WORLD HEALTH ORGANIZATION

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Making pregnancy safer

Report by the Secretariat

BACKGROUND

1. Each year around 210 million women become pregnant. Among the 130 million or so births annually some 10% to 15% require rapid and skilled intervention if the woman is to survive without lifelong disabilities. In about 5% of cases life-threatening complications develop. According to the latest available figures, more than half a million women are estimated to have died in 1995 from complications during pregnancy, delivery and the postpartum period.

2. In addition, it is estimated that of the 7.1 million infant deaths each year more than half occur in the neonatal period, largely as a result of maternal ill-health, poor hygiene and inadequate care, inefficient management of delivery and lack of essential care of the newborn.

3. Most of this suffering and many deaths are preventable through actions that are effective, feasible and affordable in resource-constrained developing country settings.

4. The Safe Motherhood Initiative, launched in 1987 by WHO, UNICEF, UNFPA, the World Bank and other organizations directly concerned with maternal health, put maternal mortality at the forefront of international public health. It led to significant improvements in knowledge and gave greater visibility to the hidden inequity of maternal ill-health. The initiative supported evidence-based practices and contributed to the Joint WHO/UNFPA/UNICEF/World Bank Statement on Reduction of Maternal Mortality in 1999, which summarized the consensus on necessary actions, namely, prevention and management of unwanted pregnancy and unsafe abortion, provision of skilled care in pregnancy and childbirth, and access to referral care when complications arise.

5. However, decreases in maternal mortality globally have been limited. Progress towards fewer unwanted pregnancies and timely access for women to care in order to reduce maternal and newborn deaths and morbidity implies policy changes, interventions in the health care system, and action at community level.

6. In addition, the target of an infant mortality rate less than 35 per 1000 live births by the year 2015 was adopted;[1] neonatal mortality will have to be lowered if that goal is to be attained.

[1] Programme of Action adopted at the International Conference on Population and Development (Cairo, 1994) (document ST/ESA/SER.A/149).

7. At current rates of progress the above goals will not be achieved. All over the world, women and babies – particularly in poor communities – do not have access to or benefit from essential health care that would substantially lessen the dangers they face.

8. Research results and practical experience have demonstrated that specific health interventions can, if made widely available, reduce the incidence and severity of major complications associated with pregnancy and childbirth. Expanding access to, and improving the quality of, fertility regulation services will reduce the numbers of unwanted pregnancies, unsafe abortions and associated maternal deaths. Thousands of lives could be saved if women were attended by a skilled attendant during childbirth and able to access emergency obstetric care for complications. Whereas traditional birth attendants can provide culturally appropriate health education and emotional support to women during pregnancy and childbirth, they cannot give the essential obstetric care needed to manage complications.

9. The United Nations General Assembly at its special session in New York in mid-1999 on the implementation of the Programme of Action of the International Conference on Population and Development (ICPD, Cairo, 1994) agreed that, globally, skilled attendants should be present at 80% of births by the year 2005 (and confirmed the goal set earlier of a 75% reduction, from the 1990 level, in pregnancy-related mortality by the year 2015). Where the maternal mortality rate is very high, at least 40% of all births should be assisted by skilled attendants by the year 2005; by 2010, this figure should be at least 50% and by 2015 at least 60%.[1]

MAKING PREGNANCY SAFER: A WHO STRATEGY FOR REDUCING MATERNAL AND PERINATAL MORTALITY AND MORBIDITY

10. The Making pregnancy safer strategy was launched by WHO to highlight its commitment to the international Safe Motherhood Initiative. The strategy sets out the practical actions that can be taken by governments, civil society and women in poor countries towards attainment of the global targets of reduced maternal and infant mortality.

11. Building upon existing efforts within countries to reach the goal of lower maternal and infant mortality rates, the strategy on making pregnancy safer provides normative guidance and technical support to target countries in order to increase their capability:

- to establish (or update) national policy and standards for family planning, induced abortion (where it is not against the law), maternal and newborn care (including post-abortion care), and to develop a combination of regulatory measures to support these policies and standards;
- to develop systems for ensuring that these standards are properly implemented;
- to improve access to cost-effective maternal and newborn care and fertility regulation services through promoting increased investments in the public sector and arrangements (such as contracting) to maximize the contribution of the private health sector to the national health goals;

[1] United Nations General Assembly. Report of the Ad Hoc Committee of the Whole of the Twenty-first Special Session of the General Assembly. Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development (document A/S-21/5/Add.1).

- to encourage and foster practices, at home, in families and in communities, that promote maternal and newborn health, and fertility regulation;

- to improve systems for monitoring maternal and newborn health and care services, including fertility regulation services; and

- to keep safe motherhood high on national health and development agendas.

12. WHO will commence work in 10 countries in all regions[1] in the first, two-year phase of the strategy and will carefully document lessons learned so that experiences can be introduced into other countries. The countries were selected by the regions according to pre-established criteria, such as high maternal mortality rates, number of deaths, population size, political support and commitment to health sector reform.

13. Through the Making pregnancy safer strategy WHO will work with countries towards their safe motherhood goals by: promoting partnerships; undertaking advocacy; providing technical and policy support and increasing national capacity; establishing norms and standards, and developing tools, technologies and interventions; promoting, coordinating and disseminating research; and monitoring and evaluation.

PROGRESS IN IMPLEMENTING ACTIVITIES TO MAKE PREGANCY SAFER

14. A document on the strategy of making pregnancy safer was presented in June 2000 to WHO regional offices, donors, and the Meeting of Interested Parties.

15. Discussions are continuing with all regional offices and the 10 countries in the first phase of the strategy about activities to make pregnancy safer at country level. The meetings allow the review of existing safe motherhood activities in the countries, the identification of national needs and priorities, and the formulation of initial work plans. Ministries of health are asking WHO for technical support in drawing up national strategies and work plans to make pregnancy safer, as well as strengthening their health systems and coordinating inputs from multiple partners. Some ministries are already establishing appropriate task forces with WHO support, in order to facilitate the national efforts.

16. The strategy has been discussed from the outset with UNICEF, UNFPA, the World Bank and other United Nations organizations, and regular contacts will continue at global and national levels. At the international level, contacts are also being developed and maintained with a variety of leading players in the field of safe motherhood, including nongovernmental organizations and the private sector. At country level, ministries of health and their task forces on making pregnancy safer will coordinate partnerships that are essential for the success of the Making pregnancy safer strategy.

17. Funds received or pledged currently amount to about half the US$ 10 million needed to finance the initiative during the present biennium. The balance will be sought from international and national partners. Most of the budget for the Making pregnancy safer strategy is dedicated to strengthening capacity at country level.

[1] Bolivia, Ethiopia, Indonesia, Lao People's Democratic Republic, Mauritania, Moldova, Mozambique, Nigeria, Sudan and Uganda.

18. An external group of experts will be called upon to provide independent advice on the technical and operational aspects of implementing the Making pregnancy safer strategy. Its members will include programme planners and managers, practitioners, researchers and academics, multilateral and bilateral donors to safe motherhood initiatives, women's health and advocacy groups, United Nations agencies, and governmental and nongovernmental organizations.

ANNEX[1]

TABLE 1. MATERNAL DEATHS – MAIN CAUSES AND INTERVENTIONS

Cause of maternal death	Percentage	Proven interventions
Bleeding after delivery (postpartum haemorrhage)	25	Treat anaemia in pregnancy. Skilled attendant at birth: prevent or treat bleeding with correct drugs, replace fluid loss by intravenous drip or transfusion if severe.
Infection after delivery	15	Skilled attendant at birth: clean practices. Treat with antibiotics if infection arises.
Unsafe abortion	13	Skilled attendant: give antibiotics, empty uterus, replace fluids if needed, counsel and provide family planning.
High blood pressure (hypertension) during pregnancy: most dangerous when severe (eclampsia)	12	Detect in pregnancy; refer to doctor or hospital. Treat eclampsia with appropriate anticonvulsive ($MgSO_4$); refer unconscious woman for expert urgent delivery.
Obstructed labour	8	Detect in time, refer for operative delivery.
Other direct obstetric causes	8	Refer ectopic pregnancy for operation.

TABLE 2. NEWBORN DEATHS – MAIN CAUSES AND INTERVENTIONS

Cause of newborn deaths	Percentage	Proven interventions
Infections, neonatal tetanus, congenital syphilis (sepsis, meningitis, pneumonia)	33	Maternal immunization with tetanus toxoid, syphilis screening and treatment, clean delivery, warmth, support for early and exclusive breastfeeding, early recognition and management of infections.
Birth asphyxia and trauma	28	Skilled attendant at birth. Effective management of obstetric complications.
Preterm birth and/or low birth weight	24	Antimalarials for women at risk of malaria during pregnancy. More attention to warmth, breastfeeding counselling and support, infection control and early detection and management of complications. Treatment of sexually transmitted diseases. Smoking cessation.

[1] Mother-baby package: implementing safe motherhood in countries – practical guide. Geneva, World Health Organization, 1996 (document WHO/FHE/MSM/94.11).

TABLE 3. STILLBIRTHS – CAUSES AND MAIN INTERVENTIONS

Cause of stillbirths	Percentage	Proven interventions
Birth asphyxia and trauma	40	Skilled attendant at birth. Effective management of obstetric complications.
Other known causes (pregnancy complications, maternal diseases, malaria, malformations)	25	Pregnancy care. Presumptive treatment for endemic diseases. Effective management of pregnancy complications.
Congenital syphilis	8	Screening for maternal syphilis and treatment of positive cases.
Cause unknown	27	-

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