Parliamentarians Take Action for Maternal and Newborn Health and Survival

Report on WHO/IPU meeting, Kampala, the Republic of Uganda, 23-25 November 2009
Parliamentarians take action for maternal and newborn health and survival

© World Health Organization 2010

WHO/WHO/10.04

All rights reserved. Publications of the World Health Organization can be obtained from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel: +41 22 791 3264; fax: +41 22 791 4857; e-mail: bookorders@who.int). Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to WHO Press, at the above address (fax: +41 22 791 4806; e-mail: permissions@who.int).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers’ products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

This publication is a report of a meeting of parliamentarians in Kampala, Uganda, from 23-26 November 2009. It does not necessarily represent the decisions or policies of the World Health Organization.

Compilation: Alice Duffil
Editing: Marie-Agnes Heine
Design: Duke Gyamerah
Photo credit: WHO / Marie-Agnes Heine
# Contents

Parliamentarians take action for maternal and newborn health ................................................................. 3
Executive summary ........................................................................................................................................ 4
Political power and commitment ................................................................................................................. 5

**Background**

Maternal and newborn mortality worldwide .............................................................................................. 6
Millennium Development Goals .................................................................................................................. 6

**Day one**

Opening plenary ........................................................................................................................................... 7
Breaking down barriers ................................................................................................................................ 7
Taking action worldwide .............................................................................................................................. 8
Address by the President of the Republic of Uganda .................................................................................... 8
Introductory session ..................................................................................................................................... 9
Maternal and newborn health ...................................................................................................................... 10
Maternal mortality in Africa .......................................................................................................................... 11
The health system: at the core of reducing maternal and newborn mortality .............................................. 11
Country report: Uganda ................................................................................................................................ 12
Maternal and Newborn Health in Crisis Situations ..................................................................................... 13
Case Studies .............................................................................................................................................. 13

**Day two**

Site visits ....................................................................................................................................................... 15
Removing barriers for women: Promoting good practice ........................................................................... 19

**Day three**

Global initiative to improve maternal health .............................................................................................. 21
Case study: Soroti, Uganda .......................................................................................................................... 22
Closing session ............................................................................................................................................ 24

**Annex1: The seven pillars** ....................................................................................................................... 26
List of Participants ...................................................................................................................................... 29
Parliamentarians take action for maternal and newborn health

Parliamentary representatives from 32 countries came together in Kampala, Uganda on 23-25 November 2009 to continue international discussion on how parliamentarians can contribute to the improvement of maternal and newborn health. The three-day meeting was the third annual event under the Parliamentarians Take Action for Maternal and Newborn Health and Survival series of international discussions hosted by the World Health Organization (WHO). The series was first launched in 2007 in response to interest expressed by parliaments to enhance governmental capacity to advance the health of mothers and babies. At the invitation of the Ugandan Parliament, the Kampala meeting aimed to build upon discussions held by parliamentarians from developing and developed countries in the previous two years. The inaugural meeting in London in March 2007 aimed at promoting parliamentary action on investment and interventions to reduce maternal mortality and putting maternal and newborn health and survival on the government agenda. The second meeting, held in The Hague in 2008, identified parliamentary strategies to achieve Millennium Development Goals (MDGs) 4 and 5 set by the United Nations in 2000. These goals aim to reduce the maternal mortality ratio by three quarters, to achieve universal access to reproductive health, and to reduce the under-five child mortality rate by two thirds between 1990 and 2015. The Kampala meeting brought together male and female parliamentarians, health officials from developing and developed countries and representatives from international agencies and non-governmental organizations.

Executive summary

The objective of the meeting was to build awareness of the challenges facing maternal and newborn health in many developing countries and to urge parliamentarians to raise the issue at the highest level in their home countries. Participants were encouraged to develop a common vision for governmental policies that will help to achieve the MDGs on maternal and child health.

The Kampala meeting also presented an opportunity to review progress made since the 2008 meeting in The Hague. Parliamentarians from the countries represented discussed their achievements and best practices to collectively map out the next steps for each country and to strengthen effective parliamentary cooperation nationally and internationally. Host country Uganda showcased its achievements in reaching targets for MDG 6 (Combat HIV/AIDS malaria and other diseases) and its action plan to replicate the same success for MDGs 4 and 5. Rwanda’s health insurance scheme was also highlighted as an effective country-based action to help reduce maternal mortality. Meeting representatives also resolved to develop a network for discussion among parliamentarians, international organizations and civil society around the world.
Political power and commitment

Discussion at the conference focused on the role of parliamentarians in efforts to meet the health-care needs of pregnant women, mothers and babies at various levels in their home countries. Participants also reviewed ways to secure necessary funds for maternal and newborn health interventions, showcasing the Ugandan and Rwandan experiences as models for other countries.

Parliamentarians attending the Kampala meeting agreed on the following key discussion objectives:

- Creating a common awareness and understanding of key policies and interventions needed for countries to achieve MDGs 4 and 5;
- Reviewing progress made and/or setbacks encountered in participants’ countries;
- Sharing experiences from developing and developed countries;
- Fostering global debate on maternal and newborn health;
- Strengthening international and national political will and commitment;
- Facilitating cooperation and solidarity among members of parliament worldwide.

Over the past few years, closer attention has been directed to the role of parliaments and their members in achieving progress for the health and survival of women and babies. Parliamentarians in many countries are aware of the tragic health crisis facing many women and newborns, and have subsequently taken action to find solutions to the situation.

At the 2007 London meeting, which was jointly hosted by WHO and the Parliament of the United Kingdom, parliamentarians agreed on the need to make maternal and newborn health a key national and international priority. In 2008, participants at The Hague meeting adopted a road map for members of parliament to take action on maternal and newborn health. The Dutch Parliament joined WHO and IPU in hosting this second event in the series.
Background

Maternal and newborn mortality worldwide

Every year, approximately 358,000 women die due to complications during pregnancy and childbirth. In the last decade, over 7 million women died from pregnancy-related causes and millions more suffered motherhood-related disabilities. Every year, 4 million babies die within their first 28 days of life and another 3.3 million are stillborn. And every year, 600,000 newborns are infected with HIV, mainly through mother-to-child-transmission. Despite this, maternal and newborn health remains a largely neglected public health issue.

Data analyses and studies of maternal and newborn mortality worldwide reveal a global disparity and inequity in healthy childbirth between rich and poor, and between urban and rural populations. Differences not only occur regionally, but also within countries themselves. Most maternal and newborn deaths and disabilities are preventable with cost-effective interventions. However, the appalling numbers of maternal and newborn mortality and morbidity will continue to rise until these interventions are implemented, with necessary budget allocations and improvements in national health services.

Millennium Development Goals

In 2000, the international community adopted eight key thematic targets - the United Nations eight Millennium Development Goals (MDGs) - to halve the world’s poverty by 2015. MDGs 4, 5 and 6 are directly related to health. MDG 4 aims to reduce child mortality, while MDG 5 seeks to improve maternal health and achieve universal access to productive health. MDG 6 is aimed at combating HIV/AIDS, malaria and other diseases and is a goal closely linked with maternal and child health. Under the United Nations MDG initiative, the 189 Member States committed to reduce under-five mortality by two thirds and maternal mortality by three quarters and to achieve universal access to reproductive health between 1990 and 2015.

While many countries have made progress in reducing under-five mortality, maternal and perinatal mortality rates have stagnated or even increase in 43 countries. The HIV/AIDS pandemic has caused serious setbacks, with the overwhelming majority of HIV transmission related to sexual intercourse, pregnancy, childbirth and breastfeeding. Malaria infection during pregnancy also poses a major threat to the mother and her unborn child. MDG 6 emphasizes the need to prioritize the health of women and children in combating HIV/AIDS and malaria and to ensure that both sexual and reproductive health initiatives and initiatives for the prevention and treatment of HIV/AIDS and malaria must be mutually reinforcing.

At the current pace, it will take many years to attain MDG 4 and 5 in sub-Saharan Africa and South Asia. Governments, parliaments, civil society and the international community need to redouble their efforts and join forces internationally to reach global maternal and newborn health and survival targets by 2015.
Parliamentarians take action for maternal and newborn health and survival

Day One

Opening plenary

Uganda

Ms Rebecca Kadaga
Deputy Speaker of Parliament, Uganda

Ms Rebecca Kadaga welcomed participants to the third meeting of the Parliamentarians Take Action for Maternal and Newborn Health and Survival series, and the first to be hosted by a developing country. As host of the meeting, Ms Kadaga urged all parliamentarians to evaluate what their governments had done to overcome basic barriers to improving maternal health.

“We have gathered here to discuss how quickly a mother can reach help. Are the roads there? Are the facilities there? We want to examine the first port of call,” she stressed.

WHO

Dr Joaquim Saweka
WHO Representative, Uganda Country Office

Dr Joaquim Saweka praised the efforts of the Ugandan Government in achieving its MDG 6 target for combating HIV/AIDS and called for similar efforts to improve the health of women and newborns. “Under your commitment and leadership, history could be repeated for MDGs 4 and 5,” he said, addressing directly the President of the Republic of Uganda, Yoweri Kaguta Museveni, who was present during the opening session of the meeting.

There is an urgent need for drastic measures to be taken by all countries represented to reverse the bleak outlook for mothers and babies worldwide. Of all the MDGs, MDG 5 is the least likely to be met and parliamentarians must assess the progress made towards improving maternal and newborn health at a governmental level and address the obstacles hindering the process. According to Dr Saweka, universal coverage of skilled birth attendance can be achieved through boosting trained personnel by 330 000 additional midwives. The most effective intervention to reduce newborn mortality is the provision of programmes that offer a continuum of care for both mother and baby before, during and after birth.

Breaking down barriers

Governments must oversee and maintain accountability for maternal and newborn health-related policies, including monitoring the delivery of health services. Parliamentarians should be encouraged to use their legislative powers to facilitate better access for mothers and babies to essential health care. Among the global support for maternal and newborn health, Dr Saweka highlighted the Task Force on Innovative Financing for Health Systems, an initiative of the International Health Partnership (IHP+). In September 2009, the Task Force had announced new financial commitments totalling US$ 5.3 billion to help prevent millions of women and babies in developing countries from losing their lives at childbirth.

In the face of the global economic crisis, Dr Saweka reiterated the request of WHO Director-General Dr Margaret Chan to take urgent action, both within the health sector and beyond, “to improve the health and lives of girls and women around the world from birth to older age.” Despite pressures to cut health
and social sector spending, governments need to increase investment in this priority area for global health.

**IPU**

**Mr Martin Chungong**  
*Director, IPU Division for the Promotion of Democracy*

Mr Martin Chungong called on parliamentarians to “pool their resources and energies” to make sure all countries fulfil the objectives of MDGs 4 and 5. Every woman should be in a position to decide about the timing of her childbirth and the spacing of her children. She also should be aware of her health needs and know when to seek medical attention. He quoted IPU Secretary-General Mr Anders Johnsson who underlines that, “sustainable change will require a collective response in which we all have a role to play.” Referring to the identification of seven pillars of action at the 2008 meeting in The Hague, Mr Chungong emphasized the importance for all sectors of society to have access to adequate healthcare. “This conference will focus precisely on access,” he said. Pregnancy should not be synonymous with a death sentence for women.

**Taking action worldwide**

Parliamentarians worldwide have a duty to oversight and lawmaking powers to pressure governments and assist in developing and implementing national action plans. Developed countries can also help through financial support for development aid programmes focusing on maternal and newborn health. Other legislative changes that have a direct impact on maternal health, such as gender equality and anti-discrimination laws, also need to be addressed. Improvements to data collection and monitoring have enabled better understanding of the current situation, identification of gaps and appropriate actions at both national and international levels. “Change is, therefore, possible,” Mr Chungong underlined.

**Address by the President of the Republic of Uganda**

**Mr Yoweri Kaguta Museveni**  
*President of the Republic of Uganda*

President Museveni talked about the belief of the Ugandan Parliament in the importance of having a simple focused plan of action. Using Uganda as an example, the President set out steps to be taken to achieve tangible changes in the maternal and newborn health situation at a national level. He pointed out that it is necessary to

- adopt a simple and adequate distribution of health units, split by sub-counties;
- focus on the range of personnel needed in each unit including medical assistants, a midwife and two nurses;
- ensure adequate supply of drugs and equipment;
- encourage prenatal attendance at clinics, with larger health units at county level and hospitals at district level. (Each health unit must include ambulances, an operating theatre and a qualified doctor);
- undertake community-focused campaigns against underage marriage and harmful traditional practices;
promote good nutrition, particularly through radio campaigns, using simple language that the population can understand.

The Ugandan Government had set up inspection units where doctors can monitor the structure and operations of health units to deter corruption and theft of drugs that are sometimes moved illegally from government hospitals to private clinics. Despite this problem, private clinics remain an integral part of the programme. “If the clinic is efficient, the people will come,” President Museveni said.

Introductory session

Uganda

Ms Sylvia Ssinabulya
Member of Parliament, the Republic of Uganda

Ms Sylvia Ssinabulya welcomed all parliamentarians to Uganda and expressed her hope that the three-day meeting would encourage open discussion and sharing of ideas and experiences about best practices in the promotion of maternal and newborn health worldwide. She also drew attention to this meeting as an opportunity to advance strategies set out in two key working documents developed at the 2008 meeting in The Hague. Both, the Roadmap and the Seven Pillars for MDG 5, provide a framework for parliamentary action which identifies priorities and set out innovative strategies to prevent the needless deaths of women and babies.

A summary of the Seven Pillars can be found in Annex 1 of the report.

Mr James Kakooza
State Minister for Health (Primary Health Care), the Republic of Uganda

According to State Minister James Kakooza, maternal mortality figures indicate that approximately 6000 women die every year in Uganda. Pregnancy-related complications are among the leading causes of death and disability for women aged between 15 and 49 years. While current health systems are constrained by low staffing rates, poor skills and badly equipped health facilities, the State Minister expressed confidence that the country would find the necessary funds to improve maternal and newborn health by 2015. His announcement of a new allocation of US$ 25 million by the Ministry of Health to provide beds and help midwives at health centres was applauded by the plenary.

Availability and access to transport and education are key components to ensuring high quality of health care. Mr Kakooza called on the parliamentarians represented to work collaboratively across government sectors to address the problem. This involves commitment from the agricultural sector to maintain food security to ensure that the nutritional needs of mother and child are met; support from the finance sector to allocate funds to the health sector; the provision of safe water and attention to gender-based issues related to culture, tradition, vulnerability and equity. “We need to ensure commitment at all levels and by all sectors. If we do this, by 2015, we shall achieve our goals,” Mr Kakooza said.
Maternal and newborn health

World Health Organization
Dr Monir Islam
Director of the Department of Making Pregnancy Safer, WHO

Dr Monir Islam summarized the proposed strategies for improving maternal and newborn health at a parliamentary level, including the prioritization of investment and the improvement of the status of women.

Closing the gap
The WHO Making Pregnancy Safer Director used a comparison of data from countries in Africa and Japan to highlight the large disparities in access to maternal health care between rich and poor countries and between rich and poor, urban and rural women within countries. Maternal death from pregnancy-related complications is a serious and prevalent health issue in developing countries. In Niger, one in seven women die due to pregnancy and childbirth problems, compared to Japan where only one in 12,000 pregnant women face the same risk. There is also a serious imbalance in the death rate among newborn babies between developing countries such as Sierra Leone where there are 56 deaths per 1000 live births, and developed countries such as Japan where the equivalent figure is 1 per 1000 live births.

Dr Islam emphasized that every woman “should have access to skilled care, so that when complications arise there are emergency care services available.” Changes need to take place to also address the disparity of access within countries themselves, notably in rural populations where access to health services is often more limited than in urban areas. For example, although 43% of all women in Uganda have access to services, the rich still have three times higher access than the poor. Similarly, only 43% of the women from the poorest communities in Indonesia have access to maternal health services, compared to 95% of the women from the rich communities. In Zambia, the percentage of the poorest women with access to health services has dropped from 4% to 1.2%, whereas the access of rich women has increased from 4% to 9%. In Ethiopia, most women deliver at home because they lack access to services.

The model of Three Delays
Dr Islam identified access to efficient quality care as a key component of all strategies to reduce maternal and newborn mortality. He urged the participants to use their parliamentary power to help overcome the barriers preventing women from accessing maternal health services. In order to reduce maternal and newborn deaths, parliamentarians need to address the reasons why a large percentage of women with obstetric complications fail to get the care they need in time to save their lives and the lives of their babies. The model of Three Delays shows at which point in time of her pregnancy a woman’s access to receiving care can be blocked due to different factors. There can be an initial delay during pregnancy when women need to seek antenatal care but when it is not up to them to make the decision to do so. The second delay can occur once the decision has been made that a woman should go to the health facility. But then no transportation, no road or no money is available. The third delay can happen at the facility when, for example, no skilled personnel or no drugs are available. Any of these three delays can result in a woman’s death.

Eradicating each of these barriers would significantly reduce maternal and newborn mortality as well as stillbirth. Saving the lives of mothers also helps to save the lives of their children, and has thus a positive impact on the livelihood of families and communities.
Maternal mortality in the African Region

Dr Tigest Ketsela
Director of Family and Reproductive Health, WHO African Region

“No mother should die of preventable causes”
Dr Tigest Ketsela explained that maternal and newborn health can be better promoted in Africa if it is ensured that planning, technology and data collection translate into effective programme implementation. Of the 30 million African women who become pregnant each year, as many as 265 000 die due to preventable causes. The cause of death for the 1.16 million babies who die every year during their first month of life is frequently related to the deaths of their mothers. The current average mortality rate for African countries stands at 900 per 100 000 live births. While the facts are clear, governments must give greater attention to the coordination of programmes at country level. “So many different partners and a multitude of people are doing things in an uncoordinated manner. The governments have to control this and determine who does what,” Dr Ketsela said. Much is available in terms of policies, strategies and technologies. What is needed is urgent action to make optimum use of these.

The voices of the voiceless
Strengthening health systems, investing in maternal and child health, coordinating efforts and empowering women should be in the focus of efforts to achieve MDG 5, Dr Ketsela urged.

Empowerment of women to increase their social status, through education, better wages and seats in parliament is one of the issues needing attention. The lack of infrastructure, human resources, skilled birth attendance, emergency obstetric care and family planning are ongoing weaknesses in health systems that need to be tackled. Parliamentarians also need to push for the adoption of legislation against female genital mutilation and early marriage.

There is opportunity for better coordination of government-run programmes and policies with NGOs, as well as private and public sector activities. Linking maternal health interventions with malaria and HIV/AIDS prevention and treatment programmes is an example of a combined approach that could further help to increase the coverage of major interventions. Special attention should be paid to the plight of women in emergencies caused by conflict or natural disaster. These collaborative efforts further ensure effective interventions to reach those with the greatest need. Parliamentarians must hold their governments accountable for maternal and newborn health and push for greater investment in effective interventions. They have an important role in overseeing government implementation of programmes, monitoring the use of donor funds and ensuring the equitable distribution of health services. “Be the voices of the voiceless,” Dr Ketsela urged the participants.

The Health System: At the core of reducing maternal and newborn mortality
Ms Alice Alaso, Member of the Parliament of Uganda, chaired the second session. She asked participants to articulate the major challenges faced by current health systems in achieving the MDG 5 targets and share experiences from their countries to prompt group discussion. Ms Jean Kapata from Zambia said her country had lost the services of hundreds of nurses due to more lucrative salaries abroad. The global economic crisis is posing an additional challenge to the health system.
Parliamentarians take action for maternal and newborn health and survival

The challenges facing Uganda’s progress are fourfold:
1. Lack of human resources, often as a result of restrictions on recruitment and low salary packages;
2. Poor infrastructure making accessibility of care very difficult;
3. Lack of essential medicines and equipment, including some reproductive health commodities that are excluded from the national credit line of vital products despite being on the essential drugs list;
4. Insufficient funding which affects all other challenges and leaves many interventions unfinished.

Call to oversee the health budget
Making sure adequate budget allocations are made to support maternal and child health programmes is an important task for parliamentarians to take on. Similarly, it is the role of parliamentarians to oversee and hold governments accountable for their budget expenditure, “to ensure government compliance with approved plans and programmes” and to identify any gaps in service coverage in the area of sexual and reproductive health issues. She urged parliamentarians to conduct field visits, initiate internal debate and new legislation, ensure the fair distribution of resources and services and carefully examine government bills prior to plenary debate. She mentioned that many people cannot afford insurance coverage in particular when they are unemployed.

To achieve MDGs 4 and 5, governments should make a commitment to promote collaboration among all sectors which have a direct or indirect impact on maternal and newborn health, including improved education, agriculture (for nutrition), infrastructure, environmental programmes and social development. “Every policy implementation is a result of political
Parliamentarians take action for maternal and newborn health and survival

Maternal and newborn health in crisis situations

WHO
Dr Nevio Zagaria
Coordinator for Strategy, Policy and Technical Development/Health Action in Crises

Dr Nevio Zagaria discussed the direct effects of increased mortality and morbidity in countries affected by humanitarian crisis. The situation is particularly difficult for women during complex emergencies. Among the estimated 200 million people living in areas in conflict, around 20 million are internally displaced and registered refugees currently number two million. The recovery process in the countries upset by the 2007 tsunami demonstrates the missed opportunity to strengthen basic community-based interventions, as the deployment of village-based trained midwives, with direct impact on maternal mortality, and the over-investment in building new health infrastructures, now unused due to the lack of health staff. “This is an example of a key challenge in the health system,” Dr Zagaria said.

Case studies

Indonesia
Mrs Ida Ria
Member of Parliament, the Republic of Indonesia

Mrs Ida Ria from Indonesia talked about the effects of natural disasters and catastrophes to women and children in developing nations. As well as dealing with the elevated psychosocial load, pregnant women also have to fight for survival in areas of poor sanitation and disease. Following emergencies, it is often not possible for mothers to breastfeed due to malnutrition. Breastfeeding is the main source of nutrition for babies. Lack of basic support, immunization and mother care can contribute to hypothermia, which is commonly found in malnourished newborns.

In 2007, the Indonesian Government passed 24 laws on disaster management to set a legal framework for fund distribution and management when a disaster occurs. In 2008, the National Agency for Disaster Management was founded with the mandate of coordinating emergency relief efforts and aiding prevention, preparedness and post-disaster recovery. Governments themselves can take action by ensuring availability of food for the disaster survivors and displaced people. Providing food in post-disaster areas is crucial to preventing sexual exploitation and long-term reliance on financial support.

Sierra Leone
Mrs Alice Foyah
Member of Parliament, the Republic of Sierra Leone

Mrs Alice Foyah described the devastating long-term effects that conflict has on women and particularly children in her country, in terms of poor growth development caused by malnutrition. Further to this, Sierra Leone also lacks adequate health centres and sufficient medication. The Sierra Leone Government introduced an immunization scheme, raising the proportion of immunized children from 7% to 19%. Additional effort was made to extend the intervention to provinces with poor infrastructure. Sierra
Leone also established a commission to monitor the smooth running of the country’s health system.

“As parliamentarians, we need to pass a law that each woman who is pregnant should be taken care of from the first day she visits the health centre to the time the baby is at least five years old,” Mrs Foyah said.

**Group discussion**

Representing Uganda, Mrs Aol said her country was confronting problems resulting from war and conflict. She raised the topic of abduction which, she said, had resulted in the problem of underage mothers who are unable to raise their children or pass on to them their bad habits. She asked whether this was also a problem in Sierra Leone.

Mr Alimamy Kamara explained that Sierra Leone acted quickly after conflict to introduce national policies for the provision of social amenities, including electricity and water supply. Discouragement of early age marriage and sexual abuse occurs at the local government level. The Government had also adopted a zero-tolerance policy for corruption.

Member of Parliament in Uganda Mrs Mugerwa sympathized with those countries that had endured conflicts and acknowledged the particularly grave impact of poor health conditions on women and newborns. She appealed to fellow parliamentarians “to reject man-made wars, because the people who suffer most are the women who often cannot run away as they have many children.”

Mrs Vanda Sarundajang from Indonesia stressed the psychological impact of conflicts and asked what strategies WHO had implemented to deal with psychological health issues. WHO representative Dr Zagaria said psychological health is an area that WHO supports, particularly following conflicts. Specific WHO guidelines are available for key services to be used to respond effectively to emergency situations. Psychosocial support needs to be established at the community level as well as at the primary care level and secondary care level and complement existing mental health services. Both mental health and psychosocial support should be provided for vulnerable groups, including people who are stigmatized and marginalized in villages with poor access to health facilities.
Day Two

Site visits

Meeting participants conducted a series of field trips to institutions in Uganda connected to or involved in issues of maternal health. Small teams visited the Wakiso Health Centre IV, the Namayumba Health Centre IV, the Mulago National Referral Hospital and The AIDS Support Organization (TASO) and reported their impressions of the services to the plenary.

A system of five levels

Health care in Uganda is organized through a five level structure within the national health care system. Health centres in the Level I category provide basic care, with a team of 10-15 staff visiting villages to encourage people to attend clinics. The second level (Level II) encompasses the provision of twelve-hour services for family planning and the referral of complicated cases. Health centres at Level III consist of an outpatient department, and provide antenatal care and simple deliveries. At Level IV, health centres usually have 20 staff including midwives, nurses, health assistants, clinical officers and up to two doctors. General hospitals are positioned at Level V.

Wakiso Health Centre IV

Participants from Ethiopia, Namibia and Uganda were led by Mrs Foyah from Sierra Leone on their visit to the Wakiso Health Centre IV, located 10km from the centre of Kampala. The Centre’s staff includes a health unit doctor, nurses, midwives and support personnel. Immunization, antenatal care, family planning, deliveries and HIV/AIDS services are free services provided by the Centre. The team identified the strengths of the Centre in the commitment and confidence of its staff, high number of trained staff, 16 week timeframe for antenatal care and routine screening for HIV/AIDS for everyone including babies (who are tested at six weeks). In addition, the health centre operates an outreach programme to provide HIV/AIDS treatment to people in communities not situated close to metropolitan centres.

The visitors also noted some limitations. These include a lack of space and running water, no provision for post-natal treatment and no tuberculosis testing. There is also no trained staff available to manage abortions.

Mrs Foyah and her team made the following suggestions:

- The delivery room should be expanded to address the lack of space;
- A post-operation ward and mortuary would be beneficial for the Centre;
- Numbers of trained staff should be increased and their residential facilities on the premises should be expanded;
- HIV screening should be offered on two or three days a week.

Namayumba Health Centre IV

The second team led by Dr Jennifer Wanyana, visited the Namayumba Health Centre, located 30km from the centre of Kampala.
Kampala. An evaluation and photographs of the Centre were delivered to the plenary by Dr Stephen Yakubu.

Namayumba Health Centre IV provides care to about 40,000 people living in the area, and offers free services to anyone in need. The centre provides antenatal care for 24 hours, as well as HIV testing and counselling.

Dr Wanyana and her team said that they found the clinic to be very clean, with the provision of piped water. Dr Wanyana particularly highlighted the success of a specific performance recognition programme for staff. This allows the hospital to monitor staff competency and performance levels, with yellow stars indicating high performance and blue indicating underperformance. As a member of the health committee in Ghana, Dr Yakubu stressed that this is an idea he would put forward in his home country.

The AIDS Support Organization (TASO)
Mrs Irene Akena from Uganda presented the third team’s findings from their trip to TASO. She told delegates that the organization was founded in 1987, with the aim “to contribute to the process of preventing HIV/AIDS and improving the quality of the lives of people having AIDS.” Some of the services provided include voluntary testing and counselling, provision of antiretroviral therapy, prevention of mother-to-child transmission and family planning. According to its records, the organization provides care for 240,000 people living with HIV/AIDS in Uganda.
In 2008, TASO launched its Prevention of Mother to Child Transmission (PTMCT) programme to combat the second most common way of HIV transmission in many parts of sub-Saharan Africa. Between 25,000 and 30,000 mothers in Uganda pass on the disease to their children each year. TASO applies the WHO-recommended four-pronged approach. The four elements of this approach are (a) the reduction of HIV transmission to potential mothers; (b) the reduction of unintended pregnancies among women and girls living with HIV; (c) the reduction of mother-to-child transmission of HIV; and (d) the provision of care, treatment and support for mothers and their infants, partners and families. Maternal health is very important for TASO, as over 82% of the organization’s clients are of reproductive age.

The team found that the PMTCT programme requires intensive counselling and education. The main challenges are socio-cultural and economic issues, such as poverty and polygamy. The team also noticed a gender imbalance in participation in the programme with very weak male involvement.

Mrs Akena stressed the need to provide family planning options to people living with HIV. She also mentioned TASO’s recommendation for exclusive breastfeeding only for the first six months to reduce the risk of transmission.
Mulago National Referral Hospital

Dr Daniel Zaake from Uganda spoke on behalf of the fourth group that visited Mulago National Referral Hospital, which is both a referral and a teaching hospital. The group visited the labour wards, the gynaecology wards, the antenatal clinics, the postnatal and baby clinics, the prevention of mother-to-child transmission clinic and the uro-gynaecological unit.

Mulago Hospital operates a busy labour ward with approximately 30,000 deliveries per year. The maternal health unit is overcrowded as it was originally designed to handle 20 deliveries per day, but today actually deals with 60 to 95 deliveries every day. Local councils have tried to ease the congestion in the referral unit by making other maternity units more available. In the gynaecological ward, 40% of the beds were occupied by women with cervical cancer. Team members agreed that increasing screening services and early treatment could help to reduce the number of women referred to the hospital. The group found that the antenatal clinics were full, partly due to Uganda’s success at achieving a 90% attendance rate. The group also visited the PMTCT clinic, where they were told that early screening of women and an appropriate regimen could reduce mother-to-child transmission to less than 5%. However, the later a woman attends services, the higher is the risk of transmission.
Parliamentarians take action for maternal and newborn health and survival

Removing barriers for women: Promoting good practice

Rwanda

Mr Ezechias Rwabuhihi
Member of Parliament, Rwanda

Mr Rwabuhihi stated that the Rwanda experience in the post-genocide context has shown, “that every problem may have a solution, even maternal and child mortality.” Despite the obvious reasons for poor maternal and newborn health care in developing countries, lack of political will and money are the biggest barriers. A health insurance system has been adopted by the Rwandan Government to improve community health. People pay US$ 2 per year, an amount which is then matched by the Government. “This has had a big positive impact on the use of health facilities by mothers, children and the whole population,” Mr Rwabuhihi said.

Rwanda has also introduced a performance-based financing scheme whereby measurable indicators are linked with financial incentives for health workers. The latter are paid according to their actual performance rather than receiving fixed bonuses. Other planned actions by the Rwandan Government include a priority focus on family planning, building the role of community health workers, integrating the services of maternal and newborn health, establishing maternal mortality audits and the inclusion of new vaccines into the country’s immunization package.

Infant mortality in Rwanda has fallen from 107 per 1000 live births in 2000, to 62 in 2008. Mr Rwabuhihi was confident of Rwanda reaching the United Nations Millennium Development Goals targets, set in 2000. “We believe that we can achieve MDGs 4 and 5 if we improve services and increase access by building new health centres and by supplying more ambulances,” he said. “We should also reinforce postnatal care, adolescent health services and increase the government contribution to the health sector budget.”

Mr Rwabuhihi urged fellow parliamentarians to push for better representation of women in parliament, noting that in Rwanda 56% of parliamentary seats in the Lower House are filled by women.

El Salvador

Mr Guillermo Francisco Mata Bennett
Member of Parliament, the Republic of El Salvador

Mr Bennet explained that in El Salvador the infant mortality rate stands at 11 per 1000 live births and that 64% of births are attended by skilled personnel. Current efforts by the Government of El Salvador to overcome access barriers for women and newborns include the extension of rural coverage, the distribution of additional medical equipment, an increase in the number of nongovernmental organization (NGO) health specialists and the introduction of sex education programmes. In 2009, El Salvador invested US$ 4 million to immunize children against infectious diseases in order to reduce infant mortality. The Government has also established free health check-ups and delivery care and was strengthening the capacities of delivery care units. Efforts had been stepped
Parliamentarians take action for maternal and newborn health and survival

up to train more midwives and to decentralize the deployment of health specialists in order to ease congestion in the capital’s health services. Legal and financial assistance was also extended to women to empower them and to make them more independent.

Group discussion
Mrs Ssinabulya, from Uganda reiterated the importance of overcoming the Three Delays to accessing care discussed earlier in the meeting. Many women in Uganda are illiterate and subordinate to male family members and therefore lack both economic and social power. Failings in community infrastructure, such as impassable roads, can also make it impossible for a pregnant woman to reach a clinic. Once at the facility, women face a lack of trained medical staff, drugs and equipment. Therefore, many women in Uganda are forced into home deliveries, with an increased risk of maternal death and complications.

Dr Volontè from Italy emphasized that investment is primarily needed for blood banks, caesarean sections and the treatment of haemorrhage and infection, which are primary causes of maternal mortality. Parliamentarians must ensure that funds secured at the G8 and G20 summits in 2009 are directed towards the reduction of maternal mortality, as one of the main emergency priorities in global health.

Mrs Kapata from Zambia urged participants to remember “that maternal health is a human right and that maternal health and newborn health are closely linked.” She presented the following five-point action plan, as a strategy to reach out to all women and newborns:

- To generate political will and commitment;
- To strengthen the health system and addressing constraints;
- To empower families and communities to adopt key family practices;
- To promote partnerships to achieve equality of access to assured quality, cost effective and affordable health services as close to the family as possible;
- To facilitate a safe and enabling environment for women and children.

Zambia has developed a number of national and local government plans to address the issue of achieving MDGs 4 and 5. The national development plan, Vision 2030, promotes a productive and healthy population with a particular focus on maternal and newborn health. A further plan currently under development focuses specifically on the MDG 2015 countdown, again with a focus on maternal and newborn health. Parliamentary caucuses on children and women are useful instruments to help high-level advocacy and lobby for more budgetary resources.

Mr Rwabuhiihi pointed to the important role of the church. In Rwanda, the church wields a lot of influence and owns 40% of the health facilities. It was therefore important to initiate a dialogue with the church if family planning policies and other activities were to be successful.

Mrs Ssinabulya highlighted the various government groups in Uganda working towards improving maternal health. The Network of Women Ministers and the Women and the Social Services Committee are two examples of how parliamentarians can play an active role in ensuring women and newborns have access to care. The authority vested in parliamentarians to spearhead legislative changes and pass bills where necessary should be used to set out strategies and allocate money to maternal and newborn health as a priority. Such legislation would cover women’s rights and empowerment as well as their education. Parliamentarians could also push governments to raise funds locally to finance the health sector instead of relying fully on donors. “We have those powers as parliament and we can use them even when we feel that our governments are not acting fast enough,” Mrs Ssinabulya said.
Global initiatives to improve maternal health

The Partnership for Maternal, Newborn and Child Health (PMNCH)

Dr Pius Okong
Obstetrician and Gynaecologist, Nsambya Hospital, Kampala, the Republic of Uganda

Dr Okong talked about the establishment and work of the Partnership for Maternal, Newborn and Child Health (PMNCH), an alliance of more than 300 organizations, academia, governments, etc. In 2009, PMNCH published a consensus for maternal, newborn and child health including an agreed set of policies and priority interventions aimed at accelerating progress towards MDGs 4 and 5. Rather than viewing health as an isolated event, PMNCH adopted a continuum of care model that includes integrated service delivery for mothers and children from pregnancy to delivery, the immediate postnatal period, and childhood and implementation of evidence-based interventions. PMNCH also works to raising US$ 30 billion, the amount of money globally required to address the issue of reducing maternal and newborn mortality between now and 2015.

Raising funds for maternal and newborn health

Recent global initiatives also include fundraising through an innovative mechanism launched by the UN High Level Task Force on Innovative Financing where individuals are encouraged to make a micro-donation of US$ 2, which is added on to the cost of their flight. Dr Okong informed the plenary that all Kampala meeting participants’ flights had contributed to this scheme, called Voluntary Solidarity Contribution (VSC).

Thanks to the work of PMNCH, maternal health was on the agenda of the recent G8 meeting. Parliamentarians have reportedly raised more than US $3 billion through increased awareness and fundraising activities within their home countries. Becoming aware of global initiatives and suggested programmes, parliamentarians can assist PMNCH to monitor and ensure cost-effective use of the funds allocated to maternal and newborn health in each country.

H4+

Marie-Agnes Heine
Communications Officer, Department of Making Pregnancy Safer, WHO

With five years to go until 2015, UNFPA, UNICEF, WHO, and the World Bank, as well as UNAIDS, have joined forces as Health 4+ (H4+) to support countries with high rates of maternal and newborn mortality. The objective is to accelerate these countries’ progress towards achieving MDGs 4 and 5 and to improve the health of women and newborns.

Mrs Heine explained that the five partners work with countries to provide better maternal and newborn health services. The joint effort focuses on strengthening health systems in order to reduce the maternal mortality ratio by 75% and achieve universal access to reproductive health – the two targets under MDG 5. Due to the close links between a mother’s health and the health and well-being of her children, particularly newborns, the collaboration of the five organizations will also help to reduce child mortality (MDG 4).
The H4+ partners are working with governments and civil society to enhance national capacity to:

- Conduct needs assessments and ensure that health plans are MDGs-driven and performance-based;
- Cost national maternal, newborn, and child health plans;
- Mobilize required resources;
- Scale up quality health services to ensure universal access to reproductive health, especially for family planning, skilled attendance at delivery, and emergency obstetric and newborn care, ensuring linkages with HIV prevention and treatment;
- Address the urgent need for skilled health workers, particularly midwives;
- Address financial barriers to access, especially for the poorest;
- Promote innovations in service delivery;
- Tackle the causes of maternal and newborn mortality and morbidity, including gender inequality, adolescent pregnancy, low access to education, inadequate knowledge and inappropriate health practices and care-seeking, discriminatory values and attitudes, harmful social norms especially for girls, such as female genital mutilation and child marriage; and
- Strengthen monitoring and evaluation systems for maternal and newborn health.

Together with government officials, the UN country teams, donor partners and other stakeholders, H4+ is developing comprehensive government-led work plans to support maternal and newborn health and survival. These work plans have clear benchmarks and address community participation and communications activities. The agencies involved will work and coordinate with existing global, regional, and national initiatives.

Case study

Soroti, Uganda

Dr Olive Sentumbwe-Mugisa
National Professional Officer, Family Health and Population, WHO Uganda

Dr Sentumbwe-Mugisa presented a case study on an initiative in Uganda launched by the WHO Department of Making Pregnancy Safer. The goal of this initiative was to reduce the exceedingly high maternal mortality rate in Soroti, a rural district in the eastern region of the country. When the MDGs were introduced by the United Nations in 2000, Uganda was among the five initial priority countries with the highest Maternal Mortality Ratio (MMR) worldwide. At the time, the country’s maternal mortality rate stood at 505 deaths per 100 000 live births. Soroti had an even higher MMR with 885 deaths per 100 000 live births mainly caused by obstetric complications and the lack of timely access to care.

To ensure that no woman or baby in the district dies as a result of pregnancy-related complications or during childbirth, the MPS initiative strengthened the relevant obstetric skills of doctors, nurses and midwives. In addition, the initiative focused on improving the referral system and the transport availability in remote communities and health centres to allow for quick referral to the Soroti Referral Hospital. The programme equipped the community...
with adequate resources and services including bicycle ambulances, drugs starter packs and clean water supplies. This was accompanied by a public reproductive health education campaign on the benefits of accessing antenatal care, giving birth in health facilities, preventing early pregnancy and understanding responsible fatherhood. The education programme also addressed poor knowledge on warning or danger signs during pregnancy. While the country’s overall maternal mortality rate had decreased and stood at 435 deaths per 100,000 live births in 2006, the rate of maternal mortality in the Soroti district in the same year had fallen to 221. In addition, the number of maternal deaths and stillbirths had also been reduced.

Dr Sentumbwe-Mugisa used this case study to demonstrate that positive change is possible even in low-resource settings. “We can definitely put a dent on maternal mortality if we follow a logical way of doing things and ensure that communities are participating and governments are providing the necessary logistics for quality care,” she said.

**White Ribbon Alliance for Safe Motherhood**

**Dr Joseph Byamugisha**

*Head of the Department of Obstetrics and Gynaecology, Makerere University College, Kampala, the Republic of Uganda*

Dr Byamugisha, a representative of the White Ribbon Alliance (WRA) talked about his experience of working with parliamentarians and their initiatives. With members in more than 143 countries, the White Ribbon Alliance endeavours to lead advocacy by providing information for parliamentary enquiries and by initiating debates in developed and developing nations. WRA has also been actively involved in campaigns in Malawi, the development of a roadmap in Uganda and public hearings in India. Dr Byamugisha reiterated that the barriers causing delay for a woman seeking medical attention are the key concern. “I know they are discussed over and over again, but we really need to understand that they are the major causes and that they are preventable,” he said. Previous WRA activities in Uganda have been supported by Uganda’s First Lady Mrs Janet Museveni and the wife of former UK Prime Minister Mrs Sarah Brown. Dr Byamugisha urged all parliamentarians to help advocate for the campaign by wearing a white ribbon.

**Group discussion**

Mrs Barbara Contini, Member of Parliament of Italy, reported that two bills had been passed in her country recently. The first one aimed to reduce the high level of caesarean deliveries in Italy, as recommended by WHO, and the second one to increase international development aid for maternal and newborn health. Italy has since increased its funding for maternal and newborn health by 66%. An exchange programme of health professionals between Italy and some African countries is promoting greater awareness of reproductive health issues and the need for technical support. The Italian Government has built a close relationship with Uganda’s Ministry of Health through its sponsorship of a hospital in Uganda where pregnant women are treated free of charge.

**East African Legislative Assembly** member Dr Nyiramilimo requested a review on what had been done to date in reference to the seven pillars of action identified at the previous meetings of parliamentarians. Two examples of the success of good relationships between parliamentarians and governments are The Network of Parliamentarians for Health, Population and Development in Africa and The Association of African Parliamentarians for the Advancement of the MDGs, created in Nairobi in 2009. Partnerships between governments of developing and developed countries and private sector members, such as the Bill & Melinda Gates Foundation, have also proved helpful in implementing health strategies by raising funds and assisting in the development of infrastructure.
Community partnerships between religious groups, friends and families must continue to be strengthened “to unite forces and resources in order to reduce maternal and newborn mortality.”

Mrs Amongi from Uganda identified the question of financing as the most relevant issue for parliamentarians in the campaign for increased budget allocations for maternal health. “There is a need to ensure parliamentary committees have adequate resources to function as good as possible,” Mrs Amongi said. She also highlighted the importance of advocacy and coordination between countries, particularly in terms of the formulation of bilateral agreements for skill transfer between countries. In addition, parliamentarians should focus on strengthening the quality of care provided at the community level to reduce the disparity in access between the rich and poor. Performance-based incentives should be introduced to motivate medical staff and health professionals in rural areas to encourage women to use health facilities. She concluded by calling on the participants to review existing laws regarding gender discrimination in order to empower women and challenge traditional stereotypes.

Closing session

First steps back home

Participants were each asked to present to the plenary their intended first steps towards improving maternal and newborn health in their home countries. Common responses were to influence the budget debate, to review legislation and to ensure the most effective government strategies for maternal and newborn health. Mrs Rwakimari from Uganda raised the issue of partnership between agencies, and highlighted that each should understand their role, so that parliamentarians can work with international bodies in the most successful way. The representative for El Salvador Mr Bennett Francisco Mata pushed for international bodies to cooperate with governments to provide essential equipment at better prices. This effort would assist in improving adequate treatment for newborns with respiratory difficulties, which is a problem in his country.

Mrs Sylvia Ssinabulya from Uganda stressed the importance of having subcommittees at parliamentary level to track incoming funds and to decide how best to use them. Mrs Ssekabira, also from Uganda, suggested that rather than establishing new committees, countries should focus on improving existing networks. Indonesia representative Mrs Ida Ria called on the IPU to create a means by which parliaments can share information, coordinate strategies and create global awareness about the maternal and newborn health situation. Mr Almamy Kamara from Sierra Leone encouraged international bodies to ensure high-risk countries are assisted appropriately. For example, expert health personnel could visit hospitals to provide recommendations on how to best organize staff to improve maternal mortality within the country.

Continued support to countries

On behalf of WHO, Dr Islam acknowledged the hard work of organizers and participants to make this meeting in Uganda a great success. He thanked the President of Uganda and the Parliament of Uganda for hosting the 2009 meeting on Maternal and Newborn Health and Survival, held for the first time in a developing country. Dr Islam called on parliamentarians to be empowered by what they had learned at the conference and to return with renewed motivation for action at home. He encouraged all to use the latest evidence-based policies and statistics produced by WHO to improve maternal and newborn health. “We maintain our commitment to provide that support,” he said. “We are not going to stop until every woman has access to quality care.” The WHO Director-General, Dr Margaret Chan, considers Africa and maternal and newborn health a priority. Therefore, WHO will also continue to provide information and advice that could inform policy at
national level and could help raise financial resources although WHO is not a funding agency itself.

Mr Chungong also thanked the Ugandan Parliament and affirmed IPU’s commitment to working closely with WHO to continue to support parliamentarians. Maternal and newborn health and survival will remain an important objective for both agencies. He urged participants to take home the recommendations and to devise action plans. “We should go now and conquer,” Mr Chungong said. “We are going home with a strong resolve to take this agenda forward in partnership with international organizations and other stakeholders.”

As host of the Kampala meeting, the Deputy Speaker of the Ugandan Parliament, Mrs Rebecca Kadaga, thanked all the organizers and participants for their contributions to a successful event and urged them to develop ideas from the areas discussed into action in their home countries. In particular she expressed gratitude to the IPU for its input and ongoing support, “so that when we get together we can put our energies together.” Finally she expressed the delight of the Ugandan Parliament to have hosted such an important meeting and welcomed all participants to return to Uganda soon.
Parliamentarians take action for maternal and newborn health and survival

During the 2008 Parliamentarians Take Action for Maternal and Newborn Health and Survival meeting, which took place in The Hague, a roadmap was developed to assist parliamentarians from 36 countries represented to build momentum towards achieving MDG 5 in their home countries and worldwide. As part of the roadmap, the parliamentarians identified seven priority areas (pillars) necessary to all frameworks for action to ensure progress is made to achieve the MDGs by 2015. The seven pillars consist of Political Commitment, Legislation, Financial Resourcing, Health System, Education, Cultural Practices and Partnership. Parliamentarians also established the conditions that must be met to make progress in these areas and defined specific parliamentary activities to promote progress by all stakeholders.

Pillar 1: Political Commitment
The conditions of successful political commitment include accurate data to know the situation, good governance and transparency in political commitments and action, engagement of the media and international bodies to pressure for and promote accountability of political commitment, and building awareness across political parties to promote favourable political decision-making.

Actions parliamentarians can take to improve political commitment include raising the topic of MDG 5 publicly and frequently in parliament, questioning governments and calling ministers to account on their global commitments, building cross-party coalitions to engage more MPs and political leaders, strengthening national commitment through public events involving constituents and the wider public, and organizing field visits to facilities and projects to monitor the situation and evaluate existing initiatives.

Pillar 2: Legislation
Legislative changes to further promote maternal and child health at the government level depend on the following conditions: support within parliaments for safe motherhood, common understanding of the key issues, and partnerships and coordination with other stakeholders including international organizations, civil society, and supportive donors.

In order to make legislative changes, parliamentarians identified the need for leadership by one or several parliamentary committees to facilitate a review of existing laws that address maternal health, women’s access to health care services and gender discrimination, hearings with government, civil society, the private sector and other stakeholders to locate legislative gaps, challenges and solutions, collaboration with Courts of Audit to monitor the implementation of legislation, greater recognition and support for the work of midwives and streamlining concerns for MDG 5 with existing legal instruments.

Pillar 3: Financial Resourcing
Adequate financial resourcing of action for maternal and newborn health must include some of the following conditions: sufficient allocation of the national budget to the health sector, gender-sensitive budgets that track and increase allocations to maternal and newborn health where needed, support to microfinance initiatives and a good health insurance system, free health services for women and children and the use of taxation for additional resources.

Parliamentarians can take responsibility for liaising with the budget or finance committee in parliament and the
Parliamentarians take action for maternal and newborn health and survival

Parliamentarians take action for maternal and newborn health and survival

Making Pregnancy Safer

Pillar 4: Health System
Conditions within health systems identified by the parliamentary group as key to success reflect how important a well-functioning health system is to making progress on MDG 5. One of the main conditions is sufficient human resources, which includes the availability of well-trained personnel with a range of skill sets, funding and support for initiatives to discourage migration to more attractive job opportunities abroad, and improvement of the working environment and sufficient remuneration to retain staff. The health system must address issues related to reproductive rights that impact on maternal and newborn health including early marriages, gender-based violence and other harmful practices, lack of family planning as well as adolescent and youth services. Availability of quality care services with a functioning infrastructure, no or low fees for health services and accessibility at all local levels (rural, urban and urban slums) are also key conditions to making progress towards MDG 5. Availability of timely official government-produced data, national statistics, maternal reviews and accreditation based on real evidence, supplemented by the use of UN country-specific data, will assist parliamentarians in monitoring the success of these health services.

Parliamentary actions to strengthen the health system include the use of parliamentary oversight mechanisms (oral and written questions to government, enquiries, hearings) to ensure accountability and adherence to set health objectives, the monitoring of budget allocations to health and their effective use, the support of funding to build independent national statistics institutes, and the liaison with UN and other sources to access data.

Pillar 5: Education
Success also depends on the existence of an educational environment that includes a National Strategic Plan for education with clearly identified means, objectives and targets, sufficient budget allocation for education, training of teachers and midwives and cooperation with mass media.

Parliamentarians can take an active role in regularly monitoring and evaluating government work on education and the effective use of budget allocations. Other actions include ensuring that human rights and gender equality are part of the school curricula, requesting sex-disaggregated data to closely monitor the situation of girls, and organizing events with the media to promote awareness within the government, especially new members of parliament, as well as the wider public on maternal public health issues and MDG 5.

Pillar 6: Cultural Practices
Support for maternal and newborn health must also be driven by the following conditions of cultural practice: media support in exposing bad practices and launching open discussion and debate on the influence of cultural practices, clear consideration of the links between cultural practice, human rights and legislation, collaboration with grassroots organizations and initiatives working for change to approach and challenge harmful cultural practices with adequate funding.

Parliamentarians can take the lead by speaking out publicly against harmful cultural or traditional practices to raise awareness in constituencies, by debating these issues in
Parliamentarians take action for maternal and newborn health and survival

Parliamentarians can help promote and create partnerships by building cross-party coalitions, engaging male parliamentarians on MDG 5, holding regular meetings with various partners including ministers and key members of civil society, reaching out to communities, grassroots organizations and local partners, and investing in parliaments’ technical capacity to bridge the digital divide and facilitate communication.

Pillar 7: Partnership
Developing partnerships to promote maternal and newborn health requires common objectives, mutual respect, including open-mindedness, win-win relationships, clear identification of the individual needs of different partners and creation of links through common ground, an inclusive approach and cross-level cooperation, including national, provincial and district levels and, most importantly, information sharing.

Parliamentarians can help promote and create partnerships by building cross-party coalitions, engaging male parliamentarians on MDG 5, holding regular meetings with various partners including ministers and key members of civil society, reaching out to communities, grassroots organizations and local partners, and investing in parliaments’ technical capacity to bridge the digital divide and facilitate communication.
List of participants

I. Guest Speakers

H.E. Yoweri Kaguta Museveni
President of the Republic of Uganda

Rt Hon. Edward K. Ssekandi
Speaker of the Parliament of the Republic of Uganda

Mr. James Kakooza
Minister of State for Health, Primary Health Care, Uganda

Dr Joaquim Saweka
WHO Representative, Uganda

II. Participants

Bolivia

ROJAS CARITA, Cristina (Mrs)
Member of the Chamber of Deputies

El Salvador

MATA BENNETT, Guillermo Francisco (Mr)
Member of the Legislative Assembly, Member of the Committee on Health, Environment and Natural Resources and of the Committee on Culture and Education

SAMAYOA, Rodrigo (Mr)
Member of the Legislative Assembly

AHUES KARRÁ, Miguel Elías (Mr)
Member of the Legislative Assembly, Member of the Committee on Health, Environment and Natural Resources and of the Committee on Modernisation

Ethiopia

BADO, Lome (Mrs)
Member of the House of Federation, Member of the Committee on Social Affairs

SHIFERAW, Ethune (Mrs)
Member of the House of Federation, Member of the Committee on Social Affairs

ASFAW, Tewabetch (Mrs)
Member of the House of Federation, Member of the Committee on Foreign Affairs

ADDISU, Hagos (Mr)
Member of the House of Federation, Member of the Committee on Foreign Affairs

Ghana

AKUNYE, Simon (Mr)
Member of Parliament, Member of the Special Budget Committee, of the Committee on Health and of the Committee on the Judiciary

YAKUBU, Stephen (Mr)
Member of Parliament, Member of the Committee on Government Assurance, of the Committee on Health and of the Committee on Environment and Science

Indonesia

RIA, Ida (Mrs)
Member of the House of Representatives

SARUNDAJANG, Vanda (Mrs/Mme)
Member of the House of Representatives, Member of the Commission on Population, Health, Labour and Transmigration

HARI SATA, Dwiana (Mrs)
Staff of the Inter-Parliamentary Cooperation Bureau
Parliamentarians take action for maternal and newborn health and survival

**Mali**

TRAORE, Toure Safiatou (Mrs)
Member of the National Assembly, President of the Committee on Health, Social Affairs and Solidarity

AYA, Aliou (Mr)
Member of the National Assembly

**Namibia**

NAWASES-TAEYELE, Evelyn (Mrs)
Member of the National Assembly, Member of the Committee on Human Resources, Social and Community Development and of the Committee on Constitutional and Legal Affairs

**Rwanda**

MBAI, Asser-Gabriel (Mr)
Member of the National Assembly, Member of the Committee on Public Accounts and of the Committee on Human Resources, Social and Community Development

**Sierra Leone**

KAMARA, Alimamy A. (Mr)
Member of Parliament

**Turkey**

CERCI, Mehemet (Mr)
Member of the Grand National Assembly

---

**Italy**

CONTINI, Barbara (Mrs)
Senator, Member of the Committee on Defense, of the Standing Committee on European Policies and of the Committee on the Protection and Promotion of Human Rights

VOLONTÉ, Luca (Mr)
Member of the Chamber of Deputies

BELLINI, Alessandro (Mr)
Protocol Officer

**Kenya**

ESELI SIMIYU, David (Mr)
Member of the National Assembly, Member of the Committee on Health and of the Committee on Public Investments

**Lesotho**

MARUPELO, ‘Mamolili Elizabeth (Mrs)
Member of the National Assembly, Member of the Committee on Business

KOJOANA, Mabuo ‘Mathabo (Mrs)
Member of the National Assembly

MAKOA, Kose (Mr)
Member of the National Assembly, Member of the Committee on Public Accounts and of the Committee on Finance and the Economy

**Nigeria**

Effendi Raden Usman (Mr)
Advisor

Mahendra Wisnu, T. (Mr)
Indonesian Embassy

PRIAMBODO IGNATIUS P.
Indonesian Embassy

---

Making Pregnancy Safer
Parliamentarians take action for maternal and newborn health and survival

BAYDAR, Mustafa Fatih (Mr)
Secretary

Uganda

SSINABULYA, Sylvia (Mrs)
Member of Parliament

ALISEMERA, Jane (Mrs)
Member of Parliament

NYOMBI, Sarah (Mrs)
Member of Parliament

RWAKIMARI, Beatrice (Mrs)
Member of Parliament

KADAGA, Rebecca (Mrs)
The Deputy Speaker, Parliament of the Republic of Uganda

SSENINDE, Rosemary (Mrs)
Member of Parliament, Chair of the Committee on Social Services

MASIKO, Winnie (Mrs)
Member of Parliament

WONEKHA, Olive (Mrs)
Member of Parliament

NALUBEGA, Mariam (Mrs)
Member of Parliament

MUHWEZI, Jim (Mr)
Member of Parliament

DABA DIRI, Margaret (Mrs)
Member of Parliament

ANOKBONGGO, Washington (Prof)
Member of Parliament

KUBEKETERYA, James (Mr)
Member of Parliament

LUKWAGO, Rebecca (Mrs)
Member of Parliament

KIGYAGI, John (Mr)
Member of Parliament

BAYIGGA LULUME, Michael (Mr)
Member of Parliament

ANGUFIRU, Margaret (Mrs)
Member of Parliament

EPATAIT, Francis (Mr)
Member of Parliament

KASAMBA, Mathias (Mr)
Member of Parliament

SABILA, Herbert (Mr)
Member of Parliament

ALASO ASIANUT, Alice (Mrs)
Member of Parliament

ANYWAR, Beatrice (Mrs)
Member of Parliament

NANKABIRWA, Ruth (Mrs)
Member of Parliament

NAKADAMA, Lukia (Mrs)
Member of Parliament

AMONGI, Betty (Mrs)
Member of Parliament

NAMPIJJA, Suzan (Mrs)
Member of Parliament

NALULE, Safia (Mrs)
Member of Parliament

TUNYAMIKAYO, Paula (Mrs)
Member of Parliament
Parliamentarians take action for maternal and newborn health and survival

ZIRALEMA, Charles (Mr)
KYADONDO, Betty (Dr)
PARTNERS IN POPULATION AND DEVELOPMENT
LAKSSIR, Abdelylah (Mr)
REPRODUCTIVE HEALTH, UGANDA
SONGA, Martha (Mrs)
HASIFA, Naluyiga (Mrs)
SAVE THE MOTHERS
AGABA, Selah (Mrs)
WHITE RIBBON ALLIANCE, UGANDA
BYAMUGISHA, Josephat (Mr)
BITEYE, Robin (Mrs)
COORDINATOR, WHITE RIBBON ALLIANCE UGANDA

III. ASSOCIATE MEMBERS

East African Legislative Assembly
OGALO, Daniel (Mr)
Member of the East African Legislative Assembly (Uganda)
NYIRAMILIMO, Odette (Mrs)
Member of the East African Legislative Assembly (Uganda)
NASSOR, Sebutuu
Member of the East African Legislative Assembly (Uganda)

IV. OBSERVERS

United Nations Population Fund
JACKSON, Janet (Mrs)
Representative
MADRA, Primo (Mr)

DBW
MONA, Herbert (Mr)

TUSIME, Benard (Mr)

Hope Foundation
MIREMBE, Caroline (Mrs)

Population Secretariat
ZIRALEMA, Charles (Mr)
KYADONDO, Betty (Dr)
PARTNERS IN POPULATION AND DEVELOPMENT
LAKSSIR, Abdelylah (Mr)
REPRODUCTIVE HEALTH, UGANDA
SONGA, Martha (Mrs)
HASIFA, Naluyiga (Mrs)
SAVE THE MOTHERS
AGABA, Selah (Mrs)
WHITE RIBBON ALLIANCE, UGANDA
BYAMUGISHA, Josephat (Mr)
BITEYE, Robin (Mrs)
COORDINATOR, WHITE RIBBON ALLIANCE UGANDA

V. SECRETARIAT

Host Group
KAKOOZA, James (Mr)
Member of Parliament, Minister of State, Primary Health Care
MBONYE, Anthony K. (Dr)
WABWIRE, Paul G. (Mr)
Deputy Clerk, Legislative Services
COSIAN, Opata (Mr)
Private Secretary to the Deputy Speaker
Parliamentarians take action for maternal and newborn health and survival

BAMUWAMYE, James (Mr)
Minutes Secretary

ISMAIL, Ranny (Mrs)
Press Officer

ROGERS, Matte (Mrs)

HASIFA, Naluyiga (Mrs)

Inter-Parliamentary Union

BALLINGTON, Julie (Mrs)
Programme Specialist, Gender Partnership Programme

SISTEK, Valeria (Mrs)
Administrative Assistant, Gender Partnership Programme

CHUNGONG, Martin (Mr)
Director of the Division of the Promotion of Democracy,
Inter-Parliamentary Union

World Health Organization

ISLAM, Monir (Dr)
Director, WHO/MPS

HEINE, Marie-Agnes (Mrs)
Communication Officer, WHO/MPS

ZAGARIA, Nevio (Dr)
WHO/Health Action in Crises

SENTUMBWE-MUGISA, Olive (Dr)
WHO/Uganda

KETSELA, Tigest (Dr)
Director of Division for Family and Reproductive Health, WHO
Parliamentarians Take Action for Maternal and Newborn Health and Survival

Report on WHO/IPU meeting, Kampala, the Republic of Uganda, 23-25 November 2009