WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA

ORGANISATION MONDIALE DE LA SANTE
BUREAU REGIONAL DE L'AFRIQUE

ORGANIZAÇÃO MUNDIAL DE SAÚDE
SEDE REGIONAL AFRICANA

REGIONAL COMMITTEE FOR AFRICA

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31 August 2000

Fiftieth session
Ouagadougou, Burkina Faso, 28 August - 2 September 2000

ORIGINAL: ENGLISH

Provisional agenda item 11

REPORT OF THE TECHNICAL DISCUSSIONS

Reducing Maternal Mortality in the African Region: A challenge for the 21st Century

Introduction

1. The Technical Discussions were conducted in Ouagadogou, Burkina Faso, on 31st August 2000 during the fiftieth session of the Regional Committee. Representatives from Member States participated in these discussions. The bureau was constituted as follows:

Chairman: Professor Kelsey Atangamuerimo Harrison (Nigeria)

Vice-Chairman: Professor Maria do Rosario de Fatima Madeira Rita (Angola).

2. The list of participants is given in the Annex.

3. Following the introductory remarks by Professor B. Nasah, Coordinator, Division of Family and Reproductive Health, at the Regional Office, the Chairman, Professor Kelsey Atangamuerimo Harrison introduced the working document (AFR/RC50/TD1).

4. Professor Kelsey Atangamuerimo Harrison, using a series of slides, explained that maternal mortality in the African Region, estimated at an average of 870 deaths per 100,000 live births, was the highest in the world.

5. The determinants of this dramatic situation included the prevailing poor health conditions, including, *inter alia*, the HIV/AIDS epidemic, the depressed economy, poverty and persisting low literacy levels, the devastating effects of natural and man-made disasters, wars and civil strife. The paper then presented an outline of strategies that needed to be considered in efforts to reduce maternal mortality, focussing in particular on the fundamental principles that should underlie safe motherhood programmes; the utmost importance of a well-functioning health care system providing quality care at all levels and incorporating efficient referral systems; the need to ensure that women have access to services for the prevention of unplanned pregnancies as well as access to skilled care during pregnancy, delivery and the postpartum period, and to emergency obstetric care (EOC) when complications arise; and the need to strengthe community participation in the design, implementation and evaluation of programmes.

6. Prof. Harrison drew the attention of the group to the high maternal mortality found among "unbo emergencies", that is women who had not received antenatal care but who arrived at the hospita major complications. Drawing on his experience in Zaria (Nigeria) of a survey of hospital births the period 1976-1979, he revealed that the maternal mortality ratio (MMR, i.e. the number of m deaths per 100,000 live births) among such women was 2884, or about 70 times higher tha women who had received antenatal care and remained healthy during pregnancy (MMR of

finding illustrated, among other things, the importance of antenatal care in the detection and early referral of complications. Obviously, antenatal care could be expected to be effective only if it was supported by well-organized and well-equipped facilities for managing complications.

7. Poverty, lack of formal education and low GNP were identified as the most important indirect factors that significantly accounted for maternal mortality. In conclusion, Prof. Harrison encouraged the meeting to think positively and warned against fatalism. Although the reduction of maternal mortality (and morbidity) was a challenge, there were several clear examples of countries, including African countries, that had succeeded in bringing down their levels of maternal ill-health.

Organization and method of work

8. Professor Maria do Rosario de Fatima Madeira Rita, Vice-Chairman, explained the organization and method of work of the Technical Discussions. Participants were requested to discuss the successes, failures and obstacles that had impeded the reduction of maternal mortality since 1987, and formulate recommendations for Member States, WHO and development partners. They were divided into three groups: English-speaking, French-speaking and Trilingual (French-, English- and Portuguese-speaking). They met separately and each group elected a chairman and a rapporteur as follows:

English-speaking group:	Chairman	: Dr W.G. Manyeneng (Botswana)
	Rapporteur	: Dr L. K. Shodu (Zimbabwe)
French-speaking group:	Chairman	: Professor K. Bohoussou (Cote d' Ivoire)
	Rapporteur	: Dr S. Kaba (Guinea)
Trilingual group:	Chairman	: Dr. F. Songane (Mozambique)
	Rapporteur	: Dr E. Traore (Benin)

9. The Technical Discussions did not form part of the Regional Committee's work. The Chairman of the Technical Discussions will, however, submit a report to the Committee under Agenda item 11(document AFR/RC50/1).

10. At the plenary session, the participants made the following comments:

Successes

After the launching of the Safe Motherhood Initiative in 1987, there was greater awareness on the of maternal deaths, the discussion of which was previously a taboo. Knowledge about the e of the problem increased and its underlying causes were more clearly identified and quantified. afe motherhood activities are being implemented in most countries. Although attendance at as clinics increased, the quality of care has fallen in most places. On the whole, the gains patchy and limited to certain countries. Examples of such gains include policies, s and training of health workers in life-saving skills and in post-abortal care; an ning activities, organization of referral systems and the training and re-training of Furthermore, few countries have community participation in the financing of f needy expectant mothers to the hospital.

decision by the chiefs of a certain community to abolish harmful riage, female genital mutilation (FGM), and to encourage schooling

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Failures and obstacles

13. A wide range of factors that have impeded progress in the reduction of maternal mortality were identified by the group. They were classified into the following categories:

(a) Socioeconomic and political factors
- abject poverty of the masses, especially women;
- illiteracy;
- the socioeconomic status of women;
- inability to implement global plans at country level;
- charging of user fees deterring women from using services;
- decision makers not taking into account the views of the community;
- insufficient resources to match the magnitude of the problem.
- globalization aggravating unfair terms of trade.

(b) Health system factors
- generally low institutional deliveries;
- absence of mechanisms to collect community data on maternal deaths;
- weak TBA programmes in terms of management, support and supervision;
- skewed distribution of health workers;
- negative attitude of health workers;
- weak health systems failing to provide essential obstetric care, including emergency obstetric care (EOC);
- services not putting enough emphasis on monitoring, evaluation and supervision;
- too much emphasis placed on prevention (ante-natal care and family planning);
- national standards and protocols not sufficiently developed or updated, or used where they exist.

(c) Cultural factors
- lack of male participation;
- institutionalized neglect of women;
- persistence of harmful traditional practices.

(d) Other factors
- High attrition rates of health workers;
- Lack of political commitment; whereas some countries may have real problems with resources, others do not appear to support declarations with matching resource allocations;
- Inadequate inter-sectoral collaboration;
- Inadequacy in policy frameworks: legislation and regulations on issues such as family health insurance and abortion;

Recommendations and the way forward

14. In the light of the successes, failures and obstacles identified above, the Technical Discussions group made the following recommendations for consideration by the Regional Committee:

For Governments

(a) Political commitment
- Maternal mortality reduction needs to be part of the poverty reduction strategy.
- Improving literacy, especially among women, is crucial;
- Building on recommendations from the forty-ninth Regional Committee, budgets allocated to the health sector should not be less than 15% of national budgets;
- Conflicts should be resolved because of their adverse effects, especially on women;
- Legislative frameworks to improve women's status need to be put in place;

- Mechanisms that incorporate ethical considerations should be put in place to cater for the poor.
- There is need for close co-operation and collaboration between countries in order to share information and limited resources.

(b) Improvement of accessibility and quality of care

- Health systems need to be strengthened to improve maternal and neonatal care by improving provider skills, providing appropriate and adequate equipment as well as incentives to retain staff;
- The collection and use of reliable data needs to be promoted as well as district-based research that feeds into policies and programmes;
- Training, support and supervision of TBAs should continue in countries that have them, given the low coverage of institutional deliveries;
- Monitoring and evaluation indicators need to be harmonized;
- Unplanned pregnancies, especially among adolescents, need to be prevented.

(c) Community involvement

- Communities need to be involved in the entire process of planning, implementation and evaluation;
- Radio-communication and transportation as well as community initiatives need to be strengthened;
- Elimination of female genital mutilation and other harmful traditional practices should be encouraged;
- Male involvement should be promoted;
- Information and education interventions need to be strengthened.

For WHO

- Facilitate inter-country sharing of information and best practices;
- Harmonize and co-ordinate programmes especially in training and development of norms and standards;
- Provide technical backstopping, financial support and equipment such as for emergency obstetric care.

For Development Partners

- Their support should be based on country needs, for e.g. on strengthening of health systems rather than only being concentrated on information and education and social mobilization;
- Debt cancellation benefits need to be channelled to the social sectors (health and education);
- Loans for health projects should be interest-free;
- They should cooperate in nationally co-ordinated programmes.

Proposed regional priorities

15. Since 75% of maternal deaths occur during the intra-partum and the immediate post-partum period, there is a need to focus on the following:

- Emergency obstetric care, training, re-training and quality of care;
- Elimination of the "three delays" implying functional referral systems, backed by radio communication;
- Community involvement from the beginning to ensure ownership, sustainability and effectiveness;
- Information gathering to ensure evidence-based interventions;
- Maternal death audit at community level and at the different levels of care and research to improve performance;
- Male involvement in all activities;
- Safe motherhood should be part of development plans.

Conclusion:

16. Every country needs to develop its own evidence-based programme, building on participatory broad-based assessments of prevailing conditions and community needs. The prevailing high level of social injustice in the Region is impeding progress, and sustained efforts to reduce it are necessary.

Appendix 1: Composition of working groups

Working Group No. 1

1. Angola	Dr Augusto Rosa A. Neto
2. Angola	Dr Adelaïde de Carvalho
3. Benin	Dr Esther Traoré
4. Bénin	Prof. E. Alihonou
5. Burundi	Dr Ntahobali Stanislas
6. Cameroon	Dr Basile Kolo
7. Cape Verde	Dr Alicia Wahnon
8. Cape Verde	Dr Rosa Lopes
9. Central Africa (Rep)	Dr Emmanuel Ngembi
10. Central Africa (Rep)	Dr Augustine Marthe Kirimat
11. Ethiopia	Mr Meqyuaneny Tesfu
12. Guinea-Bissau	Sr Ivonne Menezes Moreira
13. Guinea	Dr Naby Moussa Balde
14. Mozambique	Dr Martinho Dge Dge
15. Mozambique	Dr Francisco Songane
16. Nigeria	Dr Adenike A. Adeyemi
17. Rwanda	Dr Mugabo Maria
18. Rwanda	Dr Bucagu Maurice
19. Rwanda	Mr Jean Nyirinkwaya
20. South Africa	Dr Roland Edgar Mhlanga
21. Zambia	Dr Gavin Silwamba
22. UNICEF	Dr El Abassi A.
23. WHO/Burkina Faso	Dr Francis Monet

Working Group No. 2

1. Botswana	Dr Winnie G. Mangeeg
2. Eritrea	Dr Solomon Ghebreyesus
3. The Gambia	Dr Yankuba Kassama
4. Ghana	Dr Henrietta Odoi-Agyarko
5. Kenya	Mrs Kandie
6. Kenya	Dr Njaue JN
7. Lesotho	Dr M. Moteetee
8. Liberia	Dr Bernice Dahon
9. Malawi	Mrs NO Gama
10. Malawi	Richard Pendame
11. Namibia	Ms E.K. Shihepo
12. Sierra Leone	Dr Noah Conteh
13. Swaziland	Dr John M. Kunene
14. Swaziland	Doreen Dlamini
15. Tanzania	Dr Theopista John
16. Uganda	Dr Sam Okware
17. Zimbabwe	Dr Batsi Makunike
18. Zimbabwe	Dr L. K. Shodu
19. WAHO (ODAS)	Dr Kabba T. Joiwer

Working Group No. 3

1. Burkina Faso	Prof. François Tall
2. Burkina Faso/SAGO	Prof. Bibiane Koné
3. Burkina Faso/ICM	Mme Thiombiano Brigitte
4. Chad	Dr Garba Tchang Salomon
5. Côte d'Ivoire	Prof. Bohoussou Kovadio
6. Côte d'Ivoire	Dr Aie-Tanoh Laure
7. Côte d'Ivoire	Dr Koumandi Coulibaly
8. Comoros	Dr Toyb Mbaé
9. Congo (Rép. Du)	Dr André Enzanza
10. Congo (Rép. Du)	Dr Damase Bodzongo
11. Equatorial Guinea	Dr Abia Nseng S.
12. Guinée	Dr Séré Kaba
13. Mauritanie	Dr Kane Amadou Racine
14. Mali	Dr Salif Samaké
15. Mali	Prof. Amadou Dolo
16. Niger	Dr Karim Abdoulaye Maiga
17. Niger	Dr Gagara Magagi
18. Senegal	Dr Adama Ndoye
19. Togo	Dr Agbobli A. Eli
20. WHO/Burkina Faso	Dr Azara Bamba
21. WHO/AFRO	Dr Khadidiatou Mbaye

WHO Secretariat:	Professor B. Nasah
	Dr Paul van Look
	Dr J. A. Kalilani
	Dr K. Mbaye
	Dr F. R. Zawaira
	Mme E. Hoff