Parliamentarians take action for maternal and newborn health

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Printed in Geneva
Compiled by Eva Prost
Edited by Marie-Agnes Heine
Designed by Duke Gyamerah
Photo credits: WHO / Marie-Agnes Heine
CHE / Chris Reynolds

WHO/MPS/09.02
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**Preface I**

Every minute a woman dies from complications in pregnancy or childbirth. For every woman who dies, 30 more are living with disabilities acquired during pregnancy or childbirth. Every year around 4 million newborns do not survive their first month of life and 3.2 million babies are stillborn.

We know how the vast majority of these deaths can be prevented, however, half way towards our target date of 2015 we must admit that unless drastic measures are taken, the future of mothers and babies will continue to be bleak, especially in developing countries. Millennium Development Goal 5, aimed at improving maternal health, is the least likely to be met in virtually every region of the world.

At the same time we are witnessing an unprecedented commitment to global health in general and to Millennium Development Goals 4 and 5 in particular. With the power vested in them as legitimate representatives of the people, parliamentarians have a key role to play in achieving these goals. There is a lot that parliamentarians can do to improve maternal and newborn health. With the right policies, right strategies, and appropriate investment, and by strengthening the health system and focusing on primary health care, maternal and newborn mortality and morbidity can be reduced.

During the first WHO meeting with parliamentarians on maternal and newborn health and survival in London in 2007, participants agreed that maternal and newborn health is not only about doctors and medical interventions but also about politics and investment, and they came up with a Plan of Action. At the meeting in The Hague hosted by the Parliament of the Netherlands and jointly organized by WHO and the Inter-Parliamentary Union, the parliamentarians built on the momentum for improving maternal and newborn health generated by the meeting in London and other recent events. They developed a roadmap for saving mothers’ and babies’ lives and set up a network so they could continue to share experiences and best practices and support each other’s activities.

I very much hope that this report on the Parliamentarians Take Action for Maternal and Newborn Health conference and its outcome will inspire more parliamentarians to deliver results for the mothers and children of this world. If we all beat the drum for maternal, newborn and child survival the needless loss of women’s lives in pregnancy or while giving birth, and the preventable deaths of newborns and children will become a thing of the past.

Ms Daisy Mafubelu
Assistant Director-General
WHO/FCH

**Preface II**

The statistics of today are frightening. There are more than half a million maternal deaths every year. Every minute eight newborn children die. That makes 3 million dead children per year. No country is exempt from this sad reality. There are, however, huge discrepancies between regions, countries and even within countries themselves, as poor and rural women are the most affected. Today, 68 countries account for 97% of maternal, newborn and child deaths, most of them in sub-Saharan Africa and in Asia.
Growing attention has been paid to maternal health and child survival in recent years. Much effort has been made at the international, regional and national levels by different actors to raise awareness, support initiatives and most importantly track the coverage of interventions. Research and monitoring capacities have significantly improved. It is now possible to identify clearly the current situation in a country, where the gaps lie and where measures and interventions can make a significant difference in the survival of women and children. Change is therefore possible. However, for this to happen, it is crucial to strengthen and translate the political will into political and legislative acts. What could be better than to call for parliaments’ support and action?

Representatives from more than 35 countries met in The Hague at the invitation of the Parliament of the Netherlands, WHO and IPU, for a conference which, I believe says it all: Parliamentarians take action for maternal and newborn health. This meeting provided a wonderful opportunity for members of parliament to strategize, exchange experience and good practices, and build solidarity between countries and actors. I am convinced that the members of parliament who attended returned home energized and committed, with clear ideas of the steps they can take to improve the lives of mothers and their children in their country.

The IPU was very pleased to be part of this effort. I hope that you will find this report of interest and that it will inspire you in your action to make a change in the lives of women and children around the world.

2015 is just around the corner and there is still a long way to go to meet the Millennium Development Goals. Achieving MDG 4 (Newborn) and MDG 5 (Maternal health) is possible if it becomes our priority. There is no reason why every woman and child cannot receive the attention they require. All we need to do is to demonstrate political courage, show political will, and lead the way.

Anders B. Johnsson
Secretary General
Inter-Parliamentary Union
Parliamentarians take action for maternal and newborn health makes me angry and willing to fight. The crucial social role of women, especially in developing countries, should be recognized. It takes more than just money to achieve that. It involves a change in the mindset of politicians and society. Politicians should be at the service of all the citizens they represent, men and women alike. This support begins with equal rights for men and women. As politicians - women and men - we must use our knowledge and experience to achieve that goal. Together, we can make a difference!

I have already urged the parliamentarians of the world to join forces. I sincerely hope that the results achieved at the Parliamentarians take action for maternal and newborn health conference will be supported and put into practice by all the parliamentarians in their home countries. This is the only way to discuss, deal with and improve the position of women in the world, and the only way we will ever be able to make that all-important difference.

Gerdi A. Verbeet
President
House of Representatives of the States-General, the Netherlands
Parliamentarians take action for maternal and newborn health

Lawmakers from 32 countries met in The Hague on 26-28 November 2008 to discuss how parliamentarians could improve maternal and newborn health. The three-day conference entitled Parliamentarians take action for maternal and newborn health was hosted by the States-General, the Parliament of the Netherlands, with special support from Dutch Member of Parliament Ms Chantal Gill’ard. The meeting was jointly organized by the World Health Organization (WHO) and the Inter-Parliamentary Union (IPU). It was a follow-up to a meeting of women parliamentarians on Maternal and newborn health and survival held in March 2007 in London, which aimed to promote investments and interventions for reducing maternal and newborn mortality. The Hague conference brought together parliamentarians (both women and men), health officials from developing and developed countries, and representatives from international agencies and nongovernmental organizations.

Executive summary

The objective of the meeting was to create awareness of maternal and newborn health and to urge parliamentarians to raise this issue at the highest levels in their home countries. Participants were encouraged to develop a common vision for key policies that will help achieve the Millennium Development Goals on maternal and newborn health.

The conference offered participants the opportunity to report on progress and give examples of best practice in the field of maternal and newborn health. Participants from developing and developed countries were invited to exchange experiences.

As an example, the Netherlands presented its midwifery training programme and local nongovernmental organizations. Together, participants developed a roadmap of the next steps to be taken to improve maternal and newborn health. The conference also aimed to develop a network for continued discussion and support among parliamentarians, international organizations and civil society around the world.

Political power and commitment

The meeting focused on the action parliamentarians could take to reduce maternal and newborn mortality in their home countries. The participants agreed that members of parliament could use their power to:

- enact laws to ensure universal access to essential care;
- allocate budgets for maternal and newborn health;
- hold the governments accountable for implementing agreed policies;
- advocate for the achievement of the Millennium Development Goals;
- represent the voices of women and children.

In many countries, parliamentarians have become aware of the tragedy of needless maternal and newborn deaths. At the London meeting in 2007, members of parliament from 20 countries agreed on a Global plan of action to reduce maternal and newborn ill-health. They called for a universal right to health for mothers and their babies by ensuring access to skilled care before, during and after childbirth. They underlined that this also included infrastructure, community involvement
Parliamentarians take action for maternal and newborn health

and global information sharing.\textsuperscript{1} In Uganda and in other countries, parliamentarians were following up on their pledges and pushing maternal and newborn health to the top of the national agendas.

**Background**

**Maternal and newborn mortality worldwide**

Every day, 1500 women die due to complications in pregnancy and childbirth. Over the last decade, 7 million women died from pregnancy-related causes and millions more suffered from motherhood-related disabilities. Every year, 3.7 million babies die within their first 28 days of life, and another 3 million are stillborn. Sixty-eight countries account for 97% of maternal, newborn and child deaths worldwide, mainly in sub-Saharan Africa and South-East Asia.

Maternal and newborn mortality reflect the global inequity between rich and poor, and between urban and rural populations. There are not only differences across regions, but also within countries. Most deaths and disabilities could be prevented with cost-effective interventions. Millions of lives could be saved using the knowledge we have today. However, unless health system response is improved through effective programmes and budgetary allocations, the shameful numbers of maternal and newborn deaths will continue to rise.


Every year …

\begin{itemize}
\item 180–200 million pregnancies occur around the world.
\item 75 million pregnancies are unwanted.
\item 50 million pregnancies are interrupted by induced abortion.
\item 20 million abortions are unsafe.
\item 20 million women suffer from maternal morbidity.
\item 536 000 women die from complications in pregnancy and childbirth.
\item 2.8 million newborns die within their first week of life.
\item 3 million babies are stillborn.
\end{itemize}

**Millennium Development Goals**

In 2000, the international community adopted the United Nations Millennium Declaration. A total of 189 countries agreed on eight Millennium Development Goals (MDGs) to be achieved by 2015. MDGs 4, 5 and 6 are directly related to health. MDG 4 seeks to reduce newborn and child mortality, while MDG 5 aims to improve maternal health. The UN Member States agreed to reduce under-five mortality by two thirds and maternal mortality by three quarters between 1990 and 2015. MDG 5 also aims to achieve universal access to reproductive health by 2015 while MDG 6 seeks to combat HIV/AIDS and malaria, a goal also closely related to the health of mothers and children.

Many countries have made good progress in reducing the mortality rate of children under the age of five. Nevertheless,
The World Health Report 2005\(^2\) showed that in 43 countries maternal and neonatal mortality had stagnated or even increased. The HIV/AIDS pandemic has caused serious setbacks in the gains made in maternal and infant health. At the current pace, it would take many years beyond 2015 to attain MDGs 4 and 5 in sub-Saharan Africa and South Asia. For this to change, governments, parliaments, civil society and the international community need to redouble their efforts to promote maternal and newborn health and survival. To accelerate progress, all stakeholders need to join forces, raise awareness, share experiences and best practices, and promote investment.

Report

Parliamentarians take action for maternal and newborn health

Day one

Opening plenary

The Netherlands

Ms Gerdi Verbeet
President of the House of Representatives

The President of the House of Representatives, Ms Gerdi Verbeet, welcomed the parliamentarians from all over the world to the conference on maternal and newborn health. She encouraged them to join forces to address this issue of common concern and called on them to urge their governments to make it a priority. As a mother and a grandmother, she felt shocked by the magnitude of maternal death and disability. She argued that the slow progress on MDG 5 was not due to technical problems or a lack of funding. “It is a serious case of political short-sightedness and a lack of interest,” she said. “So far, we have failed to make it a priority.” In many countries, it remained a matter of luck whether a woman would survive childbirth. However, every woman should have the right to safe pregnancy and childbirth. Parliamentarians were in a position to achieve this. They must act and use all available instruments to convince their governments to prioritize maternal health.

Motherhood and female powers of persuasion

“The pivotal question during this conference is: how can parliamentarians contribute to making a change?” Ms Verbeet said. She encouraged her female counterparts to bring their personal experience of pregnancy and childbirth into politics. She had observed that many women politicians denied their motherhood in their professional life rather than seeing it as a source of strength and inspiration. Three Dutch parliamentarians had taken maternity leave in 2008, which was unprecedented, she added. Furthermore, she emphasized that women parliamentarians should build networks and use their female powers of persuasion to engage men in the efforts to improve maternal health.

Ms Verbeet said that MDG 5 would not be achieved by talking. “But if talking leads to empowerment and a new impetus to make women a priority in government, we can make a serious contribution to meeting the target.” She called on all participants to share their experiences on the most effective ways of influencing their governments to increase budgetary allocations for maternal health.

WHO

Ms Daisy Mafubelu
Assistant Director-General, Family and Community Health

Ms Daisy Mafubelu, Assistant Director-General of WHO’s Family and Community Health Cluster, called on the parliamentarians to beat the drum for maternal health in their home countries – in times of financial crisis more than ever. She hoped that the meeting would build on the momentum of the Meeting of women parliamentarians in London and other recent events.

Ms Mafubelu said that unless drastic steps were taken, the future of mothers and babies in developing countries would
remain bleak. Of all the MDGs, MDG 5 was least likely to be met, although there was strong international consensus about what needed to be done. “We know that skilled care before, during and after childbirth, access to emergency obstetric care and access to family planning can save women’s and newborns’ lives,” she said. She also stressed the importance of gender equality (MDG 3) in empowering women to make their own health-care decisions.

**To be the voice of the voiceless**
Parliamentarians had the power to significantly contribute to achieving these goals, Ms Mafubelu reiterated. They could oversee the government’s accountability for implementing policies and advocate for maternal health. “Be the voice of the voiceless,” she urged participants. Parliamentarians could also increase the health budget and use their legislative powers to remove barriers and facilitate women and children’s access to essential care, to pass legislation that supports and empowers women to make their own health care decisions. Ms Mafubelu encouraged participants to ratify international conventions like the Maternity Protection Convention and to support laws against child marriage. “With the right strategies and policies and appropriate investment, maternal and newborn mortality can be reduced.”

In the face of the global financial crisis, Ms Mafubelu reiterated WHO Director-General Dr Margaret Chan’s request that the world should not repeat the mistakes of the past. Social spending in health and education should not be cut but increased. She outlined that investing in these areas meant investing in human capital, which is the foundation of economic productivity and a prerequisite for economic recovery. In conclusion, Ms Mafubelu wished the participants a productive meeting, on behalf also of the WHO Director-General.

**IPU**

**Mr Anders B. Johnsson**  
Secretary General

Mr Anders B. Johnsson, Secretary General of the Inter-Parliamentary Union (IPU), called on the parliamentarians to be persistent in promoting women’s right to safe motherhood. He stated that both MDG 4 and MDG 5 were far from being achieved, though still achievable. “There is absolutely no valid reason why every woman and child cannot receive the attention they require,” he said. Every woman should be educated about her rights, be aware of her health needs and have access to care before, during and after pregnancy.

**Promoting gender equality**

“Sustainable change will require a collective response,” Mr Johnsson said. He stressed the need for a holistic approach to reducing maternal mortality, including the promotion of gender equality and the strengthening of health systems. Parliamentarians could make sure that maternal health remained high on the political agenda. “You can raise questions in parliament and speak out publicly. You can set targets, develop national action plans and hold your governments accountable for them.”

He encouraged parliamentarians to review legislation in order to eliminate gender discrimination. “You should take a close look at the school curriculum to make sure that education is supportive of gender equality and women’s rights,” he said. Mr Johnsson also urged the audience to promote the development of gender-sensitive national budgets and to allocate funds for women’s access to reproductive health-care.
services. Addressing the representatives of donor countries, Mr. Jonsson stressed how important it was for any planning efforts that their aid was predictable and sustainable. He called on participants to commit themselves to the improvement of maternal health: “The only thing we need is to demonstrate political courage, show political will, and lead the way.”

Maternal and newborn health

WHO

Dr Monir Islam

Director, Department of Making Pregnancy Safer

Dr Monir Islam, Director of WHO’s Department of Making Pregnancy Safer, presented strategies for improving maternal and newborn health and provided data on regional and socioeconomic disparities in access to birth care. He stressed that achieving MDGs 4 and 5 was not about technology but about access, coverage and quality. He described the three-pronged strategy for reducing maternal and newborn mortality: (1) skilled care before, during and after childbirth, (2) access to emergency obstetric care and newborn care, and (3) access to family planning.

Dr Islam provided data proving a strong link between a high ratio of deliveries assisted by skilled attendants and a low maternal mortality ratio. He reported that Thailand had been able to reduce maternal mortality by three quarters between 1960 and 1980 through an increased number of midwives. In the 1980s further progress had been made by enhancing the capacity of community hospitals.

Gaps between rich and poor

Data collected by the Demographic and Health Surveys (DHS) between 2001 and 2007 showed big disparities in access to maternal health care. The percentage of childbirths assisted by skilled personnel was lowest in sub-Saharan Africa (42%) and South/South-East Asia (44%). But there were also gaps within countries, between rural and urban areas, and between poor and rich populations. In some countries the coverage in rural areas was only half as high as in urban areas (e.g. Bolivia, Ghana) or even less (e.g. Bangladesh, Chad, Haiti). In Nigeria for example, the percentage of deliveries assisted by skilled health staff was more than 80% for the richest and less than 20% for the poorest quintile of the population. The available data also showed significant differences in coverage within cities between the poor living in slums and the members of the upper class.

The percentage of caesarean sections was used to assess access to emergency obstetric care. These figures also showed differences between rural and urban areas. In Mozambique for example, the percentage was 5% in urban areas, but less than 1% in rural areas. In the urban areas of Bolivia, more than 20% of births were delivered by caesarean section, indicating a trend towards overmedicalization. Dr Islam showed different maps reflecting the disparities within a country. In India for example, emergency obstetric care coverage was highest in the southern states and lowest in the north.

Model of the three delays

Dr Islam underlined the necessity to overcome the three main delays in accessing health services. First, there is often a delay in a pregnant woman’s decision to seek care. Secondly, she may have difficulties reaching a health facility and thirdly, the health facilities frequently lack supplies and health staff, which causes another delay.
He stressed that it was important to investigate at local level why women did not use the services available at facilities. They may lack transportation or money to pay for the care, or were perhaps concerned about the quality of the care. Cultural reasons also needed to be considered. Women may have to ask their husbands for permission. They may not want to go alone or to be treated by male staff. If costs were the main obstacle, a health insurance scheme could be an effective means of increasing access to skilled care and reducing maternal and newborn mortality. As an example of a successful strategy for reducing maternal and newborn mortality, Dr Islam cited a public-private partnership in the Indian State of Gujarat. In the Chiranjeevi scheme, the government paid private obstetricians to provide care to poor pregnant women before, during and after childbirth.

Dr Islam called on the parliamentarians to allocate resources to ensure that mothers and babies received the care they need. “Each and every woman deserves the best,” he said. “There should no longer be poor options for poor people.”

Country reports

Indonesia

Ms Tuti Indarsih Loekman Soetrisno  
Member of Parliament

Ms Tuti Indarsih Loekman Soetrisno informed her fellow politicians about the action taken by the Indonesian Parliament to achieve the health-related MDGs. According to national statistics there were 266 maternal deaths per 100,000 live births – the highest ratio in the Association of Southeast Asian Nations. Almost four in 100 children died before the age of one year; diseases like tuberculosis, malaria and HIV/AIDS were among the main health problems in her home country.

Ms Loekman Soetrisno said that the Indonesian Parliament was using its powers in legislation, oversight and budgeting to tackle these problems. The work of the Health Commission was based on the national constitution of 1945 and international commitments. She reported that the Parliament had amended laws to protect the rights of women and youth to reproductive health. The Ministry of Health had implemented programmes to train doctors and midwives and to increase community participation. In order to save the lives of infants, programmes on breastfeeding and immunization had been launched.

Call to increase the health budget

To ensure the funding of such programmes parliamentarians were urging the Government to increase the health budget from 2.6% to more than 5% of the national budget, Ms Loekman Soetrisno said. They had also advocated allocating 15% of the health budget to maternal and child health. To ensure access to health services for all, they had suggested an improvement for the national health insurance scheme to the Government.

Ms Loekman Soetrisno reported that the Indonesian Forum of Parliamentarians on Population and Development was engaged in advocacy programmes for parliamentarians at provincial and district levels. As a bottom line, she emphasized the importance of working closely together on maternal and child health.
Parliamentarians take action for maternal and newborn health

Finland
Ms Minna Sirnö
Member of Parliament

Ms Minna Sirnö from Finland told participants about her country’s long journey to reduce maternal mortality to almost zero. Today, there were between zero and six cases of maternal death per year. It was such a rare event that the media reported on it.

However, in the 18th century there were no trained midwives in Finland and one in 100 women died giving birth. It was only at the beginning of the 19th century that the political will to improve the situation and to have a trained midwife in every village had developed, Ms Sirnö said. The economy had not yet started to grow but the maternal mortality ratio was already declining, mainly due to a law that obliged municipalities to fund the services for poor mothers.

The first maternities were established in 1920, often by nongovernmental organizations. The maternity-assistance law was enacted before the Second World War. Mothers were given a maternity pack that consisted of a box with clothes and other equipment for the child, and they sometimes also received financial support. The pack was meant as an incentive for pregnant women to come to a clinic for a medical check-up and is still provided today. In 1944 a law on municipal maternal and child clinics was enacted as well as a law on municipal midwives and nurses. After the war, the central hospital network was established including five university hospitals that developed expertise in obstetrics.

Sex education in schools
There had also been progress on sex education. In the 1960s sex education was provided by organizations like the Lutheran Church. It was not included in the school curriculum until 1976. Ms Sirnö said that today a wide range of contraceptives were easily available for young people. In 1970 the Finnish abortion law was liberalized. The amendment had been followed by a decrease in the abortion rate, the Member of Parliament said. She added that the role of men in child care had been increasingly acknowledged in recent decades.

Ms Sirnö stated that sexual and reproductive health played an important role in Finland’s development cooperation. “Sex is not a sexy thing to talk about in parliament, but mothers are worth it,” she said. She affirmed that her country wanted to support other countries so that they could reach low levels of maternal mortality more quickly and achieve MDG 5.

Rwanda
Ms Spé ciose Mukandutiye
Member of Parliament

The representative from Rwanda, Ms Spé ciose Mukandutiye, presented national policies aimed at improving the performance of the health system and fighting gender discrimination. According to DHS data there were 750 maternal deaths per 100 000 live births in 2005 compared to 1070 in 2000. The health system’s infrastructure had been destroyed during the 1994 genocide, Ms Mukandutiye explained. Despite economic growth almost three in five people were living below the poverty threshold in 2005.

Ms Mukandutiye said that health was a key factor in national policy frameworks such as Vision 2020. The Parliament had
enacted a law on a mutual health insurance scheme to increase access to health services and by 2007, the scheme covered three quarters of the population. Citizens had to pay 1000 Rwandan francs (around US$ 2) annually for health care and an additional 100 Rwandan francs for any service provided in a health facility.

Also to improve the quality and coverage of health services, Rwanda had introduced performance-based funding in 2006. Eight of the 14 performance indicators were related to maternal health. The measures had resulted in increased participation in family planning programmes, more deliveries at facilities and more referrals to emergency obstetric care. Ms Mukandutiye highlighted that traditional birth attendants were involved as community health agents. They counselled pregnant women and were paid for referring them to health facilities.

**Ensuring gender equality**

The Member of Parliament also stressed the importance of gender policies. The 2003 constitution prohibited any form of gender discrimination. In Rwanda at least 30% of the posts in decision-making bodies had to be held by women. In the Lower House 56% of the members were women. The 30% threshold had also been met in the Supreme Court, the Senate, the Cabinet and among the provincial governors. To ensure gender equality, the Parliament had reviewed laws on issues like inheritance, access to land and children’s nationality. It had also enacted a law against gender-based violence.

Ms Mukandutiye emphasized the need for political commitment. To make a difference in maternal health a national institutional framework was as important as the involvement of local authorities. She concluded that parliamentarians should not only use their powers of legislation and oversight, but also visit people in order to mobilize them and follow up on initiatives.

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**Dutch commitment to MDG 5**

**The Netherlands**

**Mr Bert Koenders**

*Minister for Development Cooperation*

In a video message, the Dutch Minister for Development Cooperation Bert Koenders welcomed the parliamentarians to The Hague and encouraged the guests to push MDG 5 to the top of the agenda in their parliaments.

Minister Koenders affirmed that MDG 5 was one of his political priorities. He stated that there had been hardly any progress on improving maternal health in the past 20 years. However, countries like Chile, Honduras and Sri Lanka had shown that maternal mortality could be reduced significantly within 10 to 15 years if there was the political will to invest in women’s health. These investments not only benefited the women themselves but also their families, their communities and their countries.

**Stressing the economic impact**

In times of financial crisis the economic dimension of MDG 5 had to be emphasized, the Minister said. “To put it crudely: maternal mortality is bad for the economy.” He said that maternal deaths cost the world US$ 15 billion a year in lost productivity. He added that economic growth was often wiped out by high population growth. Hence, the Minister called for investment in family planning. He referred to studies showing that many women in developing countries would opt for family planning if it was available to them. A recent World
Bank publication had revealed that maternal mortality would decrease by 25 to 35% if the unmet need for contraception was fulfilled.

The Minister acknowledged that MDG 5 was a sensitive issue for many governments and parliaments as it was related to sexual and reproductive health. “It is up to us to break the silence,” he emphasized and added that the Netherlands had allocated €5 million for the production and distribution of female condoms in developing countries. Furthermore, the Minister reported that he had increased the aid for the UN Global Programme on Reproductive Health Commodity Security from €5 to €30 million per year.

Minister Koenders promised to continue to raise the issue of maternal health in his work, particularly when travelling abroad. He announced that he was organizing a one-day international high-level meeting on MDG 5 before the IPCI/ICPD meeting in Cairo in October 2009. He encouraged participants to promote the achievement of MDG 5 in their home countries through legislation, budget allocation and their powers of oversight.

The Netherlands
Ms Stella Ronner-Grubacic
Ambassador for the Millennium Development Goals

Ms Stella Ronner-Grubacic, the Dutch Ambassador for the Millennium Development Goals, addressed the participants during lunch. She was happy to welcome so many women and men whose work was vital to achieving the MDGs, she said.

As Ambassador for the Millennium Development Goals, she had often been appalled by reports on maternal mortality and morbidity. Not long ago, a woman from Afghanistan had told her that a woman’s risk of dying in pregnancy or childbirth was one in six in her country. “This figure is beyond imagination – at least mine,” she said. She pointed out that her biggest challenge was to ensure that such stories were not only heard but also translated into action at diplomatic gatherings and international meetings.

Need to hold governments accountable
Ms Ronner-Grubacic acknowledged the support of the UN agencies in this work. She highlighted the initiative of WHO, UNFPA, UNICEF and the World Bank to harmonize their approaches towards improving maternal and newborn health in countries and was happy to see all four organizations represented in The Hague. The ambassador also recognized that the UN had raised MDG 5 to the top of the agenda at the New York meeting in September 2008. She said that this was an important initiative to remind political leaders of their commitments and responsibilities in both developed and developing countries.

Addressing the parliamentarians she said that governments needed to be held accountable. “And this is where you come in. You are the ones who are best placed to do this.” If the conference could help participants with this important job, it could be called a great success.

The Netherlands
Her Royal Highness Princess Máxima

Her Royal Highness Princess Máxima of the Netherlands came to the venue in the Dutch Parliament to get more information on the conference and show her support for the action.
needed to improve maternal and newborn health. Ms Chantal Gill’ard welcomed the Princess and recognized her interest in the health of mothers worldwide. Her Royal Highness took the opportunity to talk to some of the parliamentarians from around the world and to representatives of local and international NGOs.

**Meshwork for Mother Care**
Ms Anne-Marie Voorhoeve and Mr Peter Merry from the Dutch Center for Human Emergence reported on the cross-sector initiative *Meshwork for Mother Care* in the Netherlands and its principles of collaboration. Both speakers stressed that progress on MDG 5 was not a technical problem but a question of mobilizing people to implement well-known solutions. The challenge was to bring people together and make them collaborate in order to achieve the goal.

**Call on national TV**
Ms Voorhoeve described how the *Meshwork for Mother Care* had been launched in February 2007 when Chantal Gill’ard MP made a call for coordinated action on MDG 5 on Dutch television. A few organizations responded to her call and on 12 May the first *Mother’s Night* was jointly organized to raise further awareness. Ms Gill’ard followed this up with a meeting to which nongovernmental organizations, companies and research institutes with an interest in MDG 5 were invited. The participants discussed new and special efforts aimed at contributing to the achievement of MDG 5 and signed a pact known as the *Schokland Agreement*. The group then developed a set of projects to be presented to the Dutch Minister for Development Cooperation and agreed to keep in touch and learn from one another.

**Heat-stable drug to stop bleeding**
Ms Voorhoeve described the group’s initial projects, which included the promotion of an annual *Mother’s Night*, and a TV project. Sub-groups started to contribute to the fight against maternal mortality in Afghanistan and Sierra Leone and another group aimed to develop heat-stable oxytocin, a drug to stop bleeding after childbirth.

Ms Voorhoeve said that by working together, members of parliament and different kinds of organizations had been able to come up with new plans for safe motherhood and that this partnership had been initiated by the Parliament. She also highlighted the support received from eight political parties. “The lesson we all learnt is: we need to work together,” Ms Voorhoeve said. “No one can do it alone.”

**A common goal despite different priorities**
Mr Peter Merry explained how the partners had managed to work together despite their diversity and stressed the importance of articulating the different priorities of the group members while also identifying a higher goal as the common interest of all partners. Whenever conflicts arose, the group aimed for complementary solutions rather than for compromise. For their work on MDG 5, the group assumed that everything they needed was already there. “For the project on heat-stable oxytocin for example, we assume that the solution is available,” Mr Merry said. “We do not need millions of dollars to develop something totally new.” In order to advance, it was crucial to identify the existing resources, he underlined, and it was important to honour the unique contribution of each stakeholder.

Both representatives from the Center for Human Emergence hoped that the example of the *Meshwork for Mother Care* could inspire participants to launch similar networks in their home countries.
Discussion and debate

Cambodia

Ms Naun Ho
Member of the National Assembly

Ms Naun Ho from Cambodia reported that her Government was developing a plan to improve maternal and child health, especially in rural areas. However, the expertise was limited. She asked whether WHO could support her country.

Dr Paul van Look, Director of the WHO Department of Reproductive Health and Research, responded by giving an overview of WHO’s three main functions apart from advocacy. First, WHO provides technical support to countries to define the best programmes in a given context. Secondly, the Organization helps develop norms and guidelines based on the best available evidence. Thirdly, it conducts research in implementing best practices and in the field of monitoring and evaluation.

His colleague Dr Elizabeth Mason, Director of the WHO Department of Child and Adolescent Health and Development, recommended reading "The World Health Report 2008: Primary Health Care – Now More Than Ever". She said that the publication dealt with the question of how to organize health care from people’s homes to the different levels of the health system. For maternal health it was crucial that pregnant women were able to first recognize their need for care and then reach the services quickly. Health care needed to be available at community level to avoid life-threatening delays.

Kenya

Dr Josephine Kibaru
Head, Department of Family Health, Ministry of Public Health and Sanitation

Dr Josephine Kibaru from Kenya said that her country aimed to improve maternal health through strengthening the referral system and increasing human resources. The Head of the Department of Family Health in the Ministry of Public Health and Sanitation said that maternal mortality was very high in Kenya with 414 maternal deaths per 100,000 live births, according to the Demographic and Health Surveys (DHS).

Dr Kibaru said that strengthening the referral system was a priority. She reported that nurses in primary health-care centres were often not confident about assisting in childbirth. Hence, women either gave birth in district hospitals or at home. The Government intended to improve the situation by introducing district ambulances and establishing effective communication systems that allowed rapid referral to higher-level facilities in the event of obstetric complications. She added that Kenya was also implementing a new strategy at community level. Community health workers who lived in villages were trained to recognize danger signs and ensure referrals to health facilities.

Dr Kibaru emphasized that Kenya had a unique human resource problem. The country had trained many midwives but could not employ all of them due to lack of funds. The skilled staff therefore migrated to other African countries. In order to solve this problem, members of Parliament were advocating for a larger health budget.

Nigeria
Ms Iyabo Obasanjo-Bello
Senator

Ms Iyabo Obasanjo-Bello from Nigeria presented new policies on the financing of health care in her country. She also described the problems associated with the focus on HIV/AIDS in recent years. Ms Obasanjo-Bello reported that Nigeria was using money from debt relief to fund MDGs 4 and 5. She said that her country was focusing on primary health care. Two years ago, a pilot programme had been introduced in six states based on a national health insurance scheme. The scheme covered the cost of delivery for all women. The Senate had also passed a national health bill intended to cover basic primary health-care services like malaria treatment.

Ms Obasanjo-Bello stated that Nigeria needed to improve its health system in general. It was a problem for her country that externally funded HIV services were generally not integrated. She called on donors to fund the strengthening of the health system as a whole and then make HIV services part of it. She argued that these services could not be separated from health in general, and in particular not from women’s health.

South Africa
Ms Refilwe Mashigo
Member of Parliament

Ms Refilwe Mashigo told the audience that South Africa’s efforts to improve its health system were focusing on primary health care and that parliamentarians kept in close touch with the communities. Ms Mashigo reported that her country had developed strategies to strengthen primary health care at a local level. They had for example expanded immunization programmes to enable districts to manage an outbreak of an infectious disease. Any member of the community could contact parliamentarians by phone to report an outbreak so that they could inform the ministries. She proudly reported that South Africa had been declared malaria-free in 2006 following effective community involvement. She stressed the importance of mobilizing patients to use the community health centres.

The parliamentarians were well informed about the needs in the communities as they had offices in their constituencies.
Parliamentarians take action for maternal and newborn health

There was also an initiative called “parliament to the people”. Once a year, the whole Parliament spent a week in one province to monitor the work of the local health and education institutions. The Member of Parliament was confident that the activities at local level would help to bring about change.

Thailand
Dr Porapan Punyaratabandhu
Member of the National Assembly

Dr Porapan Punyaratabandhu from Thailand told the audience about the multisectoral approach her country had taken to reduce maternal and newborn mortality and about a more recent policy promoting universal coverage. Dr Punyaratabandhu reported that Thailand had improved maternal and newborn survival through national development programmes intended to offer a better quality of life. The country had not only invested in general health, but also in environmental health, roads, buildings, and communication systems. She stressed that these changes had been achieved when Thailand was still a poor country.

More recently, in 2001, the Government had adopted a national policy on universal coverage of health care providing free care for everyone, Dr Punyaratabandhu said. The reform also aimed to establish health-care facilities at all levels, including university, provincial and district hospitals. In the villages, pregnant women could go to health offices and were referred from there if there were complications. In the high-risk mountainous areas, a system of radio communication ensured that experts could be consulted and a safe referral organized.

Tunisia
Mr Mohamed Elies Ben Marzouk
Member of the Chamber of Councillors

Mr Mohamed Elies Ben Marzouk from Tunisia wanted to translate debate into action and asked what the parliamentarians could do as a first step upon their return home.

Ms Chantal Gill’ard answered this question by describing the initial steps she had taken to build the Meshwork for Mother Care. She said that she had decided to commit herself to MDG 5 because she had realized that this goal would not be reached without extra effort. While seeking to make a valuable contribution, she had learnt that 125 000 maternal deaths a year could be prevented if severe bleeding after childbirth were treated effectively. As a biotechnologist, she believed that it would be possible to make the first-line drug oxytocin heat stable so that its usage would no longer depend on the availability of refrigerators and electricity. She had finally called on pharmaceutical companies in a one-minute spot on national television. The initial feedback from the industry had been positive, but there were also some organizations that supported her idea. Ms Gill’ard reported that she had invited the organizations to a public meeting and asked them to commit themselves to this cause. The discussions had ultimately led to the development of a cross-sector collaboration that supported not only the development of heat-stable oxytocin but also other projects.
Women Parliamentarians take action for maternal and newborn health

Viet Nam
Dr Vo Thi De
Member of the National Assembly

The representative from Viet Nam, Dr Vo Thi De, asked how she could get exact data on maternal and newborn mortality for her country.

Dr Monir Islam, Director of the WHO Department of Making Pregnancy Safer, thanked her for bringing up this important, though often neglected, issue. “Only what gets counted gets done,” he quoted WHO Director-General Dr Margaret Chan. Unfortunately, the data on pregnancies, maternal deaths, newborn deaths and stillbirths were incomplete. Therefore, global estimates had been generated based on various indicators and models. He encouraged participants to invest in monitoring. He added that support was available from HRP, a special UN programme of research, development and research training in human reproduction.

Ms Sietske Steneker, UNFPA Director in Brussels, encouraged countries to use the data from the Demographic and Health Surveys (DHS). Her colleague Dr Renee van de Weerdt from UNICEF added that her organization had committed itself to conducting multiple indicator cluster surveys (MICS) to complete the available information on maternal health.

White Ribbon Alliance for Safe Motherhood
Ms Kathy Herschderfer
Board of Directors

The chair of the conference, Ms Chantal Gill’ard, asked Ms Kathy Herschderfer representing the White Ribbon Alliance about her experience of working with parliamentarians. She reported that Ms Herschderfer had helped her in 2007 to send Mother’s Day cards to all members of the Parliament, ministers and missions in the Netherlands. “How do you support parliamentarians to achieve MDG 5?” Ms Gill’ard wanted to know.

Ms Herschderfer emphasized that it was important to communicate what was needed and to mobilize people at different levels. She had been working in advocacy not only for the White Ribbon Alliance but also for the International Confederation of Midwives. Her advocacy work in the Netherlands had shown the need to work together, putting an emphasis on cooperation between politicians and civil society. She encouraged parliamentarians to monitor government action, for example through parliamentary enquiries. She said that she aimed to mobilize parliamentarians to use their powers to control whether the budget was being allocated in the agreed way and whether it was used effectively.

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5 Link: http://www.who.int/reproductive-health/hrp/about.html
6 Link: http://www.unicef.org/statistics/index_24302.html
Day two

Site visits

The second day of the conference started with field trips to Dutch institutions involved in issues of health and finance. Small groups of participants visited the Midwifery Academy Amsterdam and Groningen (see below), the local department of public health of the Municipality and the birth centre “Wereldwonder” (see p. 23). The Netherlands Court of Audit presented its work (see p. 23) and the Rabobank Foundation provided information on its grants scheme for women in rural areas of developing countries (see p. 24). Other participants learnt about Waternet’s management of drinking water in the Amsterdam area (see p. 24).

Midwifery Academy Amsterdam and Groningen

Midwifery in the Netherlands and abroad

At the Midwifery Academy Amsterdam and Groningen, a group of parliamentarians was welcomed by managing director Dr Lucienne A.J.M. van Laar and teacher Ms Anita van der Lei. They were joined by Ms Franka Cadée from the Royal Dutch Association of Midwives (KNOV) and Ms Nester T. Moyo from the International Confederation of Midwives (ICM). The four speakers gave an overview of midwifery training in the Netherlands, their efforts to achieve MDG 5 and the need for midwifery care in developing countries.

Dr van Laar told the audience that midwifery training had begun in the Netherlands in the 17th century. The first training courses were offered in 1668 under the supervision of the Collegium Medicum. The 1865 act governing medical practice established midwifery as a separate discipline. The independence the midwives had gained through this act was still relatively unique in Europe. In the Netherlands, midwives acted as autonomous case managers. Pregnant women could contact them directly and were only referred to doctors if there were complications. Specially trained midwives were also involved in clinical care.

Learning from case studies

The educational programme for midwives was laid down in law, Dr van Laar said. Since 1993, it had consisted of a four-year training programme, which was integrated into the Bachelor-Master-System in 2007. Ms van der Lei explained that training was both competency- and problem-based. Students were trained in anatomy, embryology and gynaecology for example. They also learnt from case studies in daily midwifery practice. The teacher stressed the importance of excellent communication skills so as to be able to deal with women in a sensitive way. In future, Dutch midwifery training should be elevated to academic levels to strengthen its independence and the research in this field, she added.
The Midwifery Academy had joined the Schokland Agreement to better contribute to the achievement of MDG 5, Dr van Laar said. It offered training-of-trainers courses in midwifery care for developing countries and maintained exchange programmes. Ms Cadée added that KNOV was a member of the Meshwork for Mother Care. They supported the awareness-raising event Mother’s Night and had an exchange programme with midwives in Sierra Leone. Ms Cadée stressed that this exchange was mutually advisory and not a one-way lecture.

Legal recognition needed
Ms Moyo from ICM stressed the need to strengthen midwifery care in developing countries. She said that there was a huge gap in so-called “remote areas”. However, this gap resulted from a lack of infrastructure, which needed to be tackled by governments. Intensive training was needed to increase the number of skilled midwives. However, as it was not possible to train a sufficient number of midwives in the short term, ICM suggested having at least one midwife for every 10 to 15 local health workers to supervise the care. Ms Moyo also stressed that countries needed to strengthen midwifery through legal recognition. The other speakers joined her in encouraging guests to support midwifery in their home countries.

The Hague Municipality and Birth Center
Midwives play a crucial role for safe pregnancy in the Netherlands
Parliamentarians from Finland, Haiti, Nepal, Sudan, Thailand, the United Kingdom and staff from the World Health Organization were warmly welcomed to the new City Hall of The Hague, designed by renowned architect Richard Meier and inaugurated in 1995.

The presentation started with an overview of the city’s public health programmes related to maternal health and pregnancy and was followed by a guided tour of the building. In the Netherlands, women can choose to give birth at home. They are monitored by a midwife from the first weeks of their pregnancy and if there are any complications, the midwife can refer the woman to a hospital within 12 minutes.

Visit to birth center
The important role of midwives for pregnant women in the Netherlands became even more apparent during the group’s visit to the MCH Birth Center which had opened in May 2007. The Birth Center is located close to the largest hospital in town. The midwives, nurses and breastfeeding councillors at the Center are independent of the hospital. If any complications arise, they refer the women to their colleagues at the hospital with whom they work closely together. The Center has a variety of pleasant rooms for the women as well as for their partners and families.

Parliamentarians were invited to share experiences from their respective countries over a light lunch.

The Netherlands Court of Audit
Checking development and emergency aid
Parliamentarians from the Republic of Korea and Tunisia were warmly welcomed to the Netherlands Court of Audit. The High Council of State was created around 200 years ago and its role is to audit and improve the efficiency, effectiveness and
integrity with which the State and associated bodies operate. It also audits the Netherlands’ compliance with its obligations under international agreements. The results are passed on to the Government, the Parliament and those responsible for the audited bodies, and are also available to the public. The Court operates independently from the executive and legislative bodies and decides on its own what and how it will audit, and whether the results will be published.

The Court presented details of two projects that involved auditing expenditure on development and emergency aid. One project reviewed a clean drinking water programme that had been launched in seven developing countries with bilateral, multilateral and nongovernmental aid between May 2006 and August 2007. This investment in sanitation had resulted in an improvement of maternal and newborn health in those countries.

Audit trail of foreign aid
The international Tsunami Initiative INTOSAI was launched in November 2005 to audit tsunami-related aid one year after the disaster had hit South-East Asia. The Netherlands Court of Audit helped trace the flow of donations to the tsunami-affected regions. It carried out a pilot study, developed guidelines and collected examples of best practice. The initiative aimed to make audit trails a standard element of foreign aid in order to support efficient and effective aid planning and implementation.

During the discussion, parliamentarians shared their experiences of working with courts of audit in their home countries, and expressed interest in further collaboration between their national institutions and the Netherlands Court of Audit.

Rabobank Foundation
Providing grants for small enterprises in rural areas
One group of parliamentarians visited the Rabobank Foundation in The Hague. Rabobank’s origins lie in agriculture, since it began life at the end of the 19th century as a collection of small rural banks.

The Rabobank Foundation was established in 1973 as an independent foundation, funded in part by the net profits of local Rabobanks. The aim of the institution is to provide grants, local currency financing and technical assistance to small, rural microfinance institutions. The Rabobank Foundation’s reach significantly increased in 2007 when it was transformed into a fund for the entire Rabobank Group, which includes the bank’s subsidiaries and affiliated institutions.

The Rabobank Foundation is committed to improving the lives of underprivileged and disadvantaged groups in society by providing them with the opportunity to live full and independent lives in the Netherlands and in developing countries. The Foundation’s activities focus mainly on the development of small cooperatives in rural regions and include grants, loans, trade financing and technical assistance. In line with Rabobank’s own cooperative background, the Rabobank Foundation aims in particular to establish and promote cooperative savings and loan systems.

In Bangladesh, for example, the Foundation is cooperating with local and Dutch nongovernmental organizations to start new microcredit units in rural areas. In Tanzania, the Foundation helps rural families set up cooperatives to produce, package and sell milk in a more effective way.

The Rabobank Foundation supports an average of 150 projects a year. Approximately 50 of these projects are carried out in the Netherlands and the other 100 are conducted in developing countries. In 2007, local member Rabobanks and Rabobank Nederland contributed no less than €7 million to the work
of the Rabobank Foundation. In addition, since substantial amounts flow back into the fund via the loan portfolio, the Rabobank Foundation had a total budget of nearly €18 million in 2007.

**WaterNet**

**Safe drinking water**

A dozen parliamentarians received first-hand information on WaterNet, the first company in the Netherlands to manage the complete water cycle including drinking water, waste water, surface water and groundwater. WaterNet was launched in 2006 and claims that the integrated water management by a single company will save €8 million annually. One of the company’s most important goals is to provide safe drinking water at a low cost and in a sustainable way. In the Amsterdam area, the company purifies the drinking water for over 900,000 people.

**Protected water reservoirs**

The visitors were informed that the company’s engineers and researchers had to continuously adapt to new challenges, such as the residues of new chemicals used in agriculture. On a short boat ride, parliamentarians from Angola, Mozambique, Nicaragua, Spain and Tunisia learnt that the water reservoirs were protected by the European Union Habitats Directive. In this area, human settlements, recreation activities and so forth were prohibited in order to provide a habitat for various species of plants and animals.

The participants agreed that it was necessary to protect water supplies and to maintain clean water as a public resource that should not be traded or exclusively benefit selected parts of society. In the Netherlands, water management is a public task and the Government makes sure that prices are kept low. This seems to be even more important as clean drinking water is becoming an increasingly scarce resource that could trigger conflicts in some countries and regions.

**Country reports**

**Uganda**

Ms Sylvia Namabidde Sinabulya

*Member of Parliament*

The representative from Uganda, Ms Sylvia Namabidde Sinabulya, reported on a network of women parliamentarians that had been created to address maternal health issues in her country. According to DHS data, Uganda faces 435 maternal deaths per 100,000 live births, adding up to 6000 maternal deaths a year. “These numbers are unacceptably high,” said this mother of three teenagers. In Uganda, only 42% of deliveries were assisted by skilled health workers. Ms Sinabulya characterized the Ugandan health system and the referral system in particular as weak.
Ms Sinabulya said that the lack of national commitment to maternal health resulted in inadequate financial support. She reported that she had initiated the network of women parliamentarians after the WHO meeting of parliamentarians in London in 2007. In autumn 2008 it had brought together 45 women parliamentarians, including three ministers and the deputy speaker. “We all feel a moral responsibility to make a change,” she said. The network advocated prioritizing women’s health and allocating resources to reproductive health. One of their first activities had been the introduction of a resolution demanding more government commitment to reducing maternal mortality, Ms Sinabulya explained. Their demand for a master plan had pushed the development of the national roadmap. Financing, however, was still a major challenge.

Mobilizing political will
The network had agreed on a strategic plan to enhance its institutional development as a forum for reproductive health, Ms Sinabulya said. The network’s activities included training women members for advocacy, organizing breakfast meetings with parliamentarians and ministers and involving local government leaders. They were also building partnerships with other stakeholders, such as obstetricians and gynaecologists for information sharing, and women lawyers for analysing existing laws. They were looking for donors and working closely with the media. The members also visited health facilities in their constituencies and launched community-awareness programmes.

Ms Sinabulya emphasized the parliamentarians’ responsibility to mobilize political will. She stressed the need to identify champions for maternal health at all administrative levels. She called on her colleagues: “Stand up and fight. We can make a change in our countries, if we try.”

Sweden
Ms Kerstin Engle
Member of Parliament

Ms Kerstin Engle from Sweden gave a historical overview of maternal health in her home country and explained the scope and focus of Swedish development aid. In Sweden very few women died during childbirth. Only three cases were reported to WHO in 2005.

In the late 19th century, laws were enacted in Sweden to provide access to skilled midwives in all villages and towns of the country. In 1933, at a time when contraceptives were illegal in Sweden, a nongovernmental organization for sex education was founded, which is still operating today. Priests had already started to register births and deaths in the early 18th century and data could be traced back to 1720.

Sweden also had a long history of counselling mothers on breastfeeding and sanitary issues for example, Ms Engle explained. Many years ago, a maternal health programme had been set up that was free of charge for all pregnant women. Women saw a midwife early in their pregnancy. They received information on food, smoking and alcohol, medical examinations and child care. The service also involved the fathers. But Sweden was also facing challenges, Ms Engle admitted, as some mothers did not take part in the programmes, especially immigrants and women who were poor or who had little education.

1% of GNP for development aid
Sweden’s experience had shown that change was possible, Ms Engle emphasized. Within 200 years the country had developed from one of the poorest nations in Europe to
one of the richest in the world. Today, her country allocated 1% of its GNP to development aid, amounting to 32 billion Swedish kronor (around US$ 4 billion) in 2009. The Member of Parliament regretted that not all European Union (EU) countries had fulfilled their pledge to give 0.7% of their GNP. She was also disappointed that the EU had failed to speak with one voice in the UN when questions on family planning, maternal health and abortion had been raised. She added that Sweden would give another 100 million Swedish kronor (around US$ 12 million) for sexual and reproductive health in 2009.

“We have the resources and the knowledge,” Ms Engle said. “Better health for all is just a question of priority.” She cited WHO estimates that an essential basket of health services, including emergency obstetric care, costs approximately US$ 35 per capita in low-income countries. Ms Engle stressed the need to involve men, as they owned most of the resources worldwide. She called on her colleagues not to give up the fight for women’s right to reproductive health.

Discussion and debate

Cambodia
Ms Pum Sichan
Senator

Ms Pum Sichan from Cambodia wanted to know why women in the Netherlands often gave birth at home. In her country, women were advised to deliver in hospital, she said. Dr Monir Islam, Director of the WHO Department of Making Pregnancy Safer, highlighted the differences in the health systems of developing and developed countries. He explained that Dutch women could give birth at home because there was an effective system for referring them to hospitals if there were complications. In Cambodia, however, women were advised to deliver in hospitals because they could not be referred in good time from remote areas to health facilities if problems arose. Therefore, women could only opt for a home delivery without increasing their risk of maternal death if an effective referral system was in place.

Haiti
Ms Edmonde Supplice Beauzile
Member of Parliament

Ms Edmonde Supplice Beauzile from Haiti gave her fellow parliamentarians an insight into her work. She said that she had worked for UNICEF before becoming a Member of Parliament. However, she had learnt that she had to change her way of working. Parliament should and must not be a substitute for civil society, but should counter-balance the executive, she stressed. She reported that the Haitian Parliament used its powers of oversight very effectively. Ministers had to present their budget plans, outline their goals and strategies, and report on progress every three months. Currently, the Parliament was monitoring a programme on maternal health that was designed to offer free health care to all pregnant women. If Ministers failed to achieve their goals, the Parliament had the power to discharge them.

Ms Supplice Beauzile highlighted that the Parliament did indeed make use of this measure as it had already dismissed an entire government.
Parliamentarians take action for maternal and newborn health

**Kenya**

Ms Maison Leshoomo  
*Member of Parliament*

Ms Maison Leshoomo, the first Masai woman to be elected a Member of Parliament in Kenya, expressed her concern about the high maternal mortality in her home country. She stressed that there was a need for health-care education. People in the communities needed to be mobilized to access the services in health-care facilities. She called on nongovernmental organizations and other partners to increase the support they gave the Kenyan Government.

**Uganda**

Ms Sylvia Namabidde Sinabulya  
*Member of Parliament*

Ms Sylvia Namabidde Sinabulya from Uganda stressed the importance of accepting certain cultural practices for persuading women to give birth in hospitals. She said that in Uganda it was local cultural practice for traditional birth attendants to give women their placenta. In hospitals the placenta was not returned to the women. She also added that some women preferred to squat during childbirth. Many women felt uncomfortable about giving birth with their legs raised, in particular when men were around. Ms Sinabulya said that disregard for cultural practices prevented women from delivering in hospitals. She emphasized that cultural practices that were not harmful should be respected.

**Nepal**

Ms Durga Jayanti Rai  
*Member of Parliament*

Ms Durga Jayanti Rai from Nepal reported that the new democratic Government was committed to the health of the people. She outlined that health care was not only provided for free in the health posts, but it had also been available in the district hospitals since 2008. There was also a policy of free delivery care for all women in Nepal. Furthermore, the Ministry of Health had drawn up a safe motherhood act. This act still needed to be passed. However, with the knowledge she had gained during this conference she felt confident that she would be able to convince her fellow parliamentarians to vote in favour of this act.

**United Republic of Tanzania**

Ms Martha Moses Mlata  
*Member of Parliament*

Ms Martha Moses Mlata from the United Republic of Tanzania asked what the United Nations was doing to prevent mothers from dying during pregnancy or childbirth. To her it seemed that the UN intervened in armed conflicts but not in this humanitarian tragedy.

**Nepal**

Ms Durga Jayanti Rai from Nepal reported that the new democratic Government was committed to the health of the people. She outlined that health care was not only provided for free in the health posts, but it had also been available in the district hospitals since 2008. There was also a policy of free delivery care for all women in Nepal. Furthermore, the Ministry of Health had drawn up a safe motherhood act. This act still needed to be passed. However, with the knowledge she had gained during this conference she felt confident that she would be able to convince her fellow parliamentarians to vote in favour of this act.

Ms Thea Fierens, Regional Director of UNFPA for Eastern Europe and Central Asia, outlined the mandate of the United Nations Population Fund. First, UNFPA supported projects on population and development, which were key to reducing poverty and achieving the MDGs. Secondly, it emphasized sexual and reproductive rights and health. Thirdly, it promoted gender equality. Ms Fierens said that UNFPA was working
Meeting with nongovernmental organizations

On the evening of the second day, the parliamentarians had an opportunity to meet representatives from various nongovernmental organizations to discuss possible cooperation. Additional organizations were present for lunch on the last day. The representatives reported on their work in the areas of general health, sexual and reproductive health and the health-related MDGs. In addition, they presented activities for assisting women in conflict, capacity-building for parliamentarians and international advocacy for maternal health.

Ms Olga de Haan and Ms Isabel Saiz presented the activities of the Netherlands School of Public and Occupational Health in Central Asia and Europe. The Dutch public health NGO SIMAVI was represented by its executive director Ms Rolien Sasse.

Ms Moniek van der Kroef from STOP AIDS NOW! chaired a session on the relationship between maternal mortality and HIV/AIDS. She was joined by Mr Reinier van Hoffen from Prisma, Mr Paulus Samuel from Red een Kind and Ms Sophie Dilmitis from World YWCA. Ms Pauline Haasdrecht presented the work of the Rutgers Nisso Groep on sex education in the Netherlands. Her colleague Ms Joanne Leerlooier enriched the discussion with her experiences with the World Population Foundation in Asia and Africa. On day 3, Ms Marijke Priester presented the work of Youth Incentives on family planning. Dr Rebecca Gomperts from Women on Waves reported on the fight against unsafe abortion. Professor Koos van der Velden from the Radboud University Nijmegen Medical Centre made a plea for more research on reproductive health and safe motherhood.

Mr Nils Gade told the audience that Population Services International supported countries in their efforts to achieve MDGs 4, 5 and 6. Ms Janet Meyers affirmed that maternal health was also a priority for CARE International. Mr Piet van Gils represented Cordaid, which is involved in projects to reduce maternal mortality in Afghanistan and Sierra Leone. The Dutch Catholic development organization is a member of the Meshwork for Mother Care, as is the African Medical and Research Foundation (AMREF). Ms Anneke Wensing from AMREF talked about the human resource crisis that was hampering progress towards MDG 5. She was joined by Ms Anke Tijtsma from the advocacy NGO Wemos.

The president of the PEP International Foundation, Ms Conny Bergé, stressed the importance of caring for women in conflicts. Ms Sabra Bano from Gender Concerns International also drew attention to the health of people in conflict areas. Ms Fatumo Farah, who left her home country Somalia in 1992, presented HIRDA, a Somali-Dutch organization which aims to empower women in Somalia.

The Association of European Parliamentarians for Africa (AWEPA) was represented by Ms Katharine Bulbulia, a member of the Council. The organization supports parliamentarians in Africa in their efforts to build capacity and knowledge. Ms Kathy Herschderfer presented the advocacy work of the White Ribbon Alliance for Safe Motherhood, which addresses politicians, health-care professionals, community groups and media. Ms Mariëtte Flipse from MYBODY shared her experience of organizing the awareness-raising event Mother’s Night in the framework of the Meshwork for Mother Care.
Parliamentarians take action for maternal and newborn health

The Roadmap

Building a bridge to reach MDGs 4 and 5

On day one, Ms Chantal Gill’ard outlined the task that lay ahead of the parliamentarians: identify concrete steps to improve maternal and newborn health and achieve MDGs 4 and 5 together. “To reach these goals we have to build a strong bridge,” Ms Gill’ard said. “And this bridge has to be built on strong pillars.”

In the subsequent sessions, Ms Anne-Marie Voorhoeve and Mr Peter Merry from the Center of Human Emergence facilitated plenary discussions and interactive debates to identify the pillars that should serve as the basis for the bridge to MDGs 4 and 5. They also asked the parliamentarians to identify the conditions for success for each pillar and to share examples of best practice. On that basis, the participants discussed concrete action they could take as parliamentarians to build the pillars. On the third and final day, the conference rapporteur, Ms Sylvia Sinabulya (MP from Uganda), summarized the results of the debate, presenting a roadmap for improving maternal and newborn health through parliamentary action (see p. 36).

In order to allow participants to share experiences and continue the discussions beyond the conference in The Hague, a virtual network was designed (see p. 41). The platform is structured along the pillars identified and their conditions for success. Participants can create their own profile, exchange experiences and discuss new ideas. “This is where you can share your actions with a global audience,” Dr Monir Islam said. He encouraged participants to use the forum to come back to The Hague in a virtual sense whenever they wanted.

Presentation: Taking action on maternal and newborn health

Conference rapporteur Ms Sylvia Sinabulya summarized the results of the meeting on the third and final day. She highlighted that members of parliament from 32 countries had come together to discuss, share experiences and develop strategies on maternal and newborn health. “Our objective has been to identify key priorities and parliamentary action for achieving MDG 5 on maternal health and MDG 4 on newborn mortality,” she said.

Need to target the poorest

Ms Sinabulya reiterated the facts that had framed the debate from the very beginning. First, there was an urgent need to act. Every year more than half a million women died due to complications in pregnancy and childbirth; every year almost 4 million newborns died. All countries – in the developing and the developed world – were concerned. However, disparities needed to be taken into account, Ms Sinabulya said. She reported that in 2008, 68 countries had accounted for 97% of maternal and child deaths, most of them in sub-Saharan Africa and Asia. There were also disparities within countries, leaving poor and rural women at the greatest risk. “We need to target the poorest of the poor,” she emphasized.

“Nevertheless, we know that achieving MDGs 4 and 5 is still possible,” Ms Sinabulya said. “It will certainly be difficult but it is doable if we have the will.” The Member of Parliament said that there was certainly not one magic bullet to address the different challenges in countries. There was a variety of approaches reflecting the diversity of situations. Therefore,
the point of the meeting was to share experience and to build relationships among fellow parliamentarians and other partners.

**Seven pillars to build on**

“Together, we have identified seven major areas of work or pillars for MDG 5,” she summarized. These pillars were: (1) political commitment, (2) legislation, (3) financial resourcing, (4) the health system, (5) education, (6) cultural practices, and (7) partnership. The participants had linked these pillars with conditions for success and shared examples of best practice from their countries. They had come up with ideas for parliamentary action. Ms Sinabulya presented the conditions and action points in detail (see p. 37ff).

The rapporteur stressed that this was not an exhaustive summary of the range of experiences and practices that were examined during the conference. Rather, the roadmap was designed to help the parliamentarians take action back home. “We need to keep this process alive and build on it,” Ms Sinabulya said, and called on her colleagues to continue to share experiences and support one another in order to make a difference for mothers and babies.

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**How to become a member of the MDG 5 network**

We are inviting NGOs, government agencies, scientific and professional organizations as well as other partners in the area of maternal and newborn health to become members of the Internet community platform created to help stakeholders connect, share knowledge and improve the monitoring of achievements and successful activities in countries.

If you are interested in becoming a member and contributing to the network, please email the following registration details to **MPSinfo@who.int**

- Last and first name
- Professional title
- Email address
- Institution/Company
- Country
- Region (AFRO, AMRO, SEARO, EURO, EMRO, WPRO)

If your free membership is approved, you will be emailed your username and password.

[http://mdg5.che.gaiaspace.org/](http://mdg5.che.gaiaspace.org/)
Global initiatives to improve maternal health

Dr Monir Islam gave an overview of global initiatives to improve maternal health. The Director of the WHO Department of Making Pregnancy Safer encouraged the parliamentarians to find out how global programmes could help their countries and to follow up with their governments on the pledges made in international forums.

Dr Islam reported that in October 2007 representatives from more than 100 countries had attended the Women Deliver Conference in London. The conference had demonstrated international consensus on three pillars to save the lives of women and newborns: (1) comprehensive reproductive health care, (2) skilled care during and immediately after childbirth, and (3) emergency care when life-threatening complications develop. In a final statement, 70 cabinet ministers and parliamentarians had pledged to make MDG 5 a high priority on national and international agendas and committed themselves to advocating for increased resources for maternal health in their home countries.

Dr Islam also mentioned the Countdown to 2015 Conference that took place in South Africa in April 2008 in conjunction with the assembly of the Inter-Parliamentary Union. Delegations from 61 countries including Ministers and deputy-Ministers of Health assessed the progress made in the area of maternal, newborn and child health.

Thanks to a Japanese initiative, maternal health had been discussed during the 34th G8 Summit in Tokyo in 2008. The Prime Minister and the Minister of Foreign Affairs had put the topic on the agenda for the very first time in 2008. Before that conference, Japan had also hosted the fourth Tokyo International Conference on African Development (TICAD). They had invited all African countries to discuss MDGs 4 and 5 and then presented the results during the G8 Summit.

Dr Islam explained that there were more and more efforts to coordinate the resources for development assistance. In 2004, UNAIDS and other partners had established the “Three Ones” principles: one national plan, one national coordinating authority, and one national monitoring and evaluation system. In 2007 the International Health Partnership (IHP) was founded to coordinate the work of different actors dealing with development assistance. The partnership included international agencies, donors and developing countries. Launched in 2005, the Partnership for Maternal, Newborn and Child Health (PMNCH) had almost 260 members who worked together for the health of mothers, babies and children.
Dr Islam pointed out that UN agencies including WHO, UNFPA, UNICEF and the World Bank were increasingly allocating money to maternal and newborn health. He added that the Gates Foundation also provided such funding. Furthermore, countries should consider how they could use other funds for the benefit of mothers and newborns. Dr Islam mentioned for example the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), which committed billions of dollars to programmes that fight these three diseases. Money from that fund could be used for the prevention of mother-to-child transmission of HIV, the care of HIV-positive mothers or the treatment of malaria in pregnancy. He also mentioned the Roll Back Malaria Partnership, including the US President’s Malaria Initiative, and the Global Alliance for Vaccines and Immunization (GAVI) as possible donors.

In presenting these initiatives, Dr Islam encouraged the parliamentarians to learn more about what was going on at a global level and to follow up with their governments. They should urge their political leaders to stick to the agreements they had signed, to allocate the promised funds and to spend the money effectively. The parliamentarians should ask how much funding was dedicated to the health of mothers and newborns. Dr Islam also called upon participants to use their power to ask for data. “To make a difference you have to take action at country level,” he concluded.

**Address by the Minister of Health**

The final conference session was chaired by Ms Daisy Mafubelu who welcomed the Dutch Minister of Health Ab Klink. She acknowledged that he had come to the conference even though he had a cabinet meeting. On behalf of the conference participants Ms Mafubelu asked the Minister to join their efforts to improve maternal health by:

- voicing political commitment to maternal health and speaking out for its prioritization in international forums;
- working together with parliamentarians in support of his colleague Minister Koenders;
- giving MDG activities and programmes financial support.

**The Netherlands**

Mr Ab Klink  
*Minister of Health, Welfare and Sport*

Dutch Minister of Health Ab Klink said that urgent joint action was needed to tackle maternal mortality. He welcomed the participants and thanked the organizers for this outstanding congress on maternal health.

Minister Klink pointed out that the maternal mortality ratio was an important indicator of both women’s health and the quality of the health system. Maternal deaths did not only occur in developing countries but also in the developed world. However, there were big differences in the numbers of deaths: in the Netherlands there were nine maternal deaths per 100 000 live births compared to up to 900 in sub-Saharan Africa or even 1800 in Afghanistan. A woman’s risk of dying in pregnancy or childbirth was closely related to her socioeconomic status, in other words her poverty and education levels. He said that these disparities should provoke the global community into taking action.

**Impact of infrastructure and culture**

Though the UN had included maternal health in the Millennium Development Goals, it was disconcerting that the achievement of MDG 5 was in jeopardy, he said. “With still half a million
mothers dying each year we cannot simply sit back and watch time going by.” Minister Klink stressed the importance of political will to reduce maternal mortality all over the world. He was therefore delighted to hear about the roadmap that parliamentarians from so many different nations had been able to develop during the conference. He reiterated that maternal health was not an isolated health problem but was strongly related to infrastructure, sanitation, and economic and cultural factors. Therefore, concerted action was needed among policymakers in both health and development cooperation. He confirmed that he and Minister Koenders were close allies.

The Minister of Health stressed that it was fundamental to raise the issue of maternal health in diverse networks, nationally and around the world. He promised to take the issue very seriously and to raise it in forums and among fellow ministers of health. He also affirmed his commitment to promoting scientific research on maternal health, both in the Netherlands and at an international level. In conclusion, he wished the parliamentarians great success in the implementation of their roadmap.

First steps back home

After two and a half days of discussion, Dr Monir Islam asked the participants to share with the plenary the first steps they intend to take once back home. The parliamentarians communicated their plans to report on the conference, to initiate networks, to influence the budget debate, to review legislation or to check on their government’s strategy for maternal and newborn health. Some participants were opting for action in their constituencies or wanted to organize public events.

The representatives from Angola, Ms Mariana Paulo Afonso and Ms Inocência de Deus Faria Morais, underlined that they would report back to their colleagues in Parliament. Ms Lemo Kumbi from Ethiopia wanted to inform the caucus of female parliamentarians as well as the committees and ministries related to women’s health. Her colleagues from Mozambique, Ms Graça Nhalinginga, and from Sudan, Dr Sayda Mohamed Bashar, shared the same intentions. Professor Mariam Marie Gisèle Guigma from Burkina Faso planned to follow the example of Uganda and build a network of women parliamentarians.

Ms Saodat Amirshoeva from Tajikistan said that she would aim to ensure sufficient funding for maternal and newborn health. Her colleague from Cambodia, Ms Pum Sichan, wanted to push for an increased budget for reproductive health. Ms Sylvia Sinabulya from Uganda said that, as she saw it, her main task was to increase the budget to implement the national roadmap and reduce maternal mortality. The Member of Parliament from Haiti, Ms Edmonde Suplice Beauzile, announced that she would involve the Ministry of Health in the debate on the next education budget in order to allocate resources for MDG 5. Ms Martha Moses Mlata from the United Republic of Tanzania aimed to develop a gender-sensitive national budget.
Dr Porapan Punyaratabandhu from Thailand said that she would closely monitor the use of funds allocated to the reduction of maternal mortality in three high-risk areas. Ms Chantal Gill’ard from the Netherlands confirmed her intention to get in contact with the Netherlands Court of Audit to monitor the effectiveness of the allocated budget. Dr Phonetep Pholsena from the Lao People’s Democratic Republic intended to supervise the Government’s strategy for improving maternal health. His colleague from Peru, Ms Fabiola Morales Castillo, stressed the importance of reviewing health-related national legislation. Ms Refilwe Mashigo from South Africa said that she would hold the Government accountable for implementing 10 recommendations from the “Saving mothers report”. The two representatives from the Republic of Korea, Ms Mi Kyung Chung and Ms Young Sun Park, came up with concrete actions for their country: they wanted to tackle teenage pregnancy, expand health care services and involve men in women’s health programmes.

Ms Tuti Indarsih Loekman Soetrisno from Indonesia said that she had made safe motherhood a topic of her upcoming election campaign. In her constituency, she would pay for the referral of pregnant women to hospitals. Dr Bangon Sayarath from the Lao People’s Democratic Republic planned to advocate for maternal and child care in the communities of her constituency. Two representatives, Ms Iyabo Obasanjo-Bello from Nigeria and Dr Mahreen Bhutto from Pakistan wanted to organize a Mother’s Night in their countries.

Closing remarks

WHO

Ms Daisy Mafubelu
Assistant Director-General, Family and Community Health

On behalf of WHO, Ms Daisy Mafubelu thanked the co-organizers and participants and assured the parliamentarians of the Organization’s future support. She thanked the Parliament of the Netherlands for hosting the follow-up conference to the Meeting of Women Parliamentarians in London. She also thanked the Inter-Parliamentary Union, the Dutch ministers, the UN agencies, and the nongovernmental organizations including the Center for Human Emergence for their support.

Ms Mafubelu also thanked the parliamentarians for their contributions. She hoped that they would leave the conference with new ideas and renewed motivation to take action back home. She also called on them to convince their fellow lawmakers to join the fight for maternal health. Parliamentarians should hold their governments accountable for their pledge to reduce maternal mortality by three quarters by 2015, she said. Institutions from civil society and UN agencies were standing ready to support them. “We at WHO will be at your side,” Ms Mafubelu affirmed. “We will help you beat the drum for the survival of mothers and newborns everywhere in the world!”

IPU

Ms Kareen Jabre
Manager, Programme for the promotion of partnership between men and women

Representing the Inter-Parliamentary Union (IPU), Ms Kareen Jabre thanked all participants for taking the time to attend the
Parliamentarians take action for maternal and newborn health

Ms Jabre emphasized that the IPU was committed to continuing to work with parliamentarians on MDGs 4 and 5. She reported that they had launched the initiative in 2008 during the 118th IPU assembly in Cape Town, South Africa, which took place in conjunction with the Countdown to 2015 conference. In Cape Town, some 900 parliamentarians had agreed that MDGs 4 and 5 should be a priority on the lawmakers’ agenda. During the next IPU assembly to be held in Ethiopia in April 2009, parliamentarians would take stock of the action taken so far. “The task is quite overwhelming,” Ms Jabre said. “But we can do it, if we do it all together!”

The Netherlands
Ms Chantal Gill’ard
Member of Parliament

Ms Chantal Gill’ard, the conference host, thanked all the organizers and participants and encouraged the parliamentarians to continue the work initiated in The Hague. Ms Gill’ard thanked her 149 colleagues in Parliament and the conference support staff. She also highlighted the partnership with WHO and IPU and acknowledged the support from the nongovernmental organizations and other partners. Her words of thanks also went to the Minister of Health and the Minister for Development Cooperation. She emphasized that all parliamentarians had designed a strong bridge to reach MDG 5. “Now we need to build strong pillars for that bridge,” she said, thanking Ms Anne-Marie Voorhoeve, Mr Peter Merry and their colleagues from the Center for Human Emergence for facilitating the discussions.

Country representatives

On behalf of all the parliamentarians, Ms Iyabo Obasanjo-Bello from Nigeria thanked the organizers of the conference. “We have all had a wonderful time in The Hague,” she said. She thanked the Parliament and the Government of the Netherlands and also HRH Princess Máxima of the Netherlands. Her thanks went also to WHO and the IPU, the other UN agencies, the nongovernmental organizations and the institutions that had offered field trips. She hoped that the cooperation would continue – until they had achieved their goals in 2015. Ms Fabiola Morales Castillo from Peru underlined her colleague’s words of thanks. She highlighted that it had been a very inspiring experience for her to meet so many women and men from different countries who shared the goal of saving the lives of mothers and newborns.
Annex I: The Roadmap

Parliamentarians take action for maternal and newborn health

The Hague, The Netherlands, 26-28 November 2008
By Ms S. Sinabulya, MP, Uganda, Rapporteur of the Meeting

Summary
At the crucial halfway point to the 2015 MDGs, members of parliament from 36 countries came together in The Hague, Netherlands, to discuss the role they can play in the achievement of Millennium Development Goal 5, identify key priorities and develop innovative strategies to prevent the needless deaths of mothers and babies.

The parliamentarians’ discussion resulted in a roadmap as a framework for action in countries based on seven priority areas (pillars) including political commitment, legislation, financial resourcing, health systems, education, cultural practices, and partnership. The participants also identified conditions that have to be met to make progress in these areas and defined specific parliamentary activities to support stakeholders make headway. All parliamentarians agreed that MDG 5 can be achieved and thereby also contribute to MDG 4 if partners work together. At the end of the meeting all members of parliament committed to follow up on at least one of the activities discussed.

The situation
Some important facts have framed the debates from the very beginning.

- The first is that there is an urgent need to act as the current situation is simply unacceptable: every year more than half a million women die, many of them adolescents, due to complications during pregnancy and childbirth; every year 3 million newborns die.
- The second is that no country is exempt from this sad reality. All are concerned, whether they are a developing or a developed country, whether they are located in the north or in the south.
- The third is that existing discrepancies need to be taken into account; there are some countries or populations that need to be targeted specifically. Today, 68 countries account for 97% of maternal, newborn and child deaths, most of them in sub-Saharan Africa and in Asia. There are also discrepancies within the countries themselves, as poor and rural women are often the most affected. The poorest of the poor need to be reached first and foremost.
- The fourth, and maybe the most important, is that all stakeholders agree that it is possible to achieve MDG 5; it will certainly be difficult but it is doable if the political will can be mobilized.

The task may seem overwhelming and there is certainly no unique solution to address these challenges and reach these objectives. Rather, there are a variety of approaches, reflecting the diversity of situations and country experiences. The purpose of the meeting was therefore to offer a space to share experiences and concerns, strategize and ultimately create knowledge and build relationships for effective action.

Objectives of the roadmap
Following an original approach that combined plenary inputs with interactive sessions, the parliamentarians collaborated to create the pillars of MDG 5, work out what conditions need to
be in place for every pillar, share stories of success and come up with ideas for parliamentary action. The interactive approach created strong relationships between parliamentarians and partners, and used the competence and professionalism of all participants to find creative and practicable solutions.

The roadmap developed collectively aims to provide a framework which should help the parliamentarians to take action individually and collectively once back home to achieve progress and change the lives of women and children. The participants need to keep it alive, build on it and continue to share their experiences and help each other out to achieve change.

The structure of the roadmap
During the conference seven pillars were identified, which would allow to build the bridge to achieving MDG 5. The seven pillars consist of Political Commitment, Legislation, Financial Resourcing, Health System, Education, Cultural Practices, and Partnership. Improvements in these priority areas can be achieved based on certain conditions of success identified by the participants.

Pillar 1: Political commitment
The conditions of success include:

- Accurate data to know the situation, give visibility to it and engage others;
- Good governance, including need for transparency in commitments and action;
- The need to engage the media, build their awareness and work with them to build political commitment;
- International pressure is also key, so is engaging political parties and building their awareness;
- Building awareness in political parties, as they are often central to political decision-making.

Parliamentary actions:

- Speak out in parliament and publicly for MDG 5;
- Champion and identify other parliamentary champions who will lead the way on MDG 5;
- Build cross party coalitions;
- Adopt a motion in parliament on MDG 5;
- Question government and call ministers to account on their global commitments;
- Hold briefings and hearings in parliament to convince and engage MPs and political leaders;
- Organize public events to sensitize the wider public and strengthen national commitment;
- Liaise regularly with constituents to educate them on MDG 5 and seek training to do that effectively;
- Organize field visits to facilities and projects in order to monitor the situation and evaluate initiatives.

Pillar 2: Legislation
The conditions of success that were identified include:

- Support within parliament for safe motherhood;
- Common understanding of the issues and speaking the same language;
- Partnership and coordination with other actors (international organizations, civil society, donors) to enact legislation supporting maternal and child health. For instance, convince partner organizations like WHO, the UN and other partners to prioritize funding for projects around the development of legislation related to maternal health.

Parliamentary actions:

- Identify one or several parliamentary committees to take the lead in parliament on legislating or reviewing legislation to facilitate maternal health;
- **Hold hearings with government, civil society, private sector and other actors to identify legislative gaps, challenges and solutions;**
- **Launch a review of existing laws to address gender discrimination and eliminate legal obstacles that limit women’s access to health care services;**
- **Work with Courts of Audit to monitor the implementation of legislation;**
- **Adopt legislation facilitating and supporting the work of midwives;**
- **Ensure that legislation passed is complementary with other existing legal instruments and that MDG 5 concerns are streamlined adequately.**

**Pillar 3: Financial Resourcing**
The conditions of success that were identified include:

- **Sufficient health budget:** within the national budget ensure that the health budget receives enough funding. Some participants mentioned that a minimum should be set, meaning for instance that the health budget should account for at least 6% of overall budget;

- **Gender-sensitive budgets:** this would allow to track and increase allocations related to maternal and newborn health, and to primary healthcare and referral;

- **Support to micro-finance initiatives;**

- **A good health insurance system;**

- **Free health services for women and children;**

- **Use of taxation for additional resources.** One example is the introduction of a 0.1% tax on personal and corporate income to be allocated for expenditures aimed at strengthening mother and child care services or a 0.1% tax on advertising to be spent on education for future mothers.

**Parliamentary actions:**

- **Liaise or work with the budget/finance committee in parliament to pay particular attention to health issues and MDG 5;**

- **Ask questions to government during the budget debate and make MDG 5 a budgetary priority;**

- **Hold hearings with women and health associations on needs and priorities prior to the budget debate in order to possibly impact on the budget;**

- **Ask that responsible ministers regularly report to parliament on the use of funds for MDG 5 so as to monitor work done;**

- **Ensure that national budgets are gender-sensitive; sensitize and inform MPs on gender-sensitive parliaments and train parliamentary staff;**

- **Ensure that the national budget process makes use of sex-disaggregated data;**

- **Organize a raising awareness / media event on MDG 5 to increase pressure during the budget debate.**

**Pillar 4: Health system**
The conditions of success that were identified include:

- **Sufficient human resources:** This includes adequate funding support, an appropriate mix of skills, the adoption of measures and initiatives to discourage migration and brain-drain and the improvement of the working environment and conditions to retain staff;

- **Quality care:** this includes close parliamentary monitoring of the care services, availability of timely data and accreditation based on real evidence;

- **Reproductive health rights:** this would include addressing early marriages, gender-based violence and other harmful practices, providing family planning services, and adolescent and youth services;
Parliamentarians take action for maternal and newborn health

- Access to information and data: this would include building the State's capacity to produce official data, making use of UN data, supporting the development of country specific data, e.g. national statistics as well as maternal/prenatal reviews;
- Training for health personnel;
- Availability of services: this would include no or low fees for health services; services at local level (rural, urban and urban slums) and a functioning infrastructure in order to facilitate access;
- Budget allocation: an adequate percentage of GDP allocated to the health system.

Parliamentary actions:
- Use parliamentary oversight mechanisms (oral and written questions to government, enquiries, hearings, parliamentary committee work) to ensure accountability and meet set health objectives;
- During the budget process, pay particular attention to health allocations, ask questions and monitor allocated amounts and their effective use;
- Support sufficient funding to build independent national statistics institutes; liaise with UN and other sources to access data;
- Review legislation; start a debate in parliament on gender discrimination, and especially harmful traditional practices.

Pillar 5: Education
The conditions of success that were identified include:
- National Strategic Plan for education, with identified means, objectives and targets;
- Budget allocation for education;
- Training of teachers and midwives;
- Cooperation with mass media.

Parliamentary actions:
- Use parliamentary oversight mechanisms to regularly monitor and evaluate government work on education;
- Request sex-disaggregated data to closely monitor the situation of girls;
- During the budget process, pay particular attention to education budget allocations, ask questions and monitor allocated amounts and their effective use;
- Organize events with the media to educate the public on maternal health issues;
- Engage with communities;
- Ensure that human rights and gender equality are part of the school curricula;
- Ensure that new members of parliament are educated and briefed on MDG 5; develop mentoring to pass on the knowledge.

Pillar 6: Cultural Practices
The conditions of success that were identified include:
- Media support: this would include using the media to expose bad practices and launch open debates on cultural practices;
- Linking culture, human rights and legislation;
- Challenging harmful cultural practices; this would include a culture-based approach through grassroots organizations working for change;
Financing grassroots initiatives.

**Parliamentary actions:**
- Raise awareness in constituencies and hold debates on harmful traditional practices;
- Speak out publicly against them, and set the example;
- Debate harmful practices in parliament, within the framework of human rights standards and initiate legislation, if needed;
- Promote the use of community advisers.

**Pillar 7: Partnership**
The conditions of success that were identified include:

- Common objectives;
- Mutual respect, including open-mindedness, win-win relationships;
- Identified needs of different partners, and creation of links through, for example, a focal point system;
- Inclusive approach and cross-level cooperation, including national, provincial and district levels;
- Information sharing.

**Parliamentary actions:**
- Build cross-party coalitions;
- Hold regular meetings with various partners (breakfast meetings with ministers; regular sessions with civil society organizations, etc);
- Engage male parliamentarians on MDG 5;
- Reach out to communities, grassroots organizations and local partners;
- Invest in parliaments’ technical capacity to bridge the digital divide and facilitate communication.
Roadmap for MDG5

MDG5 Goal

- Political commitment
- Cultural Practices
- Education
- Health System
- Legislation
- Financial Resourcing
- Partnership
- Media Support
- Rights Legislation
- Cultural Realities
- Strategic Plan
- Budget
- Training
- Human Resources
- Quality Care
- Reproductive Rights
- Health Budget
- Gender Budget
- Insurance
- Success Story
- Action
- Accurate data
- Transparency
- Media Awareness
- Common Objectives
- Mutual Respect
- Identify Needs
- Safe Motherhood
- Shared Language
- Partner Support
- Health
- Success Story
- Pillar
- Success Condition
- Action
- Success Story
- Success Story
- Success Story
- Success Story
- Success Story
- Success Story
- Success Story
**Annex II: Agenda**

**Day one (Wednesday, 26 November 2008)**

*Opening plenary*
Ms Gerdi Verbeet, President of the House of Representatives, the Netherlands
Ms Daisy Mafubelu, Assistant Director-General, WHO / Family and Community Health
Mr Anders B. Johnsson, Secretary General, Inter-Parliamentary Union

*Briefing on maternal and newborn health*
Dr Monir Islam, Director, WHO / Making Pregnancy Safer

*Country reports*
- Indonesia: Ms Tuti Indarsih Loekman Soetrisno, Member of Parliament
- Finland: Ms Minna Sirnö, Member of Parliament
- Rwanda: Ms Spéciose Mukandutiye, Member of Parliament

*Lunch inspiration*
Mr Bert Koenders, Minister for Development Cooperation, the Netherlands
Ms Stella Ronner-Grubacic, Ambassador for the Millennium Development Goals, the Netherlands

*World Café: Setting out the challenges*
Group discussions to identify key areas of work

*Visit of HRH Princess Máxima of the Netherlands*

**Day two (Thursday, 27 November 2008)**

*Site visits*
Midwifery Academy Amsterdam and Groningen, Amsterdam
Municipality of The Hague (City Hall, Birth Center), The Hague
Netherlands Court of Audit, The Hague
Rabobank Foundation, The Hague
Waternet, Amsterdam

*Open space technology*
Group discussions to identify conditions and action

*Country reports*
- Uganda: Ms Sylvia Namabidde Sinabulya, Member of Parliament
- Sweden: Ms Kerstin Engle, Member of Parliament

*Meeting with nongovernmental organizations*
AMREF, AWEPA, Meshwork for Mother Care, MYBODY, NSPOH, Prisma, Red een Kind, Rutgers Nisso Groep, STOP AIDS NOW!, Wemos, White Ribbon Alliance for Safe Motherhood, World Population Foundation, World YWCA

*Opening of a photo exhibition*
Safe motherhood in Mali, pictures by Ian Snieders

**Day three (Friday, 28 November 2008)**

*Presentation of the roadmap*
Ms Sylvia Namabidde Sinabulya, Member of Parliament

*Global initiatives to improve maternal health*
Dr Monir Islam, WHO / Making Pregnancy Safer

*Discussions on follow-up*
Sharing intentions for first steps back home
Parliamentarians take action for maternal and newborn health

Closing remarks
Mr Ab Klink, Minister of Health, the Netherlands
Ms Daisy Mafubelu, WHO / Family and Community Health
Ms Kareen Jabre, Inter-Parliamentary Union
Ms Chantal Gill’ard, Member of Parliament, the Netherlands

Lunch with nongovernmental organizations
Annex III: List of participants

Country participants

Angola
Ms Mariana Paulo A. AFONSO
Member of the National Assembly

Ms Inocência DE DEUS FARIA MORAIS
Member of the National Assembly

Mr António KIMUABI JÚNIOR
Member of the National Assembly

Brazil
Ms Aline Lemos ANDRADE CORREIA
Federal Deputy

Burkina Faso
Professor Mariam Marie Gisèle GUIGMA
Member of Parliament

Cambodia
Ms Naun HO
Member of the National Assembly
Chair of the commission on public health, social work, veterans, youth rehabilitation, labour, vocational training and women’s affairs

Ms Run IM
Member of the National Assembly
Secretary to the commission on foreign affairs, international cooperation and information

Ms Pum SICHAN
Senator
Vice Chair of the commission on health, social affairs, labour and women’s affairs

Mr Heang THUL
Deputy Director, International Department

Ethiopia
Ms Lomi Bedo KUMBI
Member of Parliament

Finland
Ms Minna SIRNÖ
Member of Parliament
Committee of development and population

Haiti
Ms Edmonde SUPPLICE BEAUZILE
Senator

Indonesia
Ms Tuti Indarsih LOEKMAN SOETRISNO
Member of Parliament
Commission IX on health, population, transmigration, and food & drug control

Kenya
Dr Josephine KIBARU
Head, Department of Family Health
Ministry of Public Health and Sanitation
Parliamentarians take action for maternal and newborn health

Ms Maison LESHOOMO  
Member of Parliament

**Lao People’s Democratic Republic**
Dr Phonetep PHOLSENA  
Member of Parliament
Dr Bangon SAYARATH  
Member of Parliament

**Mozambique**
Ms Graça NHALIGINGA  
Deputy

**Nepal**
Ms Durga Jayanti RAI  
Member of Parliament
Dr Sudha SHARMA  
Acting Secretary, Ministry of Health and Population

**Netherlands**
Ms Kathleen FERRIER  
Member of Parliament
Ms Chantal GILL’ARD  
Member of Parliament
Ms Arda Gerkens  
Member of Parliament
Mr Ab KLINK  
Minister of Health
Mr Bert KOENDERS  
Minister for Development Cooperation
Ms Elly Leemhuis-DE REGT  
Senior adviser, Ministry of Foreign Affairs

Mr Henk Jan ORMEL  
Member of Parliament
Ms Stella RONNER-GRUBACIC  
Ambassador for the Millennium Development Goals
Mr Freddy I. SIERRA FERNANDEZ  
Interim, Ministry of Foreign Affairs
Ms Pauline SMEETS  
Member of Parliament
Ms Gerdi VERBEET  
President of the House of Representatives
Ms Lutz JACOBI, PvdA  
Member of Parliament
Ms Janneke SCHERMERS, CDA  
Member of Parliament
Mr Harm Evert WAALKENS, PvdA  
Chair of the European Committee  
Member of Parliament

Ms Ma. Dolores ALEMÁN  
Member of Parliament
Ms Mónica BALTODANO  
Member of Parliament
Ms Jamileth BONILLA  
Member of Parliament
Ms Martha Marina GONZÁLEZ  
Member of Parliament
Mr Gilberto VALDEZ  
The member of the National Assembly
Parliamentarians take action for maternal and newborn health

Nigeria
Ms Eme Ufot EKAETTE
Senator
Member of Parliament
Ms Iyabo OBASANJO-BELLO
Senator
Head, Committee on health

Pakistan
Dr Mahreen BHUTTO
Parliamentary secretary for health

Peru
Ms Fabiola MORALES CASTILLO
Member of Parliament

Republic of Korea
Ms Mi Kyung CHUNG
Member of Parliament
Ms Young Sun PARK
Member of Parliament
Ms Seo Yeon CHO
Interpreter

Romania
Ms Cristina DUMITRESCU
Secretary, Romanian IPU group
Sub-committee’s secretariat
Mr Dan SABAU
Senator
Chair, Senate’s sub-committee for population and development

Rwanda
Ms Spéciose MUKANDUTIYE
Member of Parliament
Chair, Committee on social affairs of the Chamber of Deputies

South Africa
Ms Refilwe MASHIGO
Member of Parliament

Spain
Ms María Jesús CASTRO MATEOS
Senator

Sudan
Dr Sayda Mohamed BASHAR
Member of Parliament
Ms Lily KIDEN ELUZAI
Member of Parliament

Sweden
Ms Kerstin ENGLE
Member of Parliament

Tajikistan
Ms Saodat AMIRSHOEVA
Deputy

Thailand
Dr Porapan PUNYARATABANDHU
Senator
Senate standing committee on public health

Tunisia
Mr Mohamed Elies BEN MARZOUK
Member of the Chamber of Councillors
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**United Nations Children’s Fund (UNICEF)**
Dr Mark WUNE  
**Senior programme officer, UNICEF Netherlands**
Dr Renée VAN DE WEERDT  
**Chief, Maternal, newborn and child health unit, New York, USA**

**The World Bank**
Mr Sándor SIPOS  
**Special representative to the European Union institutions**
Mr Guggi LARYEA  
**Civil society and parliamentarians**
**Trade and human development**
**Office in Brussels, Belgium**

**Secretariat of the conference**

**WHO/Family and Community Health (FCH)**
Ms Daisy MAFUBELELU  
**Assistant Director-General**

**WHO/Department of Child and Adolescent Health and Development (CAH)**
Dr Elizabeth MASON  
**Director**

**WHO/Department of Health Action in Crisis (HAC)**
Dr Giuseppe ANNUNZIATA  
**Medical officer**

**WHO/Department of Making Pregnancy Safer (MPS)**
Dr Q. Monir ISLAM  
**Director**

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**Report**

Ms Faouzia KHALDI  
**Member of the Chamber of Deputies**
**Turkey**
Ms Dilek YUKSEL  
**Member of Parliament**

**Uganda**
Ms Sylvia NAMABIDDE SINABULYA  
**Member of Parliament**

**United Kingdom**
Dr Gwyneth LEWIS  
**Principal Medical Officer, Department of Health**

**United Republic of Tanzania**
Ms Martha Moses MLATA  
**Member of Parliament**

**Viet Nam**
Dr Vo THI DE  
**Member of the National Assembly**
**Vice Director of Long An Health Department**

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**UN and other partners**

**United Nations Population Fund (UNFPA)**
Ms Thea FIERENS  
**Regional Director, Regional Office for Eastern Europe and Central Asia**
Ms Sietske STENEKER  
**Director**

**The Hague**

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Nongovernmental organizations

AMREF
Ms Anneke WENSING
Project officer

AWEPA
Ms Katharine BULBULIA
Council member and senior political adviser

CARE International
Ms Janet MEYERS
Sr SRH/HIV adviser in emergencies

Center for Human Emergence (CHE)
Ms Anne-Marie VOORHOEVE
Strategic connector

Inter-Parliamentary Union (IPU)
Mr Anders B. JOHNSSON
Secretary General

Ms Kareen JABRE
Manager, Programme for the promotion of partnership between men and women
Parliamentarians take action for maternal and newborn health

Cordaid
Mr Piet C.S.M. VAN GILS
Programme officer

Gender Concerns International
Sabra BANO
Director

HIRDA
Ms Fatumo FARAH
Director

International Confederation of Midwives (ICM)
Ms Agneta S. BRIDGES
Secretary-General

Ms Abigail KYEI
International midwifery adviser

Ms Nester T. MOYO
Senior midwifery adviser

Ms Marian VAN HUIS
Executive Committee, member and treasurer

MYBODY
Ms Mariëtte FLIPSE
Head of communication department

Netherlands School of Public and Occupational Health (NSPOH)
Ms Olga DE HAAN
Project leader

PEP International Foundation
Ms Conny BERGÉ
President

Population Services International (Europe)
Mr Nils GADE
Chief executive

Prisma
Mr Reinier VAN HOFFEN
Coordinator, HIV/AIDS programme

Red een Kind
Mr Paulus SAMUEL
Coordinator, HIV/AIDS programme

Rutgers Nisso Groep
Ms Pauline HAASDRECHT
Manager, intervention development and implementation

SIMAVI
Ms Rolien SASSE
Executive director

STOP AIDS NOW!
Ms Moniek A. VAN DER KROEF
Policy adviser

UMC Nijmegen
Professor Koos VAN DER VELDEN
Gynaecologist

Wemos
Ms Anke TIJTSMA
Senior project officer, human resources for health

White Ribbon Alliance for Safe Motherhood
Ms Kathy HERSCHDERFER
Board of Directors
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Women on Waves
Dr Rebecca GOMPERTS
Director

World Population Foundation
Ms Joanne LEERLOOIER
Research and monitoring and evaluation officer

World YWCA
Ms Sophie DILMITIS
Coordinator, HIV/AIDS

Youth Incentives
Ms Marijke PRIESTER
Head

The Hague - Making Pregnancy Safer