and strengthening health systems

SRI LANKA AND MALAYSIA

Sri Lanka and Malaysia have both seen a significant improvement in maternal morbidity and mortality. Both countries are good examples of having a number of incentives in place, including leadership at the top levels, human resources aspects, and systems and procedures.

Malaysia progressed by improving reproductive health legislation and policies, expanding access to clinics including in rural areas, improving management and replacing TBAs with midwives with codes of practice and guidelines. Monitoring of births and deaths was also instigated and communities were mobilised to access the services as the quality of care improved and the workforce increased.

In Sri Lanka 30 per cent of the government's budget is spent on social welfare, education, health and poverty alleviation, despite challenging economic circumstances (Ref 19).

Both Sri Lanka and Malaysia now have a strong primary health care infrastructure, a good network of health facilities, skilled health workers and good family planning programmes, which demonstrates that with significant political will, improved maternal morbidity and mortality rates are achievable.

In both countries maternity services became free of charge.

HOW DID SRI LANKA SUCCEED IN IMPROVING MATERNAL HEALTH?

Sri Lanka reduced its maternal mortality quickly even with large numbers of rural poor. Three strategies which are interdependent made a difference in Sri Lanka to bringing down its maternal morbidity and mortality:

- 1) Establishing a solid foundation for effective maternity care (Local midwives backed up with solid referral services);
- 2) Increasing access to maternal care and targeting the rural poor (Removing the physical, social and financial barriers to care and fostering community mobilisation); and
- 3) Ensuring use of services because they are of high quality (Good supervision, accountability, organisational management, and responsiveness to public needs).

Source: ICOMP written evidence

Using mid-level providers and Traditional Birth Attendants

MOZAMBIQUE, TANZANIA & MALAWI

In countries where trained staff are not available or are poorly distributed, as was the case in Mozambique, Tanzania and Malawi, there has been success in using the strategy of training mid-level healthcare providers to provide a wider range of maternity services. In Mozambique, for example, surgical technicians now perform more than half of the obstetric surgeries in the whole country. In rural hospitals, they perform nearly all of the surgeries and have been found to have surgical outcomes comparable to physicians (Columbia University written evidence).

“Everyone who has been involved in fistula work in the developing world knows that once you provide an appropriate service, ideally free or at very low cost because they are poor women, patients come and they increase in number. They are the evaluators of how they are treated. Some of them give you a history of not being treated very kindly in hospitals when they were having their baby and various other things. In the 1970s consumer opinion and community health councils came in. We have got to get that also from the women of Africa because they can guide us so much and work with us, and some of them, of course, have become brilliant surgeons themselves with no education and we have them now trained as village midwives” (Dr Kelly’s oral evidence).

Avoid unwanted pregnancies and improve access to safe abortion

SOUTH AFRICA

Studies suggest that liberalising abortion laws can have an immediate impact in diminishing the incidence and impact of unsafe abortion. After South Africa made first trimester abortion available on broad grounds in 1994, the incidence of infection resulting from unsafe abortion decreased by 52 per cent and the maternal mortality rate declined by 91 per cent (Ipas written evidence). It is important to note, however, that liberalising laws alone are not sufficient to achieve such improvements, as governments must invest in health systems with training and equipment to ensure effective implementation of a liberalised law.

Integrated approach

NEPAL

While maternal mortality remains high in Nepal and there is much work still to be done, there has been evidence of real improvements in maternal health in recent years. Maternal mortality has decreased from 539 deaths per 100,000 live births in 1989-95 to 281 deaths in 1999-2005. Contributing factors include increased contraceptive use, more women attending ante-natal clinics, an increasing percentage of women giving birth in health facilities and an increase in skilled birth attendance. While this progress is encouraging, maternal morbidity and mortality continue to need major attention in Nepal (UNFPA written evidence).

MSI's partner in Nepal notes that from 2001 to 2006, the national total fertility rate in Nepal dropped from 4.1 births per woman to 3.1. This reduction was due almost entirely to the drop in fertility rates in rural areas (from 4.4 in 2001 to 3.3 in 2006). The contraceptive prevalence rate (CPR) increased from 39 per cent to 48 per cent during this same period. Rural areas registered the largest CPR increase in Nepal. Notably, abortion was legalised by the Nepalese government in 2002 (MSI written evidence).

Community mobilisation

TANZANIA

In Mkuranga district in Tanzania, a community based health care project was established to reduce maternal morbidity and mortality through a comprehensive community approach. The project used both health facility

and community-based strategies. In the community, the project helped to build community structures to improve the links between the community and the health system. Workers mobilised the community and gave them information. The project involved men as well, encouraging them to escort their wives to the health facility for delivery and post-natal care. The project established maternity waiting homes to provide a safe environment for mothers to prepare for childbirth. The project also strengthened health facilities and equipped the clinics with maternal and reproductive health care services. The percentage of women delivering in facilities rose from 38 per cent in 2003 to 78 per cent in 2007, while the national average remains at 44 per cent (AMREF written evidence).

Empowerment of women

BOLIVIA

The Warmi project, located in a rural area of Bolivia with little health infrastructure and widespread poverty, was the first published account of using women's groups to improve maternal and newborn care. It developed the use of community action cycles focused on mother and infant care. After three years, the project noted a reduction in perinatal mortality of nearly 50 per cent and improved practices related to prenatal care, breastfeeding, immunisation and other behaviours. In addition, women increased their participation in community planning and decision-making processes, and commented that they had never spoken to one another about these types of problems before (WCF written evidence).

It should be noted that in Bolivia the introduction of a health insurance scheme was a major contributing factor to the success of reducing maternal mortality and morbidity, as it brought women greater access to services.

NEPAL

To evaluate the effects of the Warmi women's group approach (above), a study was undertaken to improve the health of pregnant mothers and their newborn infants among 170,000 villagers living in the rural Makwanpur district, central Nepal. The potential of women's groups to bring about improvements in health outcomes was examined through a randomised control trial and a staggering 30 per cent reduction in newborn mortality and a significant reduction in maternal mortality over a two-year period was demonstrated. Other outcomes included changes in the care provided for the mother and newborn at home and improved health seeking and referral

patterns. Women who attended women's groups were more likely than non group members to have had ante-natal care, given birth in a health facility with a trained attendant or a government health worker, used a clean home delivery kit or a boiled blade to cut the umbilical cord, and for the birth attendant to have washed her hands. In addition, the women taking part in women's groups were more likely to attend a health facility if they or their infant were ill (WCF written evidence).

Ensuring essential drugs and supplies are available

ETHIOPIA

IPPF's member association in Ethiopia, the Family Guidance Association of Ethiopia operates an outreach centre in the rural Assala region of Ethiopia, in the small town of Ticho. The outreach centre provides contraceptives including injectables, basic health checks and advice on other sexual and reproductive health issues. Many clients walk up to 30km on foot to receive services. It is located next door to the market and operates every month on market day, so clients visit the centre when they come in from surrounding areas to trade wheat, hens and potatoes. "Askala has been using injectable contraception (Depo) for six years. A community-based distributor named Maraba introduced Askala to family planning and discussed the number and spacing of children with her during a home visit. Because she has limited her family to two children, Askala says 'Now I have both the time and resources to invest in my own business. Limiting my children means that I am able to nourish and care for my children, and I have also been able to maintain my own good health throughout both pregnancies and afterwards. Family planning has given me freedom'. She runs a tea shop for local people. This has given her independent income and gives her an opportunity to contribute to large decisions made within her family" (IPPF written evidence).

GHANA

The experience of the Planned Parenthood Association of Ghana (PPAG) is a clear example of what happens when family planning services and methods are unavailable. PPAG operates an extensive community-based distribution family planning service, particularly in hard-to-reach rural areas. At its peak, PPAG was the second largest provider of these services in rural areas and third in the country. In 2001, however, the Global Gag Rule meant major cuts to funding and many of these services were lost. This resulted in a contraceptive distribution drop from 7.8 million to 3.3 million. As a result, the number of unwanted pregnancies increased, and PPAG saw a dramatic rise in the number of women seeking abortion (IPPF written evidence).

The Global Gag Rule stated that US funding for family planning was denied to any non US Non Governmental Organisation that used their own money to:

- provide counselling and referral for abortion, even in countries where abortion is legal;
- advocate to make abortion legal or more available in their country, even at the request of their own government; or
- perform abortions in cases other than a threat to the life of the woman, rape, or incest.

President Obama has now overturned the Global Gag Rule and it is hoped that services will soon be reinstated.

Mechanisms to protect households from social and economic consequences

MAURITANIA

In Mauritania, an insurance scheme has been implemented whereby pregnant women pay voluntary monthly premiums (totalling \$15 per pregnancy). The premium then covers all of the childbearing costs from ante- to post-natal care. Despite widespread poverty, a surprising 95 per cent of women signed up for the scheme, which was designed by the community to be transparent and avoid corruption. This programme has now been operating for five years and is proving to be both sustainable as well as equitable (UNFPA written evidence).

KENYA

In Kenya women in the lowest wealth quintile were given vouchers that they could cash in for services. They were able to choose where to use their vouchers, so had control over where they could go for services (for example, to either a public or private provider). The vouchers entitled women to four ante-natal visits, a normal delivery, or even a caesarean section. Following the delivery, vouchers were used to obtain family planning and other post-natal care. This scheme empowered women and improved access for the poor to quality services (ICOMP written evidence).

The voucher scheme in Kenya has also increased the uptake of tubal ligation in MSI clinics (MSI written evidence).

Recommendations

Women in many European countries saw improvements in Maternal Health in the early to mid 1900s. It is time for women throughout the world to experience similar progress. Maternal Morbidity can be effectively reduced with strong political will, improved and adequately funded Sexual and Reproductive Health and Rights (SRHR) policies, equitable and strengthened health systems with strong partnerships and accountability. The UK All Party Parliamentary Group on Population, Development and Reproductive Health (the Group) makes the following recommendations:

Increase Political Will to ensure sufficient resources for maternal health (with more research needed to engage policy-makers)

- Broaden dialogue between and with Ministers for Health and Women to include Ministers of Finance. Economic arguments, as well as health and human rights arguments, must be used to persuade these Ministers in national as well as international fora.
- Encourage political participation of female politicians, as this is likely to have a positive impact on gender and SRHR policies, strategies and programmes.
- Improve data on maternal morbidity in order to assist governments and donors to better understand and prioritise maternal health.
- More cost-benefit analysis is needed at country level to strengthen the financial argument for investing in women's SRHR at individual, household, community and national level.
- For many reasons, donors have driven the intense interest in maternal deaths. Illnesses and disabilities from pregnancy-related causes are widespread and also need considered research.

Increase Resources to SRHR to 10 per cent of Official Development Aid (ODA) as recommended at the International Parliamentarians' conferences at Ottawa in 2002, Strasbourg in 2004 and Bangkok in 2006

- 10 per cent of ODA to target the three pillars of maternal health: family planning and access to safe abortion, skilled birth attendance, and emergency obstetric care.
- Make aid long-term and predictable, to better support health planning and health system strengthening, with attention to country plans based on supporting the new Millennium Development Goal (MDG) target 5.B: “achieving universal access to reproductive health by 2015” and associated indicators.
- Encourage country-wide ownership with the involvement of government officials, parliamentarians, civil society including women's groups, the private sector and donors.

Encourage Equitable Health Care by removing financial barriers and improving access to services

- Encourage Governments to reduce inequities in health care by removing financial barriers and provide free family planning and pregnancy/maternal health services (including eliminating ancillary costs) to all; especially the poor, the young, the marginalised and people in conflict areas. A variety of mechanisms exist to do this, such as equity and voucher schemes.
- Girls' education, empowerment and equality repays many times over as educated girls make informed reproductive decisions and fulfil their potential. They choose to bear the number of children they can care for well. This is a win-win situation as fewer births also mean lower rates of population growth and less pressure on government health and education systems and the earth's fragile climate, as the Group highlighted in the Parliamentary Hearings, Return of the Population Growth Factor: Its impact upon the MDGs in 2007 (Ref 13).

Work in Partnership with the United Nations (UN) and the United Kingdom (UK) and International Royal Colleges for better data and protocols

- The World Health Organization must develop a global definition of maternal morbidity, which will aid better maternal health data collection, expansion and regulation of health workers with improved codes of practice and protocols. We must also support country Management Information Systems that will enable countries to collect accurate data to assess the magnitude of maternal ill health and gain an in-depth understanding of the problem to better inform national policy makers.
- Increase and expand the role of the Royal College of Midwives, Royal College of Nursing, International Confederation of Midwives, Royal College of Obstetricians and Gynaecologists and the International Federation of Gynaecology and Obstetrics with the aim of encouraging health worker expansion and registration at country level with codes of practice, standards, protocols and guidelines to ensure a sufficient number of motivated and skilled birth attendants at all levels. This would include appropriate ‘task shifts’ and trained mid-level health workers to conduct emergency obstetric care including menstrual regulation and safe abortions and village level workers or Traditional Birth Attendants to administer life saving drugs including family planning, emergency contraception, antibiotics and misoprostol.
- Collaborate with United Nation’s Population Fund (UNFPA) at country and international levels to advocate for women’s universal access to SRHR including the more controversial areas (e.g. access to emergency contraception or safe abortion).

Improve SRHR Legislation and Policies world-wide

- Legislate against child marriage below 18 years of age and implement the law (including in the UK).
- Legislate against Female Genital Mutilation (FGM) and rape and ensure the implementation of anti discrimination policies as the Group highlighted in the Parliamentary Hearings on Female Genital Mutilation in 2000 (Ref 17).
- Decriminalise abortion and liberalise abortion laws. The rates of abortion are the same when abortion is legally restricted as when it is broadly

permitted by law; the difference is that legal abortion is safe and illegal abortion is almost always unsafe.

- Prevent and reverse legislation that criminalises transmission of HIV in relation to pregnancy, childbirth and breastfeeding, as it deters women from voluntary counselling and testing and ensure linked SRHR and HIV/AIDS policies and programmes, as the Group highlighted in the Parliamentary Hearings Linking Sexual & Reproductive Health and HIV/AIDS in 2004 (Ref 12).
- President Obama has begun to reverse harmful anti-choice policies (abolishing the Global Gag Rule, reinstating funding to UNFPA, increasing United States' international Family Planning/Reproductive Health funding, stopping abstinence only programmes and using evidence based information to guide HIV/AIDS including Presidents Emergency Plan for Aids Relief activities). In addition he should end vertical HIV/AIDS programming and all other activities which move health workers from government health services to vertical programmes.
- Promote the development of comprehensive SRHR policies, strategies and programmes (including in the UK) and encourage menstrual regulation.
- Diminish the impact of the Catholic Church's anti SRHR agenda by highlighting the church's anti-choice policies (particularly to condoms, safe abortion, and emergency contraception) to the detriment of women, their families and societies, including in conflict areas.

Make Governments Accountable

- Support civil society organisations in bringing out the grassroots voice. Women and families need to hold their governments accountable for the reproductive and maternal health promises they make.
- Empower a UN organisation to publish country league tables, that monitor progress on maternal health and 'name and shame' those countries making insufficient progress.

Acronyms

ADB	Asian Development Bank
AMDD	Averting Maternal Death and Disability
AMREF	African Medical Research Foundation
ANC	Ante-natal Clinic
CPR	Contraceptive Prevalence Rate
CRR	Centre for Reproductive Rights
DALY	Disability Adjusted Life Years
DfID	Department for International Development
EmOC	Emergency Obstetric Care
FGM	Female Genital mutilation
FIGO	International Federation of Gynaecology and Obstetrics
ICOMP	International Council on Management of Population Programmes
ICPD	International Conference on Population and Development
ICW	International Community of Women living with HIV/AIDS
ICOMP	The International Council on Management of Population Programmes
Impact	Initiative for Maternal Mortality Programme Assessment
IPPF	International Planned Parenthood Federation
Jhpiego	John Hopkins Program for International Education in Gynecology and Obstetrics
LSHTM	London School of Hygiene and Tropical Medicine
MDG	Millennium Development Goals
MIS	Management Information System
MoH	Ministry of Health
MSI	Marie Stopes International
MVA	Manual Vacuum Aspiration
NCT	National Childbirth Trust
OHCHR	Office of the High Commissioner of Human Rights
ODA	Official Development Assistance
OECD	Organisation for Economic Co-Operation and Development
PEPFAR	Presidents Emergency Plan for Aids Relief
PPAG	Planned Parenthood Association of Ghana
PPH	Post Partum Haemorrhage
PSN	Population and Sustainability Network
RAISE	Reproductive Health Access, Information and Services in Emergencies Initiative

RCM	Royal College of Midwives
RCN	Royal College of Nursing
RCOG	Royal College of Obstetricians and Gynaecologists
SBA	Skilled Birth Attendance
SRHR	Sexual and Reproductive Health and Rights
TBA	Traditional Birth Attendant
The Group	The UK All Party Parliamentary Group on Population, Development and Reproductive Health
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WCF	Women and Children First
WHO	World Health Organization
WRA	White Ribbon Alliance

Appendix 1:

List of organisations that submitted written evidence to Hearings

- Advocacy International
- African Development Bank
- African Medical Research Foundation (AMREF)
- Asian Development Bank
- Bangladesh, Ministry of Health & Family Welfare
- Bill and Melinda Gates Foundation
- Bill and Melinda Gates Institute on Population and Reproductive Health, John Hopkins School of Public Health
- Bixby Center for Global Reproductive Health Research and Policy, University of California, San Francisco (Prof. Joseph Speidel)
- Catholics for Choice
- Center for Reproductive Rights
- Child Health Advocacy International/The Advanced Life Support Group
- Columbia University, Mailman School for Public Health/Averting Maternal Death and Disability Program/ Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative
- Commonwealth Secretariat
- Department for International Development (DFID)
- Faculty of Sexual and Reproductive Healthcare
- Foundation for Women's Health Research and Development (FORWARD)
- fpa
- Guttmacher Institute
- Human Rights Watch
- Immpact, University of Aberdeen
- Interact Worldwide / Action for Global Health / Countdown 2015 Europe
- International Community of Women Living with HIV/AIDS (ICW)
- International Council on Management of Population Programmes (ICOMP)
- Ipas
- International Planned Parenthood Federation (IPPF)
- Jhpiego, an affiliate of John Hopkins University
- John Kelly OBE, MD, FRCOG, FRCS – Obstetrician
- Joint United Nations Programme on HIV/AIDS (UNAIDS)
- London School of Hygiene and Tropical Medicine (LSHTM)
- MacArthur Foundation
- Malaria Consortium
- Malaysia, Ministry of Health

- Marie Stopes International (MSI)
- Maternity Worldwide
- Medical Emergency Relief International (MERLIN)
- National Childbirth Trust (NCT)
- Nuffield Centre for International Health and Development, University of Leeds
- Oxfam
- Pakistan, Ministry of Population Welfare
- Population Action International
- Population and Sustainability Network (PSN)
- Population Media Center
- Realising Rights Research Programme Consortium
- Royal College of Midwives (RCM)
- Royal College of Obstetricians and Gynaecologists (RCOG)
- SafeHands for Mothers
- SAHAYOG – Indian NGO
- Southern Sudan (Government of), Ministry of Health
- Uganda, Ministry of Health
- United Nations Population Fund (UNFPA)
- UN High Commissioner for Human Rights (OHCHR)
- United Nations Children’s Fund (UNICEF)
- United States, Agency for International Development (USAID)
- White Ribbon Alliance (WRA)
- WOMANKIND Worldwide
- Women and Children First UK (WCF)
- World Bank
- World Health Organization (WHO)

Appendix 2:

List of expert witnesses that gave oral evidence at Hearings

Monday 8th December (morning session)

Dr John Kelly, Obstetrician; **Dr Tony Falconer**, Vice President and **Dr Nynke van der Broek**, Director International Office, Liverpool, RCOG; **Frances Day-Stirk**, Director of Learning, Research and Practice Development, RCM **Dr Gill Greer**, Director General, IPPF; **Rosey McDonald**, Programme Officer, Women and Children First (UK); **Getachew Bekele**, Senior Advisor to the MSI Global Partnership, MSI; **Karen Newman**, Coordinator PSN

Monday 8th December (afternoon session)

Dr Maliha Rashid, Bangladesh MoH representative; **Binjwala Shrestha**, WRA, Nepal and **Brigid McConville**, Director, WRA

Naana Otoo-Oyortey, Executive Director, FORWARD; **Max Lawson**, Head of Development Finance and Public Services Team, Oxfam; **John Nduba**, Director for Reproductive and Child Health, Nairobi, AMREF

Tuesday 9th December (morning session)

Gilda Sedgh, Senior Research Associate, Guttmacher Institute; **Alec Cumming**, Chief Executive Officer, Immpect; **Amy Ong Tsui**, Director and Professor, John Hopkins SPH – Bill & Melinda Gates Institute for Population & Development

Ian Anderson, Advisor, Principle Economist, Health Services Delivery, Regional and Sustainable Development Department & **Mr Bruce Purdue**, Head of the Results Management Unit, Strategy and Policy Department, Asian Development Bank; **Veronique Filippi**, Senior Lecturer, LSHTM

Tuesday 9th December (afternoon session)

Dr Hedia Belhadj, Executive Coordinator, Global Health, UNFPA; **Ian Pett**, Chief of the Health Systems and Strategic Planning Unit of the Health Section, UNICEF

Mary Ellen Stanton, Senior Advisor for Maternal Health, USAID

Malcolm McNeil, Head of AIDS and Reproductive Health Team, **John Worley**, Head of Profession, Health and **Sandra MacDonagh**, Health Adviser, Reproductive and Sexual Health, Department for International Development

Appendix 3:

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Some Maternal Health Problems (by condition)

CONDITION	DEFINITION	PREVALENCE
All Maternal Morbidity	Complications that have arisen during the pregnancy, delivery or post-partum period.	Eight to 50 million women experience maternal morbidity.
Haemorrhage	Primary post-partum haemorrhage (PPH) is loss of blood (>500ml) from the genital tract within 24 hours of delivery; secondary PPH is abnormal bleeding from the genital tract (from 24 hours after delivery to six weeks post-partum).	150,000 maternal deaths annually.
Obstetric Fistula	Fistula is a hole which develops in the wall between a woman's vagina and her bladder or rectum and is usually a result of prolonged obstructed labour. Traumatic fistula is the result of violent rape.	Two million are living with fistula around the world; 50,000 to 100,000 new cases per year.
Prolapsed Uterus	Weakening of or damage to a woman's pelvic musculature to the extent that it can no longer support the uterus.	Two to 20 per cent of women of reproductive age.
Unsafe Abortion	Abortion performed either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both, often in countries where abortion is illegal.	18 – 20 million unsafe abortions take place per year in developing countries; over 68,000 women die from these unsafe abortions per year; five million women per year are admitted to hospital with abortion complications (one in 40).
Anaemia – Malnutrition	Anaemia is a condition that occurs when a person has a reduced number of red blood cells or a low level of haemoglobin, usually resulting in a lack of energy. Malnutrition is the condition that develops when the body lacks the vitamins, minerals, and other nutrients it needs to maintain healthy tissues and organ function.	400,000 cases of severe maternal anaemia in sub-Saharan Africa. 45 per cent of pregnant women are anaemic worldwide.

<p>Infections including STIs and HIV/AIDS</p>	<p>Invasion by pathogenic micro-organisms in tissue producing tissue injury progressing to disease. Infections include a broad range of problems from urinary tract infections to STIs such as chlamydia, syphilis, gonorrhoea, genital herpes, HIV and AIDS to puerperal sepsis.</p> <p>Puerperal sepsis is any bacterial infection of the genital tract which occurs after the birth of a baby. Symptoms usually include fever, abdominal pain, bleeding and discharge.</p> <p>A sexually-transmitted infection is an infection that can be transferred from one person to another through sexual contact including intercourse (both vaginal and anal) or oral sex and rarely by kissing.</p>	<p>Fifteen per cent of maternal deaths are the result of infections.</p> <p>It is estimated that about two million women with syphilis become pregnant in sub-Saharan Africa annually.</p> <p>It is estimated that there are about two million women with syphilis.</p> <p>Approximately fifteen per cent of the babies born to women in a study in Bolivia had congenital syphilis.</p>
<p>Pre-eclampsia and Eclampsia</p>	<p>A pregnancy-induced hypertensive disorder which can induce convulsions and eclampsia.</p>	<p>63,000 deaths annually.</p>
<p>Mental Health Disorders include baby blues, moderate to severe depression, anxiety disorders and post-natal psychosis</p>	<p>Baby blues is being tearful and tired in the first week of childbirth.</p> <p>Post-natal depression usually develops four to 13 weeks after birth, but may be up to six months after birth. It causes ambivalence about the baby, low self-esteem, exhaustion and general inability to cope and thoughts of self-harm.</p> <p>Risk factors include a previous history of depression or post-natal depression, poor relationship with partner, adverse social circumstances, an unplanned pregnancy, peri-natal death.</p> <p>Puerperal psychosis is having pronounced disturbance within the first few weeks after birth with delusions and hallucinations.</p> <p>Risk factors include a previous or family history of psychosis, and young age.</p>	<p>Baby blues is very common. In the United Kingdom it affects up to 50 per cent of women.</p> <p>The prevalence of peri-natal depression is 10 to 30 per cent in many countries. 17 per cent of all maternal deaths are due to psychiatric causes in the UK.</p>

BETTER OFF DEAD?

A report on maternal morbidity from the UK All Party Parliamentary Group on Population, Development and Reproductive Health

May 2009

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