

A close-up photograph of a woman with a red bindi on her forehead and a gold nose ring, smiling warmly. She is wearing a brown shawl and holding a newborn baby wrapped in a light-colored blanket. The baby is looking towards the camera.

## Sustaining Parliamentary Action to Improve Maternal, Newborn and Child Health



## **Inter-Parliamentary Union**

The House of Parliaments  
5 chemin du Pommier  
Case postale 330  
CH-1218 Le Grand-Saconnex  
Geneva, Switzerland

Telephone: +41 22 919 41 50  
Fax: +41 22 919 41 60  
E-mail: [postbox@mail.ipu.org](mailto:postbox@mail.ipu.org)

[www.ipu.org](http://www.ipu.org)

## **Office of the Permanent Observer of the IPU to the United Nations**

Inter-Parliamentary Union  
336 East, 45th Street, Tenth Floor  
New York, N.Y. 10017  
United States of America

Telephone: +1 212 557 58 80  
Fax: +1 212 557 39 54  
E-mail: [ny-office@mail.ipu.org](mailto:ny-office@mail.ipu.org)

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**Front cover image:** Ensuring maternal, newborn and child health remains a challenge in the second most populous country in the world, India. © WHO

## Foreword

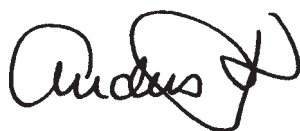
Too many women and children across the world still die unnecessarily from preventable illnesses or lack of adequate health care. Maternal, newborn and child health (MNCH) is now recognized as one of the most critical issues facing human development, requiring global solidarity and concerted urgent action. The post-2015 development agenda being discussed to succeed the Millennium Development Goals (MDGs) represents an opportunity to take bold new strides in ensuring that a fundamental human right – the right to health – is not denied to the majority of the world’s population.

Recent global and national efforts have yielded significant progress in reducing maternal and child mortality. They have spotlighted the role of parliaments and parliamentarians in tackling the issue. Whether in global forums or national processes, parliamentarians’ unique contribution to MNCH is now established and accepted. Much remains to be done, however, to ensure MNCH is a reality for women and children everywhere, regardless of where in the world they live. This presents parliamentarians across the world with both an opportunity and a responsibility to act.

At its 126th Assembly (Kampala, March 2012), IPU adopted a landmark resolution, *Access to health as a basic right: The role of parliaments in addressing key challenges to securing the health of women and children*. It spells out the concerns of parliaments and their commitments in response. Parliaments are working to deliver on their commitments, but they face clear and formidable capacity constraints and lack knowledge of what is required of them.

IPU is committed to supporting parliaments’ efforts on MNCH. This handbook is an integral part of our support to parliaments working to meet their obligations under the resolution, particularly those in countries where maternal, newborn and child deaths remain high. It is motivated by IPU’s belief that every parliamentarian, involved in women’s and children’s health or not, has an important contribution to make to this endeavour.

It is my sincere hope that parliamentarians and those working with them will find this handbook to be a practical and relevant resource as they work to overcome one of the biggest hurdles to human development today.



**Anders B. Johnsson**  
Secretary General  
Inter-Parliamentary Union

# Contents

Definitions .....	6
Acronyms .....	8
Introduction .....	9
Who has this handbook been written for?	9
What is in this handbook?	10
How to use this handbook	10
1. Why parliamentary action on maternal, newborn and child health is important .....	12
2. Maternal, newborn and child health – problem and response .....	18
Maternal, newborn and child death and illness can be prevented	18
Change has already begun	20
Improving maternal, newborn and child health – what works	23
Gender and health	24
Reproductive and sexual health – essential for women’s and children’s health	25
The power of community action – prevention and early response	27
A strong health system	29
Measuring progress to achieve the best results – accountability for results	33
3. What parliamentarians can do to advance maternal, newborn and child health .....	37
Legislation	37
Oversight	40

Budget appropriation	44
Representation	46
Taking the lead	47
Global action	50
<b>4. The importance of keeping informed</b> .....	<b>53</b>
The importance of staying informed	53
Finding out local information and capacity needs	54
<b>Annexes</b> .....	<b>58</b>
Annex 1: National data on maternal, newborn and child health	58
Annex 2: A framework for coordinated action to improve women’s and children’s health	60
Annex 3: Annotated bibliography	61
<b>Summary sheets</b> .....	<b>64</b>
Summary sheet 1: Maternal, newborn and child health – key messages	64
Summary sheet 2: MNCH-related Millennium Development Goals	66
Summary sheet 3: Key packages of interventions for MNCH	67
Summary sheet 4: Tracking financial resources – global commitments	74

# Definitions

All definitions are global UN definitions, endorsed in international commitments and treaties, unless otherwise stated.

## **Adolescent**

All individuals aged 10–19 years

## **Child**

All individuals aged 0–17 years

## **Gender**

The social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, as well as the relations between women and those between men. These attributes, opportunities and relationships are socially constructed and are learned through socialization processes. They are context/time-specific and changeable.

## **Gender-based violence**

Any harmful act that is perpetrated against a person's will based on socially-ascribed (gender) differences between males and females.

(Source: Inter-Agency Steering Committee on GBV)

## **Infant**

A child of between 29 days and one year of age

## **Infant mortality rate**

Probability of dying between birth and one year of age, per 1,000 live births

## **Under-five mortality rate**

Probably of dying between birth and five years of age, per 1,000 live births

## **Maternal death**

Death of a woman while pregnant or within 42 days of pregnancy ending

## **Maternal mortality ratio**

The ratio of the number of maternal deaths per 100,000 live births during a given time period

## **Neonatal**

First 28 days after birth



**Newborn**

An infant from the time of birth through the first 28 days of life

**Reproductive health**

A state of complete physical, mental and social well-being and not merely the absence of reproductive disease and infirmity. Reproductive health deals with the reproductive processes, functions and system at all stages of life.

**Sexual health**

Having a positive approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. (World Health Organization, [www.who.int/topics/sexual\\_health/en/](http://www.who.int/topics/sexual_health/en/))

**Sexuality**

Sexuality encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, beliefs, attitudes, values, behaviours, practices, roles and relationships (World Health Organization, Working Definition, 2006).

**Young person**

Male or female aged 15–24 years

# Acronyms

## **CARMMA**

Campaign on Accelerated Reduction of Maternal Mortality in Africa

## **GBV**

Gender-based violence

## **HIV**

Human Immunodeficiency Virus

## **ICPD**

International Conference on Population and Development

## **IPU**

Inter-Parliamentary Union

## **MDG**

Millennium Development Goal

## **MNCH**

Maternal, Newborn and Child Health

## **NGO**

Non-governmental organization

## **PMNCH**

Partnership for Maternal, Newborn and Child Health

## **PMTCT**

Prevention of mother-to-child transmission of HIV

## **UNAIDS**

Joint United Nations Programme on HIV and AIDS

## **UNFPA**

United Nations Population Fund

## **UNICEF**

United Nations Children's Fund

## **WHO**

World Health Organization

# Introduction

Millions of women and children die unnecessarily across Africa, Asia and Latin America. Every five minutes, three women lose their lives due to complications of pregnancy or childbirth, 60 others suffer disability or long-term injury, and 70 children die, nearly 30 of them in the first month of life.<sup>1</sup> Almost all of these deaths can be prevented, and countries across Africa, Asia and Latin America have shown that this can be done. Where communities have been mobilized and health systems strengthened, fewer women are dying in childbirth and more children are surviving beyond their fifth birthday.

Many countries have committed themselves to addressing maternal, newborn and child health, especially those with the highest burden of maternal, newborn and child mortality in Africa and Asia.

Parliamentarians are central in turning these commitments into meaningful change for women and children. In some countries, parliamentarians have taken the lead in this area, advancing their countries' social and economic development. In this way, parliamentarians can help turn the tide for women and children.

## Who has this handbook been written for?

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This handbook has been written for parliamentarians and those who are involved in parliamentary processes, including:

- All members of parliament, newly elected and those with on-going tenure, including, but not limited to, members of statutory parliamentary portfolio committees on health and ad hoc committees responsible for addressing women's and children's health and rights;
- Members of parliament, or those working with members of parliament, who are engaged in related issues, such as finance, children, gender, youth or HIV, and wish to link their work with maternal, newborn and child health;
- Members of parliamentary caucuses, networks, forums or associations dealing with health or maternal, newborn and child health;

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<sup>1</sup> WHO and UNICEF, 2012. *Countdown to 2015: Maternal, Newborn and Child Survival: Building a Future for Women and Children – The 2012 Report*.

- Parliamentary staff, including clerks, supporting portfolio committees;
- Members of other parliamentary bodies including regional bodies within Africa, Asia and Latin America, such as the Pan-African Parliament, Latin American Parliament (Parlatino) and Central American Parliament.

This handbook provides these audiences with the information they will need in order to take action on maternal, newborn and child health.

## What is in this handbook?

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Section 1 sets out the importance of parliamentary action if maternal, newborn and child health are to improve.

Section 2 provides a summary of the state of maternal, newborn and child health and the related opportunities and challenges that parliamentarians will encounter.

Section 3 suggests key actions that parliamentarians – as members of the legislature and as representatives of their populations – can take to provide leadership on maternal, newborn and child health.

Section 4 lists key information sources and provides information on where parliamentarians can access further technical information.

Throughout the handbook, real-life examples illustrate how parliamentarians have risen to the challenge and are contributing to the campaign to end preventable maternal, newborn and child deaths. The handbook focuses on high-burden countries in Africa, Asia and Latin America.

## How to use this handbook

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### Reference guide for members of parliament to take action

This handbook offers parliamentarians an overview of the key concepts and facts that will be helpful in raising maternal, newborn and child health on the policy agenda. The information in the handbook can be supplemented with data from individual countries. Section 4 and Annex 1 provide links to resources that parliamentarians can use to access information relevant to their own country.

## Resource for advocacy and awareness raising



Where this logo is shown, there are practical suggestions on how the information in the handbook can be used to advocate for or raise awareness of maternal, newborn and child health.

## Orientation for parliamentarians

An orientation manual for parliamentarians on maternal, newborn and child health accompanies this handbook. The orientation manual is intended for use by facilitators who will adapt its contents to reflect the national context and priorities in order to build the capacity of parliamentarians and others who are involved in parliamentary processes. It is available from the Inter-Parliamentary Union (IPU) and Member Parliaments of IPU.

# 1. Why parliamentary action on maternal, newborn and child health is important

“ In the past, we have seen that when the spotlights are switched off, world attention quickly moves on to other issues. We, parliamentarians who represent citizens from around the globe, cannot allow that to happen. *The right of women and children to the highest attainable standard of health must be consistently and persistently pursued now, through the final year of the MDG process, 2015, and beyond.*”

—United Nations Secretary-General, High-Level Plenary Meeting of the General Assembly on the MDGs, 2010.

## Everyone must act on maternal, newborn and child health

- **There is an urgent need for action.** Every year, millions of women and children die and millions more become sick or disabled from problems during pregnancy, childbirth and in early childhood. Almost all of these deaths and disabilities are preventable.
- **It is possible to make a difference.** One third as many children under the age of five are dying today than in 1990. The number of women who die in pregnancy or childbirth has nearly halved since 1990 – from 543,000 deaths a year to around 287,000 in 2010.<sup>2</sup>
- **Governments across the world have committed to take action** on maternal, newborn and child health. Parliamentarians must ensure that commitments, such as those highlighted in Table 1 below, are translated into improved maternal, newborn and child health.
- **Under the leadership of the Inter-Parliamentary Union (IPU), parliaments across the world have committed to deepening action on maternal, newborn and child health.** IPU's resolution on securing the health of women and

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2 The data in this document comes from *Countdown to 2015*, unless stated otherwise, and *Countdown's* data, in turn, comes from national health information systems. Ideally, the calculation of maternal mortality ratios would depend on high-quality vital registration, in which every death is reported and the cause of death is accurately attributed. At present, only around a third of *Countdown* countries have birth registration coverage over 75 per cent, and around 14 per cent have death registration coverage over 50 per cent. Only one fifth of *Countdown* countries collect maternal mortality data from surveys or censuses. At present, most of the data on maternal mortality is derived from estimates using models that draw on data from several sources, including vital registration, household surveys, censuses and other studies. This data is then used to estimate maternal mortality ratios by the Maternal Mortality Estimation Inter-agency Group. (See section 5 for more information on data collection and analysis.)

**Table 1:** Regional and international commitments on maternal, newborn and child health

Key commitments and resolutions on maternal, newborn and child health		
2000	Millennium Declaration and Millennium Development Goals	MDG 4 aims to reduce the global under-five mortality rate by two thirds between 1990 and 2015 (from 9.7 million in 2006 to around 4 million by 2015). MDG 5 aims to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.
2006	Maputo Plan of Action	Declaration on Sexual and Reproductive Rights for Women, signed by African Union Members who unanimously agreed poor sexual and reproductive health is a leading killer in Africa. The goal of the Maputo Plan of Action is universal access to comprehensive sexual and reproductive health services in Africa by 2015.
2009	Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA)	Campaign launched by the African Union to accelerate the availability and use of universally accessible quality health services, including those related to reproductive and sexual health.
2010	African Union Declaration for Actions on Maternal, Newborn and Child Health in Africa by 2015	AU ministers pledged to: meet the Abuja target to commit 15 per cent of national budgets to health, launch the Campaign on the Accelerated Reduction of Maternal Mortality in Africa (CARMMA), and to report to ensure greater accountability.
2010	Global Strategy for Women's and Children's Health	Provides overarching framework to address maternal, newborn and child health, with agreed strategies and indicators.
2012	IPU Resolution on securing the health of women and children	Resolution adopted unanimously at the 126th Inter-Parliamentary Assembly, 5th April 2012.
2012	Human Rights Council Resolution on preventable maternal mortality and morbidity and human rights	Resolution reaffirms 2009 commitment to addressing the root causes of preventable maternal deaths and disability, accompanied by technical guidance on how to implement a rights-based approach.
2012	Manila Declaration on Accelerating Progress for Women's and Children's Health in Asia and the Pacific	Ministers and senior officials from nearly 20 countries in the Asia-Pacific region sign the Manila Declaration, setting out concrete, measurable actions to enhance regional co-operation to advance maternal, newborn and child health in the Asia-Pacific region.
2013	General Comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (Art. 24)	At its 62nd session, the Committee on the Rights of the Child adopted this comment, which provides a conceptual framework and recommendations for concrete measures and actions required by States Parties and non-state actors to fulfil these obligations. All signatories of the Convention on the Rights of the Child (CRC) must abide by this comment.

children, which was adopted unanimously at the 126<sup>th</sup> Inter-Parliamentary Assembly in April 2012, commits IPU and Member Parliaments to work towards:

- Political commitment for maternal, newborn and child health, evidenced by the establishment of appropriate legal frameworks and information and accountability systems;
- Financial support for maternal, newborn and child health, including: ensuring efficient and effective use of available resources; proper tracking and accountability for both domestic and official development assistance funds for health;
- Ensuring availability and accessibility of essential, integrated health services for women and children through a variety of approaches, including the provision of adequate qualified health personnel;
- Mobilizing and involving all stakeholders and partners in the area of maternal, newborn and child health and ensuring a coordinated approach across sectors that contribute to health services.

## Maternal, newborn and child health is both a human right and a national development necessity

- **Women and children have a right to health**, as enshrined in the Universal Declaration of Human Rights (Art. 25) that was first endorsed by 48 members of the United Nations in 1948 and has since been translated into two legally enforceable covenants, the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). Both covenants became international law in 1976.<sup>3</sup>
- **National economic and social development can happen only if a country's women and children are healthy.**<sup>4</sup> As stated in the *Global Strategy for Women's and Children's Health*, good maternal, newborn and child health frees up money for food, housing, education and activities that generate income. Healthier women have healthier children; healthier children grow into more productive adults. The provision of basic preventive and curative health care to women and children saves spending billions of dollars on expensive medical treatment.

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3 The following countries have signed but not ratified the ICESCR, which contains commitment to health: Belize, Comoros, Cuba, Palau, São Tomé and Príncipe, South Africa and the United States. The following countries have neither signed nor ratified the ICESCR: Africa (Botswana, Mozambique, South Sudan); Asia (Bhutan, Brunei, Myanmar, Fiji, Kiribati, Malaysia, Marshall Islands, Federated States of Micronesia, Nauru, Samoa, Singapore, Tonga, Tuvalu, Vanuatu); Europe (Andorra); Latin America and the Caribbean (Antigua and Barbuda, Haiti, Saint Kitts and Nevis, St. Lucia); Middle East (Oman, Qatar, Saudi Arabia, United Arab Emirates).

4 United Nations, 2010. *Global Strategy for Women's and Children's Health*.



## Investing in maternal health as a springboard to national economic growth

Between one third and one half of Asia's economic growth in 1965–1990 has been attributed to improvements in reproductive health and reductions in child mortality and fertility rates.

Source: PMNCH/IPU, 2010. *Taking the lead: Parliamentarians engage with maternal, newborn and child health.*

In 2012, African Ministers of Finance and Health and African parliamentarians committed to greater investment in health, including maternal, newborn and child health at the Ministerial Conference on Value for Money, Sustainability and Accountability in the Health Sector, held in Tunis on 4–5 July 2012. The resulting Tunis Declaration recognized that parliamentarians have a key role to play in ensuring that Africa attains universal health coverage, the health-related MDGs and other developmental goals by 2015 and beyond. The Tunis Declaration states that improved health is instrumental to economic growth, social development and to reducing inequality and poverty.

Parliamentarians present at the Ministerial Conference promised to integrate principles of the Tunis Declaration into ongoing efforts, such as: the 2011 commitment and resolution of the Pan-African Parliament to prioritize policy and budget action for health, especially MNCH and youth development; the 2010 Parliamentary Policy and Budget Action Plan on Maternal, Newborn and Child Health and Development in Africa, and other earlier African commitments on health. These commitments highlight the importance that African governments place on maternal, newborn and child health as a social and economic investment for the continent.

Source: African Development Bank, <http://www.afdb.org/en/news-and-events/article/health-ministers-say-investing-in-health-is-key-to-inclusive-and-sustainable-growth-in-africa-9460/>.

## Investing in maternal, newborn and child health – the political imperative

Becoming engaged in maternal, newborn and child health strengthens parliamentarians' role in influencing national health and development policies.

- It is a **responsibility of the State**, through its elected representatives, to reduce death and suffering. There is a moral and practical imperative to assist all people living in a country to realize their basic rights, including the right to health.

## Parliamentary attention can generate greater parliamentary legitimacy

Bangladeshi television broadcasts a weekly political debate, *Bangladesh Sanglap* (Dialogue on Bangladesh), filmed in front of a live audience. The programme gives people the opportunity to question parliamentarians and other public figures on topics of their choice, such as justice, corruption, education, health, local government, trade, security and the institutions of state. Half the audience are women. The prime minister's adviser on health and family welfare once appeared as a panellist; one episode was devoted to how health services could be improved.

The programme is watched by seven million people every week. A survey of the general TV audience, policy makers, government officials and the media, found that:

- 86 per cent felt that the programme has improved political debate in Bangladesh;
- 78 per cent thought it has improved transparency and accountability;
- 89 per cent felt that it explains issues in a way that they could understand;
- 91 per cent believed it has helped raise the voice of the people, especially those from deprived backgrounds.

One TV viewer sums up the value of such engagement clearly: "Our voters are not aware. This is why our electoral process doesn't work soundly. If *Bangladesh Sanglap* helps them become aware, then the electoral process will work well and people will elect qualified candidates."

Source: PMNCH/IPU, 2010. Taking the lead: Parliamentarians engage with maternal, newborn and child health.

- Members of parliament have a duty to **promote the well-being of their constituents** without regard for race, gender or social standing. This means ensuring equity for all women and children and addressing the factors that make women unhealthy, including gender inequity, violence and limited access to resources.

“Improvements in maternal and child health require progress related to poverty and hunger (MDG 1), access to education (MDG 2), gender equality and the empowerment of women (MDG 3), and the prevalence of HIV/AIDS and malaria (MDG 6).”

—Resolution C-III/126/DR-cr, *Access to health as a basic right: The role of parliaments in addressing key challenges to securing the health of women and children*, 126th Assembly of the Inter-Parliamentary Union, 3 April 2012.

## Maternal, newborn and child health essential for reaching the Millennium Development Goals (MDGs)

The MDGs are the universal framework for development and poverty reduction, established in 2000 in the Millennium Declaration. MDGs 4 and 5 explicitly address women's and children's health.

- MDG 4 aims to reduce the global under-five mortality rate by two thirds between 1990 and 2015. This means reducing the number of child deaths from 9.7 million in 2006 to around 4 million by 2015.
- MDG 5 aims to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.

Accomplishing these two MDGs will require accelerated action, including action toward the other MDGs:

**MDG 1 to eradicate extreme poverty and hunger, specifically by addressing nutrition with a focus on infant and young child feeding.** Poor nutrition is a direct cause of child death and increases maternal mortality. Poor households are less likely to be able to afford essential maternal, newborn and child health services.

**MDG 2 to achieve universal primary education, especially for girls.** There is a direct link between girls' education and delayed childbirth, improved maternal health and reduced infant death and ill health.

**MDG3 to promote gender equality.** Gender equality is essential if MNCH interventions are to succeed, by enabling women and girls to make better choices, improving female income and ensuring sufficient focus on girls' and women's health concerns.

**MDG 6 to combat HIV/AIDS, malaria and other diseases.** HIV is one of the biggest threats to maternal and child health in high-prevalence countries in Africa; preventing malaria is one of the essential antenatal and infant health interventions.

**MDG 7 to ensure environmental sustainability, through tracking access to an improved water source and an improved sanitation facility.** Improved sanitation and clean drinking water would reduce infant and child deaths substantially, as well as reducing the time that women and girls spend on water collection.

**MDG 8 solidarity to provide affordable essential drugs on a sustainable basis.** The 2012 Commission on Life-Saving Commodities for Women and Children highlights 13 life-saving commodities for reproductive, maternal, newborn and child health.

See [www.un.org/millenniumgoals/](http://www.un.org/millenniumgoals/) for more information on the Millennium Development Goals.

## 2. Maternal, newborn and child health – problem and response

### KEY MESSAGES

There is global consensus on the need to take collective action on women's and children's health and on how this should be done.

The huge disparities in maternal, newborn and child health between rich and poor countries, and within countries, can and must be addressed for national economic growth and social cohesion.

A few known health interventions that are simple to administer could eliminate most maternal, newborn and child deaths. These are already being successfully delivered in some countries with high maternal, newborn and child deaths and limited resources.

A strong health system, with integrated services that link community and family through all stages of the life cycle, together with a skilled workforce, can generate significant improvements in maternal, newborn and child health. This is called the continuum of care.

Each country must measure progress on maternal, newborn and child health to ensure that it delivers results for *all* women and children, especially those who are most disadvantaged, using the proposed 11 core indicators that measure results.

Parliamentarians have a key role in ensuring accountability for results, by making sure that women and children are at the centre of the response and by managing oversight mechanisms.

### Maternal, newborn and child death and illness can be prevented

- Over 960 women and girls die every day as a result of preventable complications in pregnancy and childbirth around the world.<sup>5</sup>

5 UNICEF, 2012, *State of the world's children 2012*.



- Every year 7.6 million children die before their fifth birthday, 3.3 million of them in the first month of life.<sup>6</sup>
- Up to 2 million children each year die within the first 24 hours of life and there are 2.6 million stillbirths.<sup>7</sup>
- Teenage girls are almost a third more likely to die during pregnancy or childbirth than women aged 20 to 24 years.<sup>8</sup> Children born to girls aged 17 years and under are significantly more likely to die in their first year of life than children born to older first-time mothers. First-time mothers aged 27–29 years are least likely to have nutritional or health problems in their children.<sup>9</sup>
- For every woman who dies in pregnancy, another 30 suffer long-lasting injury or illness and the inevitable side effects, such as obstetric fistula and mental illness.
- Millions of babies suffer from birth-related injuries, infections, diseases and disabilities, which often affect their entire lives.

The most important way to prevent deaths during pregnancy and childbirth is to increase access to quality care before, during and after childbirth. This means, in particular, ensuring that there are enough midwives and making available emergency obstetric care around the clock for all women.

Table 2 below shows the main causes of death of women in pregnancy and childbirth, and of children from birth to five years. Almost all of these deaths are preventable, either through family- and community-based actions, such as malaria prevention or improved nutrition during pregnancy, or through simple health-care treatment at a local health facility with some core life-saving commodities and staff trained to recognize potential health problems at an early stage.

## Change has already begun

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Thanks to the energy and innovation of women and children, communities, health workers and many others – including parliamentarians – substantial progress has been

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6 PMNCH Knowledge summary 16: Parliamentarians.

7 United Nations Population Fund (UNFPA), 2011. *State of the World's Midwifery 2011: Delivering Health, Saving Lives*. New York: UNFPA.

8 Blanc, A. et al. 2012. *New Findings for Maternal Mortality Age Patterns: Aggregated Results for 38 countries*. Maternal Health Task Force.

9 Finlay J. et al., 2011. *The association of maternal age with infant mortality, child anthropometric failure, diarrhoea and anaemia for first births: Evidence from 55 low- and middle-income countries*. *BMJ Open* e000226. doi:10.1136/bmjopen-2011-000226.

**Table 2:** Key causes of maternal, newborn and child mortality

Cause of death*	How these deaths could be prevented
Seven out of 20 maternal deaths (35%) are due to blood loss during delivery	Prevention of early pregnancy, when young women's bodies are not ready for birth; nutrition for pregnant women. Skilled birth attendant present at delivery; immediate treatment of severe blood loss after delivery (post-partum haemorrhage), for example using drugs such as misoprostol.
Nearly two in 20 maternal deaths (18%) are due to largely preventable diseases, especially malaria and HIV	Access to insecticide-treated bed nets; access to HIV testing and HIV antiretroviral treatment for all women, especially pregnant women.
Almost one in 10 maternal deaths (9%) is caused by unsafe abortion	Information on how to prevent unwanted pregnancies and how to access early-induced abortion, where this is legal; access to family planning; quality post-abortion care in all circumstances, without fear of prosecution of the health-care provider or woman.
Two out of every five child deaths are in children under one month old	Access to regular antenatal care for all women; nutritional care for women before and during pregnancy.
Almost one quarter of child deaths are from complications before and during birth	Access to antenatal care for all women (at least four visits with a trained maternity health-care provider).
Over one third of all child deaths are from infections, including pneumonia, measles and tuberculosis	Immunization for all pregnant women and all children; nutritional education and support; vitamin A supplements for young children; early diagnosis of pneumonia and antibiotic treatment.
More than three in 20 child deaths are from diseases caused by poor water and sanitation (diarrhoea and malaria)	Access to safe water and sanitation, insecticide-treated bed nets.

\* Data in this table from *Women's and Children's Health: Needs and Challenges, Partnership on Maternal, Newborn and Child Health*, [portal.pmnch.org/](http://portal.pmnch.org/) and *Immunization, vaccines and biologicals*, World Health Organization, [www.who.int/vaccines/en/vitamina.shtml](http://www.who.int/vaccines/en/vitamina.shtml).

made in the delivery of many aspects of maternal, newborn and child health in recent years. However, more needs to be done as a matter of urgency to stop the unnecessary loss of life.

- International maternal, newborn and child health commitments are not likely to be met at current levels of effort. Only nine of the 75 *Countdown*<sup>10</sup> countries are on

10 *Countdown to 2015* tracks coverage levels for health interventions proven to reduce maternal, newborn and child mortality.

track to achieve MDG 5. Only 23 of the 75 *Countdown* countries are on track to achieve MDG 4.

- Progress is unequal both between and within countries. An African woman's life-time risk of dying from pregnancy-related causes is 100 times higher than that of a woman in a developed country. Girls, women, newborns and children in poor households, rural and remote areas, or those who are migrants or displaced and affected by conflict have much worse health than others. Women and children affected by HIV, adolescents, sex workers and women and children with disabilities often face discrimination and stigma.
- Health systems remain weak, insufficiently funded and are often unequally distributed.
- Integrated health services must be provided through the continuum of care. This includes integrated service delivery for women and children from before pregnancy to delivery, during childhood and the period immediately after birth. It also includes provision of care at the family and community levels, through outpatient services, clinics and other health facilities.
- There must be more integration with other sectors beyond health. Food insecurity and lack of access to safe water or sanitation, leading to diarrhoeal diseases, are significant causes of maternal, newborn and under-five deaths and undernutrition.

### **Global Strategy for Women's and Children's Health**

The main goal of this Strategy, launched by the United Nations Secretary-General, Ban Ki-moon, is to save 16 million lives by 2015 in the world's 49 poorest countries.

The Strategy sets out key areas where action is required to enhance financing, strengthen policy and improve service delivery:

1. Support for country-led health plans, supported by increased, predictable and sustainable investment.
2. Integrated delivery of health services and life-saving interventions – so women and their children can access prevention, treatment and care when and where they need it.
3. Stronger health systems, with sufficient health workers at their core.
4. Innovative approaches to financing, product development and the efficient delivery of health services.
5. Improved monitoring and evaluation to ensure the accountability of all actors for results.

Source: [www.everywomaneverychild.org/images/content/files/global\\_strategy/full/20100914\\_gswch\\_en.pdf](http://www.everywomaneverychild.org/images/content/files/global_strategy/full/20100914_gswch_en.pdf).





Insecurity threatens the health of women and children in Afghanistan during birth and throughout life. © UNICEF/NYHQ2010-0310/Holt

- Conflict and natural disasters are impeding progress on maternal, newborn and child health. In 2006, over 50 per cent of all maternal deaths occurred in fragile States.<sup>11</sup>

The Global Strategy for Women’s and Children’s Health (see box) is a rallying call for all countries. In response to this call, many countries have announced their commitments as to how they will contribute to the objectives of the Global Strategy.

## Improving maternal, newborn and child health – what works

The following are key, essential interventions in the area of maternal, newborn and child health that can be made at various stages, are effective and have been shown to be feasible in countries with limited resources:<sup>12</sup>

<sup>11</sup> Merlin (2009) *All mothers matter: Investing in health workers to save lives in fragile states*.

<sup>12</sup> The interventions and strategies listed here are the key components of the *Global Strategy for Women’s and Children’s health* ([www.everywomaneverychild.org](http://www.everywomaneverychild.org)) and the *Partnership for Maternal, Newborn and Child Health* ([www.who.int/pmnch/en/](http://www.who.int/pmnch/en/)). The interventions are relatively low cost, already available, and proven to improve maternal and newborn child health in low- and middle-income settings when delivered through a ‘continuum of care’ (services from pre-pregnancy to childhood) and through a functioning health system and supportive economic and social environment.

- Reproductive health, e.g., family planning, the treatment of sexually transmitted infections, post-abortion care;
- Antenatal care: four visits during pregnancy, HIV prevention, tetanus immunization;
- Childbirth care: in particular, skilled attendance at delivery, prevention of mother-to-child transmission of HIV, emergency obstetric care, family planning after birth;
- Newborn baby and child care: immunization, insecticide-treated bed nets, nutritional care, immediate care for childhood illnesses, extra care for premature babies, HIV care.

These are interventions at the point of health-care delivery. However, women's and children's health can be improved before this by investing in the proven benefits of educating girls, improving children's nutrition – in particular among adolescent girls, combating child marriage and promoting gender equity.

## Gender and health

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Gender norms and social cultural practices affect women's and children's health. For example, early initiation of breastfeeding and exclusive breastfeeding are essential for child nutrition. However, a woman may often be unable to do this because her partner or family expect her to follow tradition – such as waiting to start breastfeeding or giving the child water or traditional medicines. She rarely has a voice.

Delaying marriage and first birth could prevent many maternal deaths – a recent study found that reducing girl–child marriage by one-tenth could be associated with a 70 per cent decline in maternal mortality across 97 countries.<sup>13</sup> Preventing unwanted pregnancy could avoid almost one third of maternal deaths.<sup>14</sup> Eliminating unsafe abortion could prevent more than one in ten (13%) maternal deaths.<sup>15</sup> To do this, girls and young women need information and the freedom to make their own choices, avoid sexual violence and make decisions with their partners. Ensuring girls attend primary and secondary school is essential.<sup>16</sup>

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13 Raj A & Boehmer U (2013) *Girl child marriage and its association with national rates of HIV, maternal health, and infant mortality across 97 countries*, Violence Against Women, April 2013 19:536-51.

14 World Health Organization [www.who.int/topics/millennium\\_development\\_goals/maternal\\_health/en/](http://www.who.int/topics/millennium_development_goals/maternal_health/en/).

15 World Health Organization (WHO), *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008*, sixth ed., Geneva: WHO, 2011.

16 Commission on the Status of Women, *Elimination of preventable maternal mortality and morbidity and the empowerment of women*, fifty-fifth session, 22 February–4 March 2011. [www.un.org/womenwatch/daw/csw/csw55/panels/Panels-English.pdf](http://www.un.org/womenwatch/daw/csw/csw55/panels/Panels-English.pdf).



Addressing social cultural practices affecting women's and children's health is important to rural India.  
© UNICEF/NYHQ2005-2374/Khemka

Although men have an essential role in promoting women's and children's health, they often lack information about maternal, newborn and child health or feel excluded from maternal, newborn and child health services. Supporting women's health requires action to enable men to be respectful and supportive of women.

## Reproductive and sexual health – essential for women's and children's health

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Maternal, newborn and child health depend on reproductive and sexual health. For example, access to safe and effective family planning methods allows women, and their partners, to choose if and when they would like a family. Delaying pregnancy and spacing pregnancy are important for women's physical health. Ensuring that every child who is born is wanted is also important for the emotional health of the woman and child. Women and men must know how to avoid – or seek early treatment for – sexually transmitted infections that can lead to infertility for the woman or to death or disability for the woman or child.

Women with an unwanted pregnancy, or one that may lead to maternal or newborn death or disability, often choose to end the pregnancy, even when abortion is illegal.



Reducing unsafe abortion, by regulating abortion where this is legal and providing post-abortion care to all women, is an essential way of keeping women alive and reducing long-term reproductive health problems.

One key component of good sexual and reproductive health is promoting healthy sexuality, especially for adolescents, and reducing harmful practices, including child marriage.<sup>17</sup> Healthy sexuality means being able to express one's sexuality free from the risk of sexually transmitted infections, including HIV, unwanted pregnancy, coercion, violence, stigma and discrimination. It entails addressing gender norms and working with men and women, adolescent boys and girls to enhance mutual respect between partners. Many studies show that sexuality education programmes generally do not promote early or risky sexual activity, but have a positive impact that delays young people's initiation into and frequency of sex, reduces the number of sexual partners, and increases the likelihood that they will use condoms or other contraceptives when this is needed.<sup>18</sup>

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17 UNFPA, 2010. *Sexual and Reproductive Health for All: Reducing Poverty, Advancing Development and Protecting Human Rights*.

18 UNFPA, 2010. *Sexual and Reproductive Health for All: Reducing Poverty, Advancing Development and Protecting Human Rights*.





Liberians march through the capital, Monrovia, to support the first International Day of the Girl Child and ending child marriage. © UN Photo/Emmanuel Tobey

## The power of community action – prevention and early response

Communities – individual constituency members, traditional and religious leaders, community actors including local councillors and party members – are at the centre of what works. Parliamentarians carry considerable influence with community members and leaders, and are therefore well-positioned to educate communities and to advocate for attitudes and actions that promote maternal, newborn and child health.

Many key steps for preventing death and disability depend on family actions: parents can provide good nutrition and care and support for a growing child. Communities can promote healthy practices by setting positive role models – for example, by supporting women who exclusively breastfeed their children and their partners, or by promoting positive practices and challenging harmful traditional practices that expose girls and their babies to the risks of too-early pregnancy.

Community-based health activists and volunteers can identify for referral potential health problems, for example, pregnancies that may have complications and isolated young brides who are likely to become pregnant and unlikely to access antenatal care or skilled birth attendance.

## Investing in the community workforce for greater equity and reach

Pneumonia in infants is easily diagnosed and managed at community level and community-based treatment can save lives. In several countries, governments have therefore authorized community health workers to manage pneumonia in infants. In those countries where community workers receive adequate training and support to identify and manage pneumonia and other diseases such as acute diarrhoea, deaths have reduced dramatically. Eighteen per cent of all under-five deaths are caused by pneumonia overall, but in Nepal, where community health workers have been trained, deaths from acute diarrhoea and severe pneumonia have decreased significantly.

This is because over two thirds of children under five years have access to treatment within 24 hours of the onset of illness. In Ghana, 92 per cent of caregivers of sick children sought treatment from community-based agents trained to manage pneumonia and malaria, most within 24 hours. In Zambia, a study found that over two thirds (68%) received early and appropriate treatment from community health workers.

Source: UNICEF, 2012. *Committing to Child Survival: A Promise Renewed*. Progress report 2012

Community leaders and others, such as faith-based leaders, can support greater and earlier use of local health services and challenge unhealthy practices. For example in 2011, Muslim religious leaders from 10 countries in West and East Africa issued the West African Regional Fatwa (Religious Edict) to end female genital mutilation.<sup>19</sup> Senegal, for example, has established the key position of an Ambassador for Maternal, Newborn and Child Health and appointed a renowned imam (Muslim religious leader) to take on this role.<sup>20</sup>

Maternal, newborn and child health depends on behavioural change for individuals and in communities. For example, traditional practices that negatively affect girls' and women's reproductive health, such as female genital mutilation/cutting or child marriage, take a long time to change, although experience has shown that it is possible to shift these deeply-rooted practices. Some interventions now are only seen in the next generation – for example, it is only when today's girls have improved nutrition that their own children have a higher chance of being born healthy. Children growing

19 UNFPA/UNICEF (2011) UNFPA-UNICEF *Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change*. Annual Report 2011. [www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Annual\\_report\\_on\\_FGM-C\\_2011\\_low\\_res.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Annual_report_on_FGM-C_2011_low_res.pdf).

20 PMNCH, 2008. *Successful leadership: Country actions for maternal, newborn and child health*.

up free from harm at home now are less likely to expose their own partners and children to abusive and violent behaviour, which affect the health of future generations of women and children.

**Early treatment** can prevent a potential health problem from deteriorating, and resulting in death or permanent disability. For example, emergency obstetric care during delivery might prevent an obstructed delivery that would otherwise cause long-term injury, such as fistula for the mother or brain damage for the baby. A strong link between the community and the health sector is essential to ensure that women and children receive consistent information about when and how to seek health care quickly. Parliamentarians have an important role to play in promoting the changes in attitudes and practices that are necessary if women and children are to seek health services promptly.

## A strong health system

Although each maternal, newborn and child health intervention (see Summary Sheet 3 for more details) can make a big difference on its own, the most effective improvements happen when these interventions are delivered together through a strong health system:

**Table 3:** Key components of health system strengthening

The right PEOPLE	<ul style="list-style-type: none"> <li>● Leadership and governance</li> <li>● Human resources for health</li> <li>● Involving individuals and communities</li> </ul>
At the right PLACE	<ul style="list-style-type: none"> <li>● Infrastructure and facilities</li> <li>● Knowing where the highest need is</li> <li>● Addressing inequities</li> </ul>
With the right RESOURCES	<ul style="list-style-type: none"> <li>● Medicines, vaccines, diagnostics and devices</li> <li>● Procurement, supply and management of commodities</li> <li>● Health financing and social protection</li> </ul>
Doing the right ACTIVITIES	<ul style="list-style-type: none"> <li>● Quality care, health promotion and health literacy</li> <li>● Information systems, communication and media</li> <li>● Integrated, multisectoral response</li> </ul>
Achieving the right RESULTS	<ul style="list-style-type: none"> <li>● Universal access and equity</li> <li>● The MDGs and human rights</li> <li>● Accountability at all levels</li> </ul>

Source: PMNCH (no date) *Women's and children's health: Needs and challenges*. [portal.pmnch.org/downloads/Needs-and-Challenges.pdf](http://portal.pmnch.org/downloads/Needs-and-Challenges.pdf).



The majority of maternal, newborn and child deaths occur in Africa and Asia where health systems are weak.  
© UNICEF/NYHQ2007-0346/Nesbitt

## Putting the right people in the right place

A strong health workforce helps countries to uphold women's and children's rights to health and quality care. This means having the right people who are well trained and good working conditions at every level of the health system from community to referral hospital across the whole country. Midwives, nurses, doctors and front-line health workers are a crucial part of any health system, but currently, in many places, there are simply not enough of them.

The period of highest maternal, stillbirth and newborn mortality is during labour and delivery and the 24 hours immediately afterwards. This is because, in most countries, there are not enough fully-qualified midwives or others who can provide essential midwifery care to manage the estimated number of pregnancies and births, including the 15 per cent of births that have complications. As a result, there has been much focus on access to midwives. Even though child deaths are reducing in response, two in five child deaths occur in the first month of life.

Unfortunately, many women and babies still die from lack of access to emergency obstetric and newborn care. Coverage is especially low in rural and remote communities. Women struggle to access skilled health workers and services because of cost,



## Key actions for a healthy workforce

The Global Health Workforce Alliance ([www.who.int/workforcealliance/en/](http://www.who.int/workforcealliance/en/)) has studied health issues across Africa and other middle- and low-income countries and proposes a number of key actions:

- Improving skilled health attendance through different recruitment methods, to fill the staffing gap of nurses and midwives in rural areas. This must be done in conjunction with promoting girls' and women's education.
- Investing in ongoing education and training, linked to supervision.
- Considering innovative financing methods to retain health workers, such as housing benefits or school fees.
- Identifying where current policies and legislation are restrictive for the health workforce. Find out what task shifting opportunities exist – moving specific tasks to lower-qualified health workers who may have wider reach. Evidence is growing about the capacity of community-based health workers to prescribe a wide range of contraception, including hormonal methods, for example. Midwives and medical assistants have been shown to undertake successfully a wide range of emergency obstetric interventions and procedures although in many countries it is only doctors who are legally allowed to do so.

distance, and limited ability to make decisions about their health care. Giving birth at home is often supported by family members or traditional birth attendants, who may not recognize the warning signs of a difficult delivery and may neither be trained nor have the resources to make referrals to health-care facilities and skilled assistance.<sup>21</sup>

Although it takes time to build up a strong workforce, some countries have made significant progress in the short term through innovative approaches, such as task-shifting and incentive-based programmes for the health workforce, and the use of community-based health workers who reach girls and women in their homes and provide nutritional, reproductive and sexual health advice, as well as antenatal care.

Health services also rely on other service providers, such as adult and school educators who can advance female education, water and sanitation workers who can promote good hygiene and reduce the risk of malaria, local government officials and agricultural extension workers who can introduce and support economic empowerment and food security initiatives, or social welfare workers who can prevent and respond to violence or abuse. Good maternal, newborn and child health care is much more effective when health interventions are provided alongside other interventions that support

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21 UNFPA, 2011. *The State of the World's Midwifery 2011: Delivering Health, Saving Lives.*

economic security, access to basic services and freedom from violence for both women and children.

Nutrition is one important area in which non-health workers are essential. There is a limited window of opportunity to ensure a child's chances of good growth and development: from gestation to the age of two years. After this time, undernutrition will have caused irreversible damage to the child's intellectual and physical development. Community members, education and agriculture extension workers can ensure that a child receives enough food and the right care for his or her brain and body to grow well. Reaching adolescent girls with nutritional support and campaigns to address anaemia can also make a huge difference to the health of both women and young children – as a human right and to ensure that women's bodies are healthy prior to pregnancy.

Woman and child in Darfur, Sudan, where conflict impacts on good nutrition. © UNICEF/HQ04-0916/S.Noorani



## Measuring progress to achieve the best results – accountability for results

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The ultimate goal of any action on maternal, newborn and child health is to ensure that women and children receive the best opportunities possible for health. The accountability framework proposed by the Commission on Information and Accountability for Women's and Children's Health links accountability for resources with results, i.e., the outputs, outcomes and impacts they produce. This means that the State, health services, community leaders and community members are all accountable for ensuring that resources allocated to maternal, newborn and child health are used to achieve the intended health outcomes.

### Global accountability for maternal, newborn and child health

A time-bound Commission on Information and Accountability for Women's and Children's Health was established, after the launch of the Global Strategy for Women's and Children's Health, to develop an accountability framework and action plan. The Commission identifies three key components of accountability: monitoring (finding out what is happening, where and to whom); review (assessing whether or not pledges, promises and commitments have been kept, and whether duties have been discharged); and remedy or action (a measure or measures to put things right, as far as possible, when they have not gone as promised or planned).

The Commission has identified 10 key recommendations that focus on “ambitious but practical actions that can be taken by all countries and all partners”. These recommendations focus on:

- **Better information for better results** through national systems for registration of major events, introducing common indicators across all countries and exploring opportunities for innovation in information technology to improve access to reliable information on resources and outcomes;
- **Better tracking of resources** for women's and children's health using the same two aggregate resource indicators across all countries, developing compacts between country governments and all major development partners in that country, and reviewing health spending in relation to commitments, human rights, gender and other equity goals and results;
- **Better oversight of results and resources**, nationally and globally through the establishment of national accountability mechanisms that are transparent and inclusive of all stakeholders, transparency by all stakeholders, capturing of MNCH spending by development partners and the establishment of an independent Expert Review Group for global oversight.

See [www.everywomaneverychild.org/resources/accountability-commission](http://www.everywomaneverychild.org/resources/accountability-commission).

Parliamentarians have a key role in upholding this accountability. Parliamentarians have a role in:

- knowing what money is being received and spent for maternal, newborn and child health and what results are being achieved;
- supporting decisions on how policies and programmes are delivered, so that services are based on evidence of what works; and
- measuring what is done and using this information to improve national policies and plans of action.

The Commission on Information and Accountability for Women’s and Children’s Health (see Table 4) has proposed 11 core indicators for maternal, newborn and child health. At a minimum, every country should be able to provide accurate and up-to-date figures on these indicators.

**Table 4:** Eleven core indicators recommended by the Commission on Information and Accountability for Women’s and Children’s Health

Area of intervention	Indicator
MDG indicator (all countries to report on these globally)	Maternal mortality ratio (deaths per 100 000 live births)
	Under-five child mortality, with the proportion of newborn deaths (deaths per 1000 live births)
	Children under five who are stunted*
Family planning	Met need for contraception (proportion of women aged 15-49 years who are married or in a union and who have met their need for family planning, i.e., who do not want any more children or want to wait at least two years before having a baby, and are using contraception)
Pregnancy care	Antenatal care coverage (percentage of women aged 15–49 with a live birth who received antenatal care from a skilled health provider at least four times during pregnancy)
Pregnancy care/ Childbirth care/ Postpartum care	Antiretroviral prophylaxis among HIV-positive pregnant women to prevent vertical transmission of HIV, and antiretroviral therapy for women who are treatment-eligible
Childbirth care/ Newborn care	Skilled attendant at birth (percentage of live births attended by skilled health personnel)
Childbirth care/ Newborn care/ Postnatal care	Postnatal care for mothers and babies (percentage of mothers and babies who received a postnatal care visit within two days of childbirth)

Area of intervention	Indicator
Newborn care/ Infancy and early childhood care	Exclusive breastfeeding for six months (percentage of infants aged 0–5 months who are exclusively breastfed)
Newborn care/ Infancy and early childhood care	Three doses of the combined diphtheria, pertussis and tetanus vaccine (percentage of infants aged 12–23 months who received three doses of diphtheria, pertussis and tetanus vaccine)
Newborn care/ Infancy and childhood care	Antibiotic treatment for pneumonia (percentage of children aged 0–59 months with suspected pneumonia receiving antibiotics)

\* Percentage of children under five years of age whose height-for-age is below minus two standard deviations from the median of the WHO Child Growth Standards (wording of proposed indicator is slightly different from MDG indicator which refers to underweight children).

If maternal, newborn and child health is to be improved, information on where and why women and children are dying is required. There can be no accountability without timely, accessible and reliable health information. Knowing where there is coverage and which elements of the response are working makes it easier to decide where to focus higher staffing levels or introduce new ways of delivering services. It is important to review not only overall coverage but also equity.

## Coverage and equity

One important aspect of monitoring is measuring **overall coverage** to ensure that interventions are not only increasing in number but actually reaching and being used by women and children across the country. Coverage is the proportion of individuals who need a health service or intervention and actually receive it. Coverage is measured for a wide range of interventions including immunization, vitamin supplementation and provision of contraception.

Monitoring must also measure the **differences in coverage** for women and children in richer and poorer households. This is a human right but is also cost-effective – investing in improving the health of the poorest is a priority and will improve overall health, as the case study below shows. Generally speaking, coverage is unequal in most countries. For example, women and children in urban areas tend to have better access to a wider range of services than women and children in rural areas, although this is not always the case.

Reviewing routine data provides an insight into disparities within a country.

- Different age groups may have different coverage. For example, reductions in neonatal mortality lag behind survival gains among older children. As a result, the



share of neonatal deaths in all deaths among children under age five has increased from 36 per cent to 40 per cent over the past decade.

- There is still significant inequity between urban and educated women and their rural and poorly educated peers.
- Some health problems have received less attention than others. Although progress has been made in reducing avoidable deaths during and after childbirth, substantially less progress has been made in avoiding unwanted pregnancies or reducing the huge burden of death and disability from unsafe abortion.



National-level equity data is available from *Countdown to 2015* ([www.countdown2015mnch.org/country-profiles](http://www.countdown2015mnch.org/country-profiles)). This data provides information about which women or children may be disadvantaged. This analysis can be used for the purposes of advocacy, legislating or introducing policy on the key priority equity issues.

### 3. What parliamentarians can do to advance maternal, newborn and child health

#### KEY MESSAGES

As lawmakers, parliamentarians can design, adopt and oversee the implementation of legislation that promotes health rights for all women, newborns and children, including sexual and reproductive rights, and rights that promote equity in health-care provision.

Parliamentarians hold national governments accountable through their oversight functions. As such, they have a crucial role in monitoring the laws, policies and strategies that are in place with a view to ensuring their effective implementation and improving maternal, newborn and child health.

Budget appropriation is an important way of ensuring that funds are allocated where there is greatest need and in the most effective way. All parliamentarians should ensure that maternal, newborn and child health receives adequate funding for cost-effective interventions.

Parliamentarians can show that maternal, newborn and child health is at the core of a nation's development and the well-being of constituents by acting on the actual situation on the ground in their constituencies and carrying the voices of their constituencies up to national level.

Parliamentarians can take action to strengthen the actions and interventions described in the previous section through their core functions:

- **Legislating** to ensure universal access to essential care;
- **Ensuring oversight** or holding the government to account for the design and implementation of appropriate policies;
- **Budgeting** and spending adequately for maternal, newborn and child health;
- **Representing** the health concerns of women and children.

#### Legislation

As **lawmakers**, parliamentarians can design, adopt and oversee the implementation of legislation that promotes health rights for all women and children, including sexual





An MP meets malnourished children in North Eastern Kenya. © IPU/Jennings

and reproductive rights. The full extent of the mandate of parliaments, in relation to that of the executive arm of government, differs from country to country. However most constitutions give parliament the right to scrutinize, reject and/or amend draft legislation that is not consistent with international standards and requirements for the well-being of citizens. On this basis, parliamentarians can deliver law and policies that guarantee equitable access to health for all women and children, including those who are vulnerable or marginalized.

The following are possible actions that parliamentarians could consider:

**Introduce or amend laws that protect women’s and children’s rights**, bearing in mind the underlying causes of maternal, newborn and child deaths.

*Parliamentarians can review the underlying country-specific causes of maternal, newborn and child death and can assess whether current laws and policies in that regard address these causes. Parliamentarians can explore whether laws exist that might promote women’s and girls’ rights to health, including preventing child marriage; female genital mutilation; criminalizing explicitly the abuse of women and children, including rape within marriage; providing for equal access of women and girls to all educational opportunities, including allowing girls to re-enrol in school after having a baby; and labour laws affecting pregnant*



## Case study: Legislating for girls' health

Legislation introduced by parliamentarians can be a powerful force for change. In September 2012, Swaziland's prime minister announced parliament's intention to enforce Swaziland's new Child Protection and Welfare Act by prosecuting men who marry underage girls. Prior to this, and according to Swaziland's 2005 constitution, customary practices are allowed unless they conflict with constitutional clauses. Sexual activity with underage girls was prosecuted as statutory rape, but only if it occurred outside the bounds of marriage. Girls aged 15 and older were legally permitted to marry. Under the new law, perpetrators face statutory rape charges and are fined around \$2,400. The new law penalises parents and guardians who collude with adult men to orchestrate a child marriage. Offenders face prison terms of up to 20 years. The new Act provides an important example for other countries where child marriage is a long-standing traditional practice.

Source: Plus News, 20 September 2012. [www.irinnews.org/Report/96347/SWAZILAND-Child-marriages-banned](http://www.irinnews.org/Report/96347/SWAZILAND-Child-marriages-banned) [www.irinnews.org/Report/96347/SWAZILAND-Child-marriages-banned](http://www.irinnews.org/Report/96347/SWAZILAND-Child-marriages-banned).

women. *Parliamentarians can also examine the legislative framework to ensure that all adolescents and women have access to post-abortion care and, where abortion is legal, that there is a legislative framework for making abortion safe.*

**Introduce or amend laws that enable equitable health-care provision**, such as those relating to imports, trade and employment.

*Parliamentarians can consider whether current trade laws are preventing the delivery of affordable essential medicines, including those identified as priority for reproductive, maternal, newborn and child health by the UN Commission on Life-Saving Commodities for Women and Children ([www.ucw-project.org/attachment/child\\_labour\\_Nepal20110628\\_114207.pdf](http://www.ucw-project.org/attachment/child_labour_Nepal20110628_114207.pdf)) and whether laws currently influence recruitment and placement of health workers where they are most needed. Parliamentarians could ask whether there are legislative gaps that prevent women and children from accessing health, such as vital registration, and advocate to ensure that appropriate legislation is introduced, for example through Private Members' bills or inserting essential sections into new legislation during the scrutiny process.*

**Legislate for the establishment and effective functioning of regulatory bodies** to promote good maternal, newborn and child health.

*Successful maternal, newborn and child health relies heavily on community and primary level staff, including midwives, community health workers and other essential staff. These*

## Case study: Improving the contribution of key health workers in the legislative process

Strong regulatory bodies assist the work of parliamentarians by being a strong source of technical support and action in the advancement of women's and children's health. For example, in Uganda, the Private Midwives Association is providing support to the development of strategic plans to ensure that midwifery is appropriately represented in future plans for health service delivery. The Ethiopian Midwives Association is working with international partners to improve the quality of midwifery education, develop an effective regulatory body and ensure midwives are represented at the ministerial level.

Source: UNFPA, 2011, State of the World's Midwifery 2011.

*health cadres need recognition and quality oversight, which regulatory bodies can provide. These bodies can promote quality of care by recognizing the role of the most vital health workers through laws, policies and strategies on maternal, newborn and child health. In a recent review of midwifery services in the countries with the highest maternal and newborn deaths, only three of the 50 responding countries indicated that midwives had a distinct regulatory body that could register and oversee qualified midwives and require standards of practice.*

## Oversight

Parliamentarians have a crucial role in ensuring that the laws, policies and strategies that are in place are actually improving maternal, newborn and child health. Oversight activities include receiving regular reports from the executive arm of government on activities, tabling parliamentary questions to members of the executive arm, overseeing implementation through constituency visits, and establishing and participating in special committees and commissions of enquiry. Parliamentarians can exercise more focused and formal oversight through parliamentary structures such as public accounts committees, standing sector committees or select committees with an investigative mandate.

The following are possible actions that parliamentarians could consider in their individual oversight capacity:

### **Ensure that government commitments on maternal, newborn and child health are respected**

## Case study: Mobilize for Vital Registration by 2020

Maternal mortality is one of the few major health indicators not measured in many countries. A majority of people in Africa and Asia are born and die without ever having a legal record of their life: more than 40 per cent of the world's newborns are not registered. In the 2000s, only nine African countries had 90 per cent or better vital registration coverage of births and only five African countries attained this level of coverage for deaths, representing little progress during the last half century.

In 2011, at a meeting of African Ministers, there was a call from the Director of the US Centers for Disease Control and Prevention (CDC) to set a target of having accurate, real-time data (vital statistics) from the vital registration system in all countries by 2020. This would provide timely information to support accelerated action to reduce maternal deaths. One year later, Ministers from across Africa, with the support and backing of parliamentarians representing diverse political views, participated in a Conference of African Ministers for Vital Registration. The Conference called for the passing of laws and rapid scaling-up of innovative vital registration systems, recognising that vital registration is necessary both as a right for everyone and as a tool for understanding and responding to the health challenges, especially those of women and children.

Source: [www.safpi.org/news/article/2012/ministerial-statement-civil-registration-and-vital-statistics-conference](http://www.safpi.org/news/article/2012/ministerial-statement-civil-registration-and-vital-statistics-conference).

*Parliamentarians can use their oversight powers to ensure that the government has a road map towards increasing expenditure on health. In African States this would mean a road map towards the fulfilment of the country's commitment under the Abuja Declaration to allocate 15 per cent of domestic budgets to the health sector and ensure that health sector plans adhere to national and global gender equality commitments.*

*Many countries have made commitments regarding how they will contribute to the goals of the Global Strategy for Women's and Children's Health. Parliamentarians can ensure that these commitments are tracked and that progress towards them is reported in a transparent manner. Government commitments to regional initiatives such as the Maputo Plan of Action and the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) have resulted in regional and country level road maps. Parliamentarians can request public reports on progress against these commitments and road maps.*

**Consider establishing a multi-stakeholder national commission on maternal, newborn and child health that reports to parliament** where this is not already available. *Multi-stakeholder commissions can increase the visibility of women's and children's*

*health and generate buy-in from many actors. Parliamentarians can be pivotal in raising public attention about the need for such a commission.*

**Demand transparent figures on all domestic expenditures** – planned and actual – in the health sector, when accounts are presented to parliament as part of national budgets and plans. Advocate within parliament – through question time, motions and other processes – for government to track resources pledged for maternal and child health. Similarly, request regular and transparent reporting on the use of all international assistance intended for the health system.

**Exercise the parliamentary oversight function during constituency-level activities**, by monitoring how national commitments and strategies are being implemented in practice.

*Parliamentarians can visit hospitals within their constituency to check the availability of essential medicines and ensure that emergency obstetric and other priority services are functioning as required, or civil registration facilities to check that maternal, newborn and child health data is being updated and that there is effective liaison between ministries of health and home affairs.*

The following are possible actions that members of maternal, newborn and child health portfolio committees and other social sector committees could consider:

**Review the extent to which maternal and child health features in existing standing committees** and, if necessary, advocate for a maternal, newborn and child health standing committee.

*Ensure that this is aligned with any committees working on reproductive and sexual health. Involve parliamentary representatives and staff who have expressed interest and will provide energy, commitment and leadership.*

**Ensure that the national health strategy** supports the development of a strong health system that puts women's and children's health at the core and considers maternal, newborn and child health priorities in terms of leadership and accountability, staffing, infrastructure, funding, evidence-based activities and monitoring systems.

**Include maternal, newborn and child health indicators** in medium-term national development plans.

*Almost all countries that are making progress on maternal, newborn and child health have health sector reform plans in place. Advocate for the inclusion of health indicators, especially the 11 core MNCH indicators, to ensure greater visibility for health within national budgets.*

**Promote intersectoral collaboration** within maternal, newborn and child health portfolio committees and other social sector committees.

*Convince other sectors of the importance of multisectoral action on maternal, newborn and child health to address the underlying causes of maternal and child death. Ensure that other sectors, including those working on issues, such as education and social protection, on economic issues, for example, food security, and on other trade and industry issues, address maternal, newborn and child health coherently within their own sectors and ensure that all are working towards the national goals for maternal, newborn and child health.*

The following are possible actions that parliamentarians could consider as constituency representatives:

**Review constituency or regional health expenditure** to identify whether funds have been spent effectively, or whether there has been a noticeable underspend or overspend.

*In liaison with other parliamentarians involved in MNCH and budgetary oversight, a constituency representative can promote noticeably effective local budgets, draw attention to weaknesses and propose solutions concerning expenditure at the local level.*

### **Case study: Active oversight of children's health – Vietnamese parliamentarians**

Vietnam's parliament is very active in monitoring the implementation of the Law on Child Protection, Care and Education, and the National Health Insurance Law. Parliamentarians organize meetings at the central level with the Ministry of Health, the Ministry of Education and other relevant ministries and meet provincial and district leaders and members of local communities during regular field trips. The monitoring missions' findings and recommendations are documented and reported to the health ministry, which has an obligation to tell parliament how the recommendations will be addressed.

Source: PMNCH/IPU, 2010. *Taking the lead: Parliamentarians engage with maternal, newborn and child health* ([http://www.who.int/pmnch/topics/part\\_publications/20100716\\_takingthelead.pdf](http://www.who.int/pmnch/topics/part_publications/20100716_takingthelead.pdf)).

“ Two national functions are critical if proper reporting and oversight of commitments and pledges on women’s and children’s health are to take place. First, a sound health information system to collect and report health data. Second, a national deliberative mechanism to review these data, measure progress for country decision makers, hold those decision makers accountable to their people and to the global community, hold the global community accountable to countries, and devise remedies for remaining predicaments and barriers.”

—PMNCH, Working Group on Accountability for Results: Draft Final Paper 19 April 2011, p3.

## Budget appropriation

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The budget is the most important policy tool of government; without money the government cannot implement any other policy successfully. Budget appropriation is therefore one of the most important ways in which parliamentarians can translate good policies on maternal, newborn and child health into reality on the ground.

Parliamentary budget processes differ from country to country and function at different levels, from the national to the local level, depending on the degree/extent of financial decentralization. In countries receiving substantial donor funding for maternal, newborn or child health or other health components, alignment of sectoral budgets with national budgets is essential. Parliamentarians across the world have the important responsibility of ensuring that funds are allocated where there is greatest need and in the most effective way. All parliamentarians should ensure that maternal, newborn and child health receives adequate funding for cost-effective interventions.

The following are possible actions that parliamentarians working on budget portfolio committees could consider:

**Use gender-responsive budgeting tools**, with a view to identifying the most effective means of funding maternal, newborn and child health.

*Gender-responsive budgeting involves using a number of tools and processes in the budget development process to consider how budget allocation and expenditure may have a different and unequal impact on men and women, or on different groups of men and women because of social or economic differences.*<sup>22</sup>

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22 IPU has produced a handbook for parliamentarians on gender budgeting, see [www.ipu.org/PDF/publications/budget\\_en.pdf](http://www.ipu.org/PDF/publications/budget_en.pdf).

## Case study: Gender-responsive budgeting for reproductive health

Paraguay's Senate Committee on Equality, Gender and Social Development wanted to know how much the health ministry was allocating for sexual and reproductive health, but it was not possible to do this by reviewing existing budget allocations, which did not show where funds were being spent on this sector. The Committee succeeded in persuading the Ministry to introduce a separate line item for allocations for purchasing contraceptives. Once done, the Committee found that donors were covering 100 per cent of the amount spent on contraceptives and were able to advocate for greater government budget allocation on contraceptive expenditure.

One local government in Paraguay, the Municipality of Asuncion, was inspired by what was being achieved at national level and asked UNFPA for assistance in doing gender-responsive budgeting at municipal level. This initiative resulted in the dropping of user fees for pre- and post-natal care at municipal health facilities for pregnant adolescents. The municipality also increased by 300 per cent the amount allocated for the costs of family planning.

Source: [www.presupuestoygenero.net/s28/paginas/iniciativas.htm](http://www.presupuestoygenero.net/s28/paginas/iniciativas.htm), cited in UNFPA/UNIFEM, 2006, Gender Responsive Budgeting and Women's Reproductive Rights: a Resource Pack. ([internationalbudget.org/wp-content/uploads/Gender-Responsive-Budgeting-and-Women%E2%80%99s-Reproductive-Rights-A-Resource-Pack.pdf](http://internationalbudget.org/wp-content/uploads/Gender-Responsive-Budgeting-and-Women%E2%80%99s-Reproductive-Rights-A-Resource-Pack.pdf)).

**Ensure that a sufficient proportion of the national budget is devoted to health,** so that the country can undertake and sustain broader health system strengthening.

*African governments have committed to the 2001 Abuja Declaration. All signatory governments have committed to spending at least 15 per cent of their national government budgets on health. In 2008–2009, under the leadership of Chilean President Bachelet, Bolivia, Chile, Ecuador and Paraguay established the Latin American initiative, Deliver Now for Women and Children (*Actuemos Ya por las mujeres y los niños*), pledging to increase human resource capacity and to share the required experiences necessary to save the lives of women and children through the achievement of MDGs 4 and 5.<sup>23</sup>*

*Parliamentarians can review their country's national health financing scorecard ([www.who.int/pmnch/media/news/2012/2012\\_health\\_financing\\_scorecard.pdf](http://www.who.int/pmnch/media/news/2012/2012_health_financing_scorecard.pdf)) and determine what changes are needed in percentage and per capita investment to make a difference in health.*

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23 [www.who.int/pmnch/activities/DELIVER\\_NOW\\_LAC\\_BRIEFING\\_NOTE.pdf](http://www.who.int/pmnch/activities/DELIVER_NOW_LAC_BRIEFING_NOTE.pdf).

## Budget scorecards: understanding the impact of health investments

A review of African governments' 2009–2010 budget allocations and per capita investments in health highlights important lessons for parliamentarians engaged on budget allocation and review:

- Globally, countries that have higher government per capita investment in health, have invested in ensuring better access to medicines and equitable distribution of health workers within the country and also higher per capita investment on the underlying causes of death and illness (for example, lack of clean water, sanitation, nutrition, gender equity and education) have overall higher life expectancy. The percentage allocation of the national budget to health must be combined with actual improved per capita investment to make sustainable progress.
- Countries that have met their 15 per cent commitment on health spending but have a low per capita investment in health and low investment in social determinants are still off track for meeting MDGs. Thirty-two out of 53 African Union (AU) Member States invest under \$20 per capita in health which is less than half the WHO recommended barest minimum. This includes four countries that have met the 15 per cent commitment.
- In the 33 AU member states investing only between \$2 and \$37 per capita, little or no sustainable improvement in health is possible. Investment must be at least \$44 or higher over five years or more and must include investment in social determinants.

Source: Africa Public Health Info. Health Financing Scorecard 2012. ([www.who.int/pmnch/media/news/2012/2012\\_health\\_financing\\_scorecard.pdf](http://www.who.int/pmnch/media/news/2012/2012_health_financing_scorecard.pdf)).

**Monitor donor contributions**, where these are a significant portion of national health budgets. In addition, ensure that funding is aligned through a sector-wide approach, in which donor resources are placed into a sectoral budget for allocation and management by the relevant ministry, rather than into individual programmes dealing with single issues that are funded and managed independently of the overall health system.

## Representation

Parliamentarians have the important role of **representing** the views and concerns of their constituents in parliaments and providing constituents with information on



national and parliamentary issues. This role also requires parliamentarians to receive feedback from their constituents regarding the effectiveness of government policies.

Maternal, newborn and child health has the greatest impact on the voiceless; women, infants and children themselves often struggle to get their voices heard. Even those working directly on maternal, newborn and child health – nurses, midwives, community health workers – rarely have a chance to share their ideas about effective health provision.

Parliamentarians can show that maternal, newborn and child health is at the core of a nation's development and the well-being of constituents by responding to the actual situation on the ground and ensuring that the voices of their constituents are heard at the national level.

Awareness-raising is also necessary for representation. As **opinion leaders and decision makers**, parliamentarians can mobilize support among their constituents for quality health and related services that can reduce maternal, newborn and child deaths. Parliamentarians can work to enhance public education and the health information available to women both inside and outside parliament.

Parliamentarians, working together with other local administrative, religious and community leaders, play an essential role in demonstrating to women, children and all in the community that maternal, newborn and child health is a serious issue.

## Taking the lead

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The following are possible actions that parliamentarians could consider in their role as constituency representatives:

**Raise maternal, newborn and child health concerns** when addressing other constituency issues.

*Public works initiatives that provide clean drinking water and sanitation, for example, are an opportunity to provide clear messages about the importance of a coordinated approach to all matters pertaining to maternal, newborn and child health. The same potential exists when parliamentarians take action to promote girls' education – a powerful strategy for improving maternal, newborn and child health.*

**Stimulate debates** about what families and communities, as well as health and other services, can do to promote practices that keep women and children alive and challenge

## Case study: Getting involved and making change

The Urgent African Campaign against Child Marriage was launched at the 2012 Annual Women Parliamentarians Conference of the Pan-African Parliament, facilitated by the Pan-African Parliament, Africa Public Health Parliamentary Network, Africa MNCH Coalition and Partners. The Pan-African Parliament President, Bethel Amadi, emphasized the importance of education in empowering the girl child, and called on members of parliament to push for legislation that criminalized keeping children out of school. Parliamentarians have been urged (by the Pan-African Parliament) to support the campaign through their regional and national parliaments.

Source: First Session, Third Parliament, October 8–19, 2012. Report on the Pan–African Parliament Women’s Conference, October 4–5, 2012, Midrand, Johannesburg, Republic of South Africa.

The Asian continent is where most child marriages occur. The Asian Forum of Parliamentarians on Population and Development (AFPPD) has taken a strong leadership role to challenge child marriage. The Forum recently launched a toolkit that highlights the issue, its consequences, and presents possible actionable items for parliamentarians to share, discuss and consider with other government officials in their respective countries.

Source: AFPPD/ICRW/AusAID/UNFPA (2012) *Child Marriage in Southern Asia: Policy Options for Action*. [www.afppd.org/files/1113/4992/7261/Child\\_Marriage.pdf](http://www.afppd.org/files/1113/4992/7261/Child_Marriage.pdf)

cultural or traditional practices that harm the health or nutrition of the most vulnerable, especially adolescent girls, women and children.

**Regularly visit local health services and maternal, newborn and child health services** – including non-government services – and talk to women, children and service providers about their experiences

*In particular, it may be useful to consider health workforce issues, such as the need for access to midwives. It is important to solicit actively the views of those who are often most excluded from health services, such as adolescent mothers or women living with HIV and their partners.*

**Provide feedback to constituents** about parliamentary opportunities and events on maternal, newborn and child health to encourage a two-way dialogue on parliamentary processes.

## Case study: Increasing dialogue with constituents and civil society

Zambia's under-five mortality rate decreased significantly from 2002 to 2007 – from 168 to 119 deaths per 1,000 live births. Parliament played an important role in this success by drawing greater attention to child health through a number of MDG-focused committees, a women's caucus, a children's caucus and a forum for the discussion of population and reproductive health issues. Through 150 well-staffed constituency offices parliamentarians are better able to represent their constituents and to ensure that the legislative framework reflects the MNCH priorities on the ground. Zambia's parliamentarians have assisted civil society organizations to make their voices heard in parliament.

Source: PMNCH/IPU, 2010. *Taking the lead: Parliamentarians engage with maternal, newborn and child health.*

The following are possible actions that parliamentarians could consider in their role as opinion leaders and awareness raisers, within constituencies and more broadly at the local and national level or beyond.

**Show by doing.** Demonstrate publicly individual commitment by endorsing good practices in maternal, newborn and child health. This could be through civic acts – for example, using a child's first day at pre-school to highlight to the family the importance of pre-school and early childhood development programmes for longer-term health and well-being.

**Introduce innovative solutions** to maternal, newborn and child health at constituency level, such as advocating for the introduction of mobile phone technology for health by highlighting its success elsewhere.

**Mobilize and raise awareness** of maternal, newborn and child health issues at constituency level and at public engagements.

*In particular, it is important to support the participation of women. It may be helpful to collaborate with local civil society groups working on maternal, newborn and child health or on gender equity to support the meaningful participation of women, including young women.*

*Working with the media is essential to ensure that coverage is evidence-based, promotes the rights and survival of women and children and does not rely on sensationalist stories.*

## Women parliamentarians working together for maternal, newborn and child health

Rwanda's post-1994 constitution provided for women to hold a minimum of 30 per cent of posts in decision-making organs, including parliament. The influence has continued over the years. In the 2008 elections, women won 51.9 per cent of seats in Rwanda's lower house of parliament, placing Rwanda first among all nations in terms of women's political representation.

In 1996, women parliamentarians formed the cross-party Forum of Women Parliamentarians. They work together across party lines on issues of common importance to women. In its first year, the Forum focused on advocating on behalf of Rwandan women and on building the capacity of its members. The Forum is committed to consultative processes, both internally and externally with constituents.

Source: Powley E. *Rwanda: The impact of women legislators on policy outcomes affecting children and families*. Background paper for State of the World's Children 2007. New York: UNICEF.

In Cambodia, women parliamentarians in the Senate representing all political parties formed a women's caucus to work together on children's issues, particularly child labour among rubbish collectors. Women in the National Assembly, Cambodia's lower house of parliament, have also formed a caucus. This caucus has concluded that maternal mortality is the most important challenge facing Cambodian women. The two women's caucuses – Senate and National Assembly – plan joint field missions and intend to share information and identify how the two groups can complement each other strategically to put maternal, newborn and child health high on the policy agenda.

Source: PMNCH/IPU, 2010. *Taking the lead: Parliamentarians engage with maternal, newborn and child health*.

## Global action

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The most urgent work of a parliamentarian is that of law making, oversight, budgeting and representation, at the level to which he or she has been elected – national or local. However, the parliamentary voice is also very important in regional and global processes. Parliamentarians can support the global efforts by contributing their experiences and perspectives in global platforms where the issues of maternal, newborn and child health are discussed. For example, many of the significant global maternal, newborn and child health initiatives mentioned in this handbook have often been advocated for and encouraged by parliamentary representatives from Africa, Asia and Latin America.



Global parliamentary events and initiatives can also provide impetus for progress at the national levels. In 2010, the Sixth Annual Meeting of Women Speakers of Parliament, hosted by the Swiss Parliament together with IPU, culminated in the Bern Declaration. This Declaration embodied the political will of parliaments in relation to women's and children's health and was a call to action for parliaments all over the world. Under the auspices of the Third Standing Committee of IPU, parliaments responded to this call to action by adopting, at the 126<sup>th</sup> Inter-Parliamentary Assembly in Kampala in 2012, the resolution, 'Access to health as a basic right: The role of parliaments in addressing key challenges to securing the health of women and children'. This resolution has begun to act as a catalyst for parliamentary action at the national level.

## Case study: Uganda Private Member's Bill on Immunization leads to regional action

In November 2012, a Private Members' bill was introduced to Uganda's Parliament and the House gave consent for the proposed immunization bill to be drafted, gazetted and brought for first reading. The week after this bill was passed, three members of the Ugandan Parliament, representing the Uganda Parliamentary Forum on Immunization, met other parliamentarians from the region at the East African Legislative Assembly and advocated for the passing of a similar regional bill on immunization. The Assembly's General Purpose Committee has now agreed on a regional immunization legislative project. Having such a regional commitment is strategic. Each member country must automatically take up any bill passed by the East African Legislative Assembly. Uganda's bill will establish clear and comprehensive technical norms and standards, clearly define financing sources, allow for penalties for failing to immunize children and clear roles and responsibilities of all stakeholders. Regional inter-parliamentary legislative action for immunization is especially important for cross-border movement of vaccine-preventable diseases and greater movement of services and people throughout the East African Community.

Source: Sabin Institute, 2012, *Summary Digest: Sustainable Immunization Financing*, Vol 4, Issue 2, June 2012. [www.sabin.org/sif-library#Volume%204](http://www.sabin.org/sif-library#Volume%204).

## 4. The importance of keeping informed

“Parliamentarians can benefit greatly from having access to the latest international evidence on maternal, newborn and child health. Being informed of the choices they have when debating and developing laws will lead to better public policy and will help parliamentarians convince sceptical stakeholders of the merits of a legislative initiative.”

—PMNCH/IPU. 2010. *Taking the lead: Parliamentarians engage with maternal, newborn and child health*. Geneva: World Health Organization (hosting for PMNCH).

### The importance of staying informed

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Parliamentarians need timely access to accurate health information in order to make a meaningful contribution to maternal, newborn and child health. Parliamentary staff, especially those serving on parliamentary committees, have an important role to play in this regard. Parliamentary staff can:

#### **Making sense of data on maternal, newborn and child health**

For effective parliamentary oversight of maternal, newborn and child health, parliamentarians have to understand how data is collected and used – so that they can ensure accountability for delivering on commitments to women, newborns and children.

Maternal mortality data, for example, is vital for monitoring progress but is often not collected. Key actions for improving the quality of maternal mortality data include:

- Advocating for a harmonized programme of household surveys that would collect key maternal, newborn and child health data. This may require ensuring budget allocation, advocating for donor investment in regular household surveys and liaising with technical experts to ensure that the data is robust.
- Investing in vital registration systems and routine information systems. Maternal death audits are one way of identifying the causes of maternal mortality.
- Evaluating information and communication technologies to improve data collection.
- Allocating resources to management information systems and evaluation units within health ministries.

- note when national health data is gathered and disseminated;
- ensure that the data are reviewed by people who understand the essential elements of MNCH responses and can provide summaries on the technical and accountability implications of the results;
- disseminate this information to key allies – fellow parliamentarians with an MNCH interest, members of parliamentary oversight groups and commissions, and interest groups that, like parliamentarians, are advocating for maternal, newborn and child health;
- support data gathering to reinforce advocacy work on prioritized areas of maternal, newborn and child health; ask UN partners and civil society if they are maintaining scorecards on adolescent reproductive health, such as UNFPA's scorecards.<sup>24</sup>

## Finding out local information and capacity needs

**Review the evidence** on the state of MNCH in the country – to identify the most urgent priorities for action. *Based on identified needs and priorities, a second assessment*

### Practical example: Kenyan parliamentary rapid assessment

The Parliament of Kenya, supported by IPU, conducted a rapid assessment on the maternal, newborn and child health legal environment. It considered both the laws that directly affected health care provision and also the social determinants, such as education, gender and employment. The assessment report provides a clear summary of what the current laws and policies offer and how far they are aligned with global good practice, and considers how the policy framework and legal implements are translated into action. In particular, the assessment report focuses on the actions that parliamentarians and others need to take if maternal, newborn and child health outcomes are to improve.

The report also identifies key gaps or conflicts in current policies which would need changing, the areas where a policy or law has not been developed in an open or participatory manner and thus requires greater focus. The report identifies the need for periodic policy reviews that are participatory. Recommendations provided clear guidance for parliamentarians to understand their role in advancing MNCH and identifying key policy and legal priorities.

Source: Inter-Parliamentary Union (2012) *Rapid Assessment of Kenya's Legal Framework for Maternal, Newborn and Child Health: Executive Summary*, October 2012.

24 [africa.unfpa.org/webdav/site/africa/users/Lbarnes/public/2012%20RSH%20Scorecard\\_Highlighting%20Youth\\_Adolescent%20Health\\_Child%20Marriage\\_Educ\\_MM\\_HIV.pdf](http://africa.unfpa.org/webdav/site/africa/users/Lbarnes/public/2012%20RSH%20Scorecard_Highlighting%20Youth_Adolescent%20Health_Child%20Marriage_Educ_MM_HIV.pdf).



*can explore the potential for parliamentarians to engage in MNCH and, in particular, identify areas in which parliamentarians need extra strength or capacity in order to become more effective as legislators, advocates and overseers of MNCH policies and programmes. A needs assessment involves interviewing all key stakeholders and analyzing plans, budgets, audit reports and health-sector documents.*

## Sources of technical information and support

Parliamentarians can develop a network of allies to provide them with the information they require to take effective action on maternal, newborn and child health. Allies can include local institutions involved in knowledge gathering, academic and research institutions, NGOs, government agencies, international development organizations and donor agencies. This handbook provides an overview of key international agencies through which parliamentarians can access information on maternal, newborn and child health.

**The Inter-Parliamentary Union** ([www.ipu.org](http://www.ipu.org)) is a focal point for worldwide parliamentary dialogue and for the promotion of representative democracy. It has, for over 120 years, worked to ensure that parliaments are present on the world stage and have the requisite means to fulfil their mandate. IPU is committed to providing support to parliaments in the area of development, including maternal, newborn and child health. Its resolution on the role of parliaments in addressing key challenges to securing the health of women and children is a rallying call to all parliaments.

**The United Nations Population Fund – UNFPA** ([www.unfpa.org](http://www.unfpa.org)) has a technical support role to government in the area of reproductive and sexual health, family planning and adolescents. As a result, in many countries UNFPA supports the efforts of parliaments in issues relating to population and development, in particular maternal health. UNFPA also has many supporting publications and news updates on its website. UNFPA coordinates the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) ([www.au.int/pages/carmma/maputo](http://www.au.int/pages/carmma/maputo)).

**The World Health Organization – WHO** ([www.who.int](http://www.who.int)) plays a technical support role in all aspects of health systems strengthening, maternal and newborn health. WHO coordinates the Global Strategy for Women’s and Children’s Health ([www.everywomaneverychild.org](http://www.everywomaneverychild.org)) and the associated Commission on Information and Accountability ([www.everywomaneverychild.org/resources/accountability-commission](http://www.everywomaneverychild.org/resources/accountability-commission)). WHO is a source of technical health information and support at the global, regional and national levels.

**The Partnership for Maternal, Newborn and Child Health – PMNCH** ([www.who.int/pmnch](http://www.who.int/pmnch)) is an alliance of more than 450 members working together to ensure that all women, infants and children not only remain healthy, but thrive. PMNCH has a range of simple and accessible resources and updates on maternal, newborn and child health (see next section).

**The United Nations Children’s Fund – UNICEF** ([www.unicef.org](http://www.unicef.org)) is the UN agency responsible for child health, especially preventive health, and for the prevention of vertical HIV transmission and paediatric HIV. UNICEF is the lead agency for the Child Survival Call to Action ([http://www.unicef.org/childsurvival/index\\_62639.html](http://www.unicef.org/childsurvival/index_62639.html)) and the associated A Promise Renewed Campaign ([www.apromiserenewed.org/](http://www.apromiserenewed.org/)).

**UN Women** ([www.unwomen.org](http://www.unwomen.org)) is the coordinating UN agency working on women’s rights, campaigns to end sexual violence, and gender-related programming.

**UNAIDS** ([www.unaids.org](http://www.unaids.org)) is the coordinating UN agency on HIV and AIDS. UNAIDS has produced a large number of briefings and policy papers on the links between MNCH and HIV and has facilitated action on health system strengthening.

In countries where **bilateral donors** are investing in maternal, newborn and child health, these donors will have technical expertise available. There may also be a network of parliamentarians from the donor countries that can form alliances for action.

**The White Ribbon Alliance for Safe Motherhood** ([www.whiteribbonalliance.org](http://www.whiteribbonalliance.org)) is a global network of health advocates that campaigns for more resources and the right policies to prevent the needless deaths of women and is largely coordinated by local civil society groups. Local conveners seek to work closely with parliamentarians.

A number of international NGOs are playing a significant role in policy and programming in the area of maternal, newborn and child health and may have representatives in countries which experience high maternal, newborn and child deaths. These include World Vision’s Child Health Now campaign (<http://beta.wvi.org/health>), Save the Children’s Every One campaign on maternal and newborn survival (<http://www.savethechildren.net/what-we-do/every-one-campaign>) and Plan International’s Because I am a Girl campaign (<http://plan-international.org/girls/>). There are many more campaigns that relate to maternal and child health, and these can be sourced locally.

## What to do to remain updated

**Regularly review global websites** for the latest information. The key websites include:

- Global Strategy for Women’s and Children’s Health:  
[www.everywomaneverychild.org](http://www.everywomaneverychild.org);

- Partnership for Maternal, Newborn and Child Health:  
[www.who.int/pmnch/en/](http://www.who.int/pmnch/en/);
- *Countdown to 2015*:  
[www.countdown2015mnch.org/](http://www.countdown2015mnch.org/);
- Committing to Child Survival: A Promise Renewed:  
[www.apromiserenewed.org/Dashboard.html](http://www.apromiserenewed.org/Dashboard.html).

**Ensure that your national data** is available for comparison with other countries, in order to compare and learn.

The World Health Organization's national health accounts data includes a global health expenditure database (<http://apps.who.int/nha/database/PreDataExplorer.aspx?d=2>) and health accounts data over time by country ([www.who.int/nha/country/en/](http://www.who.int/nha/country/en/)), linked to more detailed country-specific health data (<http://apps.who.int/ghodata/>).

# Annexes

## Annex 1: National data on maternal, newborn and child health

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Core data for the 75 countries that are included in the *Countdown to 2015* Initiative – where more than 95 per cent of all maternal and child deaths occur – are available from three main sources:

- The World Health Organization’s maternal, newborn and child health country profiles: [www.who.int/maternal\\_child\\_adolescent/documents/countries/en/index.html](http://www.who.int/maternal_child_adolescent/documents/countries/en/index.html);
- *Countdown to 2015* country profiles: [www.countdown2015mnch.org/country-profiles](http://www.countdown2015mnch.org/country-profiles);
- UNICEF’s State of the World’s Children 2012 statistical tables: [www.unicef.org/sowc\\_2012/statistics.php](http://www.unicef.org/sowc_2012/statistics.php)).

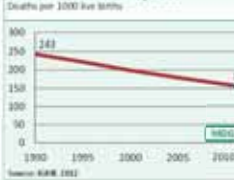
### Country-specific data – measuring progress

*Countdown to 2015* tracks coverage levels for health interventions proven to reduce maternal, newborn and child mortality. The data are laid out clearly and contain selected demographic measures, coverage rates for priority interventions across the continuum of care and indicators of equity, policy support, human resources and financial flows. Guidance on how to use and interpret the data is also included. The page below is an example of country-specific information:

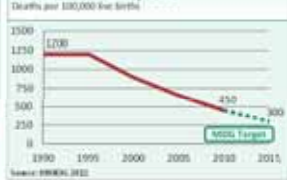
**DEMOGRAPHICS**

Total population (2008)	15,618	(2008)
Total under-five population (2008)	3,392	(2008)
Births (2008)	813	(2008)
Birth registration (%)	29	(2008)
Total under-five deaths (2008)	1,820	(2008)
Reasoned deaths, % of all under-5 deaths	29	(2008)
Neonatal mortality rate (per 1000 live births)	46	(2009)
Infant mortality rate (per 1000 live births)	96	(2009)
Stillbirth rate (per 1000 total births)	25	(2009)
Total maternal deaths	3,600	(2009)
Lifetime risk of maternal death (1 in %)	88	(2009)
Total fertility rate (per woman)	5.3	(2011)
Adolescent birth rate (per 1000 women)	165	(2009)

**Under-five mortality rate**

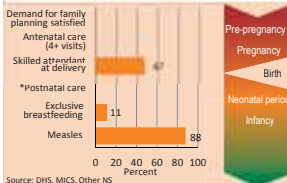


**Maternal mortality ratio**

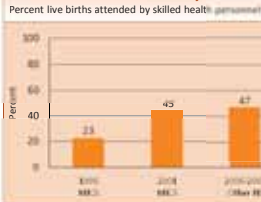


**MATERNAL AND NEWBORN HEALTH**

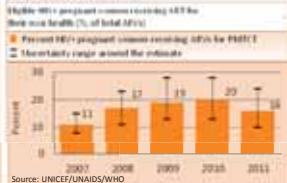
**Coverage along the continuum of care**



**Skilled attendant at delivery**

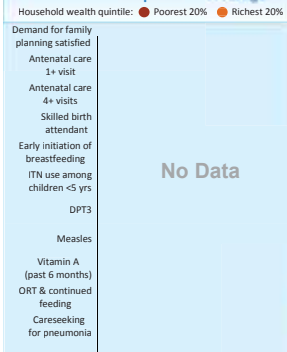


**Prevention of mother-to-child transmission of HIV**



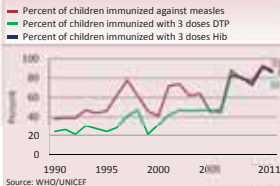
**EQUITY**

**Socioeconomic inequities in coverage**

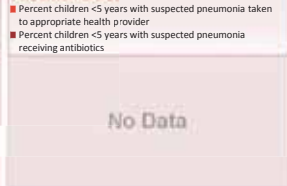


**CHILD HEALTH**

**Immunization**



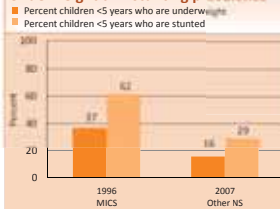
**Pneumonia treatment**



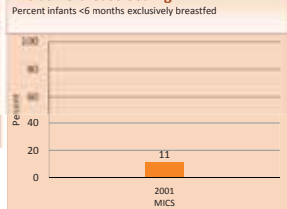
**NUTRITION**

Wasting prevalence (moderate and severe, %) **11** (2006)  
 Low birthweight incidence (moderate and severe, %) **11** (2006)  
 Early initiation of breastfeeding (within 1 hr of birth, %) **55** (2001)  
 Introduction of solid, semi-solid/soft foods (%) **55** (2001)  
 Vitamin A two dose coverage (%) **55** (2001)

**Underweight and stunting prevalence**



**Exclusive breastfeeding**

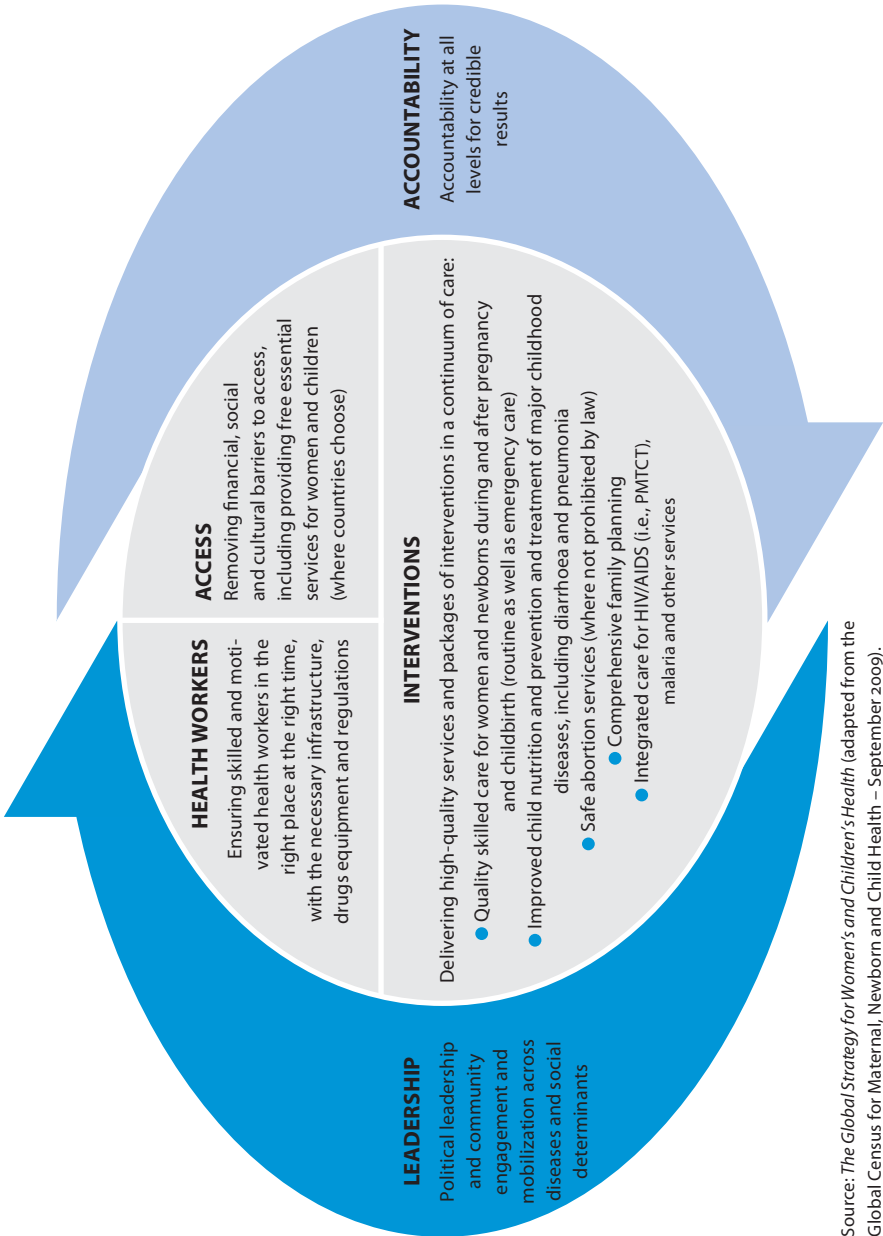


Coverage levels are shown for the poorest 20% (red circles) and the richest 20% (orange circles). The longer the line between the two groups, the greater the inequality. These estimates may differ from other charts due to differences in data sources.

Developed by Countdown to report on core indicators identified by the UN Commission on Information and Accountability, in support of the Global Strategy for Women's and Children's Health

Note: Based on 2006 WHO reference population

# Annex 2: A framework for coordinated action to improve women’s and children’s health



Source: *The Global Strategy for Women's and Children's Health* (adapted from the Global Census for Maternal, Newborn and Child Health – September 2009).

## Annex 3: Annotated bibliography

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The following resources offer more detailed information on the issues covered in this handbook.

### **Asian Forum of Parliamentarians on Population and Development, 2010. *Maternal Health: An Advocacy Guide for Parliamentarians***

A practical manual giving examples and good practice from Asia of the role of parliamentarians in combating maternal death and illness through their representative, legislative, budgetary, oversight, advocacy and accountability functions. It focuses, in particular, on the importance of addressing gender inequality and health inequity.

### **Commission on Information and Accountability for Women's and Children's Health, 2011. *Keeping Promises, Measuring Results***

This report summarizes key elements of accountability and identifies existing global mechanisms, including case studies of good practice. It identifies gaps in global mechanisms, noting that there is currently no evidence of widespread global mechanisms for NGO accountability on MNCH. (See Annex 2 for its key recommendations.) The Commission will shortly be issuing its workplan, which will be available on this website.

### **Independent Expert Review Group (iERG), 2012. *Every Woman, Every Child: From Commitments to Action***

This report, the first of four annual reviews that the iERG will complete up to and including the Millennium Development Goal target date of 2015, summarizes progress on the UN Secretary-General's Global Strategy for Women's and Children's Health and the recommendations of the Commission on Information and Accountability for Women's and Children's Health.

### **Partnership on Maternal, Newborn and Child Health. *Knowledge summaries***

PMNCH knowledge summaries are a short, user-friendly update of the most recent evidence and are intended for policymakers, advocates, programme managers and others. They provide a succinct summary of the most recent scientific evidence, technical guidelines, policy documents and experience on the ground. Each summary is peer reviewed. New summaries are regularly added to the website.

- Knowledge summary 1: Understand the burden
- Knowledge summary 2: Enable the continuum of care
- Knowledge summary 3: Cost and fund RMNCH programmes
- Knowledge summary 4: Prioritize proven interventions
- Knowledge summary 5: Provide essential commodities

- Knowledge summary 6: Support the workforce
- Knowledge summary 7: Assure quality care
- Knowledge summary 8: Strive for universal access
- Knowledge summary 9: Address inequities
- Knowledge summary 10: Foster innovation
- Knowledge summary 11: Engage across sectors
- Knowledge summary 12: Deliver on promises
- Knowledge summary 13: Make stillbirths count
- Knowledge summary 14: Save lives: Invest in midwives
- Knowledge summary 15: Non-communicable diseases
- Knowledge summary 16: Parliamentarians
- Knowledge summary 17: Civil registration and vital statistics
- Knowledge summary 18: Nutrition
- Knowledge summary 19: Food security and climate change
- Knowledge summary 20: Access to family planning
- Knowledge summary 21: Strengthen national financing
- Knowledge summary 22: Reaching child brides
- Knowledge summary 23: Human rights and accountability
- Knowledge summary 24: Economic benefits of investing in women's and children's health
- Knowledge summary 25: Integrating immunization and other services for women and children
- Knowledge summary 26: Engaging men and boys in RMNCH

**PMNCH/IPU, 2010. *Taking the Lead: Parliamentarians Engage with Maternal, Newborn and Child Health***

This short publication provides a summary of key potential actions of parliamentarians and provides case studies of how parliamentarians have taken action.

**PMNCH, 2010. *Global Strategy for Women's and Children's Health***

The strategy outlines the key approaches and builds on existing evidence of what works. The strategy is available in Arabic, Chinese, English, French, Russian and Spanish.

**PMNCH, 2012. *Investing in Maternal, Newborn and Child Health – The Case for Asia and the Pacific***

**Save the Children, 2013. *State of the World's Mothers 2013. Surviving the First Day***

This report examines data from 186 countries to show where babies are at the greatest risk of death on the day they are born. The report highlights four low-cost solutions that have great potential to save lives and presents the annual Mothers' Index, which ranks 176 countries to show where mothers fare best and where they face the greatest hardships.



### **UNFPA. *Adolescent Sexual and Reproductive Health***

UNFPA has a wide range of resources on adolescent sexual and reproductive health, which provide an essential focus on this vulnerable and priority group requiring maternal, newborn and child health support. The website includes fact sheets and country data.

### **UNFPA, 2011. *State of the World's Midwifery***

This report provides a summary of the current situation on the essential role that midwives play in improving maternal, newborn and child health. The website includes a full report, with detailed information on the importance of midwives. It also includes detailed country statistics and supporting country data, as well as short briefs on the importance of investing in midwives.

### **UNICEF, 2012. *Committing to Child Survival: A Promise Renewed. Progress report 2012***

A call to action on child health, with comprehensive information on causes and potential responses for child health and detailed country data.

### **World Health Organization, 2002. *25 Questions and Answers on Health and Human Rights***

This brief publication provides a simple summary of some of the key arguments on MNCH regarding maternal, newborn and child health.

### **World Health Organization, 2010. *Global Strategy for Women's and Children's Health***

A brief summary of the key components for successfully responding to maternal, newborn and child health. Your government has committed to this strategy.

### **World Health Organization, 2010. *Packages of Interventions for Family Planning, Safe Abortion Care, Maternal, Newborn and Child Health***

This is a summary of the key interventions and indexes (see summary sheet 3) and contains more detailed guidance on system strengthening. It also references the most essential sources of evidence for the packages of essential interventions.

### **World Health Organization and UNICEF, 2012. *Countdown to 2015: Maternal, Newborn and Child Survival: Building a Future for Women and Children – The 2012 Report***

*Countdown to 2015* is a global movement to track, stimulate and support country progress towards achieving the health-related MDGs. The report focuses on coverage levels and trends with regard to interventions, examines equity in coverage across different population groups within and across *Countdown* countries and uses these data to hold countries and their international partners accountable for progress in reproductive, maternal, newborn and child health.

# Summary sheets

The sheets below provide key messages that can be used for advocacy or as information aides memoire by parliamentarians and parliamentary staff. The sources of data are provided, making it possible to update the information when required.

## Summary sheet 1: Maternal, newborn and child health – key messages<sup>25</sup>

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### Progress . . .

- Maternal mortality has declined dramatically – maternal deaths dropped from 543,000 a year in 1990 to 287,000 in 2010.
- Deaths among children under age 5 worldwide declined from 12 million a year in 1990 to 7.6 million in 2010.

### But not enough . . .

- Only nine *Countdown* countries are on track to achieve MDG 5; 25 have made insufficient or no progress.
- An African woman's lifetime risk of dying from pregnancy-related causes is 100 times higher than that of a woman in a developed country.
- Only 23 *Countdown* countries are on track to achieve MDG 4; 13 have made little or no progress.
- Pneumonia and diarrhoea still cause more than two million deaths a year that could be avoided by available preventive measures and prompt treatment.
- Forty per cent of child deaths occur during the first month of life.
- More than 10 per cent of babies are born preterm, a figure that is rising, and complications due to preterm birth are the leading cause of newborn deaths and the second leading cause of child deaths.
- Undernutrition contributes to more than a third of child deaths and to at least a fifth of maternal deaths.

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<sup>25</sup> World Health Organization and UNICEF. 2012. *Countdown to 2015: Maternal, newborn and child survival: Building a future for women and children – the 2012 report.*

- In the majority of *Countdown* countries, more than a third of children are stunted: stunting is most common among poor children.

### Political commitment and a strong national system are necessary

- High levels of political commitment and financial resources have increased coverage levels for vaccines by over 80 per cent on average and achieved rapid progress in distribution of insecticide-treated nets.
- Interventions that require a strong health system, such as a skilled attendant at birth, show slower progress and greater inequities in coverage.
- To increase coverage, the volume of services provided must grow at a faster pace than the population.
- Domestic health funding is essential, yet 40 *Countdown* countries devote less than 10 per cent of government spending to health.

### Improved health for all requires reducing inequity in health coverage

- The need is most pronounced in rural areas.
- Poor people have less access to health services than richer people across the world.

### All stakeholders must continue to:

- Advocate for sufficient funding for reproductive, maternal, newborn and child health.
- Undertake research to develop the evidence on effective interventions and innovative strategies for service delivery.
- Support country efforts to implement innovative strategies that increase access to timely, equitable and high-quality care.

### Together we can:

- Demand accountability and act accountably.
- Build a better future for millions of women and children.

## Summary sheet 2:

# MNCH-related Millennium Development Goals

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These were signed in 2000 by all United Nations Member States

### **Two MDGs deal directly with women's and children's health:**

- MDG 4 aims to reduce under-five child mortality by two thirds from 1990 levels
- MDG 5 aims to reduce the maternal mortality ratio by three quarters from 1990 levels

### **Action on four other MDGs advances maternal, newborn and child health:**

- MDG 1 aims to eradicate extreme poverty and hunger, by halving the proportion of people living on less than \$1 per day and who suffer from hunger  
Maternal and child mortality rates will remain high while women and children are poor and undernourished
- MDGs 2 and 3 aim to achieve universal access to education by 2015 and eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

*Educating girls for six years or more drastically and consistently improves their pre-natal care, postnatal care and childbirth survival rates. Educating mothers also greatly cuts the death rate of children under five. Educated girls have higher self-esteem, are more likely to avoid HIV infection, violence and exploitation, and to spread good health and sanitation practices to their families and throughout their communities, and an educated mother is more likely to send her children to school.<sup>26</sup>*

- MDG 6 aims to halt and begin to reverse the spread of HIV/AIDS and malaria by 2015  
*Halting deaths from HIV and malaria will make a significant improvement in maternal, newborn and child health. It will also reduce ill health and malnutrition that has been caused by HIV infection or malaria in both mother and child.*

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<sup>26</sup> UNICEF, *State of the world's children 2004: Maternal health*. [http://www.unicef.org/sowco4/sowco4\\_maternal\\_health.html](http://www.unicef.org/sowco4/sowco4_maternal_health.html) Accessed 11 October 2012

## Summary sheet 3: Key packages of interventions for MNCH<sup>27</sup>

### A. Summary of key packages of interventions for MNCH – Family planning

Family planning enables women, with their sexual partners, to make decisions about when to get pregnant. It has the potential to reduce almost one third (32%) of maternal deaths and 10 per cent of newborn, infant and child deaths. Condoms, which are one family planning option, can avert up to 80 per cent of HIV infections if used consistently and correctly.

#### Indicators:

Met need for contraception (proportion of women aged 15–49 years who are married or in a union and who have met their need for family planning, i.e., who do not want any more children or want to wait at least two years before having another baby, and are using contraception).

Intervention level	Intervention
HOME/COMMUNITY	<ul style="list-style-type: none"> <li>● Health education to women, families and community</li> <li>● General awareness raising for all community members</li> <li>● Access to sexual and reproductive health services (SRH), including priority groups, e.g., adolescents</li> <li>● Awareness of signs of domestic or sexual violence and referral</li> </ul>
FIRST LEVEL HEALTH FACILITY	<p>All of the above plus:</p> <ul style="list-style-type: none"> <li>● Counselling on full range of family planning (FP) methods</li> <li>● HIV testing and counselling in generalized epidemics</li> <li>● Condoms (male/female) – FP/HIV protection</li> <li>● Screening/management of domestic and sexual violence</li> <li>● Support and referral for infertile couples</li> <li>● Referral to above facilities</li> </ul>
REFERRAL FACILITY	<p>All of the above plus:</p> <ul style="list-style-type: none"> <li>● Treatment of medical conditions</li> <li>● Management of FP choices (tubal ligation/vasectomy etc.)</li> <li>● Management of infertile couples, including HIV-discordant couples</li> </ul>

### B. Summary of key packages of interventions for MNCH – Safe abortion care

In countries where abortion is legal, it is important to have access to safe abortion services and access to treatment for complications of spontaneous and unsafe abortion.

<sup>27</sup> [http://portal.pmnch.org/downloads/low/Knowledge\\_for\\_Action\\_Annex1\\_lowres.pdf](http://portal.pmnch.org/downloads/low/Knowledge_for_Action_Annex1_lowres.pdf)

All organizations providing reproductive health must be able to identify the risks associated with illegal abortion and refer girls and women to services that can provide care.

Abortion must be linked to counselling and support on contraceptive methods as well as access to screening, treatment and referral for other reproductive health needs. Safe abortion has the potential for preventing nearly all deaths (70,000) and disabilities (5 million) from unsafe abortion.

**Indicators:**

There are no recommended core indicators for safe abortion. Recommended indicators include the percentage of health providers trained in safe abortion care to the full extent of the law and facilities that provide induced abortion to the full extent of the law; management of abortion complications; age disaggregated data concerning the hospitalization rate for unsafe abortion per 1000 women, and the maternal death ratio attributed to abortion.

Intervention level	Intervention
HOME/COMMUNITY	<ul style="list-style-type: none"> <li>● Health education to women, families and community: SRH, including safe sex, FP, unwanted pregnancy, coerced sex, consequences of unprotected sex, legal grounds for safe abortion and consequences of unsafe abortion</li> <li>● Availability of FP services, pregnancy detection and safe abortion services</li> <li>● Distribution of contraceptive methods, identification of signs of domestic and sexual violence and referral</li> <li>● Identification, first aid and prompt referral of women with signs of complications of unsafe abortion</li> </ul>
FIRST LEVEL HEALTH FACILITY	<p>All of the above plus:</p> <ul style="list-style-type: none"> <li>● Counselling on full range of FP methods</li> <li>● Uterine evacuation for first trimester and incomplete abortions</li> <li>● Diagnosis and treatment of common abortion complications, including infection, bleeding and injury</li> <li>● Referral for timely treatment of abortion-related complications</li> <li>● Diagnosis and treatment of STIs/HIV</li> </ul>
REFERRAL FACILITY	<p>All of the above plus:</p> <ul style="list-style-type: none"> <li>● Uterine evacuation for pregnancies beyond the first trimester</li> <li>● Management of women with any abortion complication</li> <li>● Provision of all contraceptive methods, including tubular ligation</li> </ul>

## C. Summary of key packages of interventions for MNCH – Pregnancy care

If the Global Consensus targets on pregnancy care are met, the deaths of up to one million women from pregnancy and childbirth complications can be prevented through simple interventions.

### Indicators (key indicators recommended in the Global Strategy):

- Maternal mortality ratio (deaths per 100 000 live births) (MDG indicator);
- Antenatal care coverage (percentage of women aged 15–49 with a live birth who received antenatal care from a skilled health provider at least four times during pregnancy)
- Antiretroviral prophylaxis among HIV-positive pregnant women to prevent vertical transmission of HIV, and antiretroviral therapy for women who are treatment-eligible

Intervention level	Intervention
HOME / COMMUNITY	<ul style="list-style-type: none"> <li>● Information and counselling for women, partners and key family members on self care, nutrition, safer sex, HIV, breast-feeding, family planning, use of insecticide-treated nets (ITNs)</li> <li>● Birth planning, advice on labour, danger signs and emergency preparedness</li> <li>● Support for compliance with preventive treatments, including HIV</li> <li>● Assessment of signs of domestic violence and referral</li> </ul>
FIRST LEVEL HEALTH FACILITY	<p>All of the above plus:</p> <ul style="list-style-type: none"> <li>● Confirmation of pregnancy</li> <li>● Regular monitoring of woman and foetus, including nutritional status</li> <li>● Detection of problems complicating pregnancy (e.g. anaemia, hypertensive disorders, bleeding, malpresentations, multiple pregnancy)</li> <li>● Tetanus immunization, anaemia prevention and control (iron and folic acid supplementation)</li> <li>● Syphilis testing and treatment of syphilis (woman and her partner)</li> <li>● Treatment of mild to moderate pregnancy complications (e.g. mild to moderate anaemia, urinary tract infection, vaginal infection)</li> <li>● Pre-referral treatment of severe complications (pre-eclampsia, eclampsia,)</li> <li>● Support for women living with violence and HIV</li> </ul> <p>Where indicated:</p> <ul style="list-style-type: none"> <li>● HIV testing and counselling, PMTCT, infant feeding counselling, intermittent preventive treatment for malaria and promotion of ITNs, deworming, assessment of female genital mutilation, treatment of mild to moderate opportunistic infections, treatment of simple malaria cases</li> </ul>

REFERRAL FACILITY	<p>All of the above plus:</p> <ul style="list-style-type: none"> <li>● Treatment of severe pregnancy complications (anaemia, severe pre-eclampsia, eclampsia, bleeding, infection, other medical complications)</li> <li>● Treatment of abortion complications</li> <li>● Management of malpresentations, multiple pregnancy</li> </ul> <p>Where indicated:</p> <ul style="list-style-type: none"> <li>● Treatment of severe HIV infection, treatment of complicated malaria</li> </ul>
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## D. Summary of key packages of interventions for MNCH – Childbirth care

With effective childbirth care, it is possible to reduce risks of maternal mortality and severe morbidity due to labour-related complications by 95 per cent and asphyxia-related newborn deaths by 40 per cent. Postpartum haemorrhage could be reduced by 67 per cent.

### Indicators (key indicators recommended in the Global Strategy):

- Maternal mortality ratio (deaths per 100 000 live births) (MDG indicator);
- Skilled attendant at birth (percentage of live births attended by skilled health personnel)
- Postnatal care for mothers and babies (percentage of mothers and babies who received postnatal care visit within two days of childbirth)

Intervention level	Intervention
HOME/COMMUNITY	<ul style="list-style-type: none"> <li>● Companion of choice to support the woman to attend a facility</li> <li>● Support for care for the rest of the family</li> <li>● Support for transport</li> </ul>
FIRST LEVEL HEALTH FACILITY	<p>All of the above plus:</p> <ul style="list-style-type: none"> <li>● Care during labour and delivery (diagnosis of labour, monitoring progress of labour, maternal and foetal well-being with partograph), infection prevention, supportive care and pain relief, detection of problems and treatment of complications</li> <li>● Initiation of breastfeeding</li> <li>● Newborn resuscitation</li> <li>● Active management of third stage of labour</li> <li>● Immediate postpartum care of mother</li> <li>● Monitoring and assessment of maternal well-being, prevention and detection of complications (e.g. hypertension, infections, bleeding, anaemia)</li> </ul>



	<ul style="list-style-type: none"> <li>● Treatment of abnormalities and complications (e.g. prolonged labour, vacuum extraction; breech presentation, episiotomy)</li> <li>● Pre-referral management of serious complications (e.g. obstructed labour, foetal distress, preterm labour, severe peri- and post-partum haemorrhage)</li> <li>● Support for the family if maternal or perinatal death</li> <li>● Counselling for family planning including insertion of IUDs</li> </ul> <p>Where indicated:</p> <ul style="list-style-type: none"> <li>● Vitamin A administration for mother, HIV testing and counselling, prevention of mother-to-child transmission of HIV by mode of delivery, guidance and support for chosen infant feeding option, care for HIV positive women/ART</li> </ul>
REFERRAL FACILITY	<p>All of the above plus:</p> <ul style="list-style-type: none"> <li>● Treatment of severe complications in childbirth and in the immediate postpartum period, including caesarean section, blood transfusion, hysterectomy; induction and augmentation of labour; management of other obstetric complications</li> </ul>

## E. Summary of key packages of interventions for MNCH – Postpartum care and newborn care (combined packages)

Postpartum care is promotive and preventive care following childbirth, from 24 hours to six weeks, including identification and management of complications, plus support for the mother through family planning, care and counselling on HIV where required and support for breastfeeding. The key component of newborn care is early identification and management of newborn problems, especially care for prematurely born or low birth weight infants. Maternal sepsis is a significant cause of maternal mortality. Timely management would reduce such deaths by 90 per cent. Postnatal care can save up to 2 million newborn lives each year.

### Indicators:

- Under-five child mortality, with the proportion of newborn deaths (deaths per 1000 live births) (MDG indicator)
- Postnatal care for mothers and babies (percentage of mothers and babies who received postnatal care visit within two days of childbirth)
- Exclusive breastfeeding for six months (percentage of infants aged 0–5 months who are exclusively breastfed)

Others include the percentage of women: discharged from facilities in less than 24 hours after delivery, receiving postpartum care within seven days after delivery, using a modern contraceptive method at six weeks after childbirth.

Intervention level	Intervention
HOME/COMMUNITY	<ul style="list-style-type: none"> <li>● All interventions in pregnancy care (see above), especially family planning/birth spacing/use of ITNs</li> <li>● Support for exclusive breastfeeding</li> <li>● Safe disposal/washing of pads (mother) and thermal protection (newborn)</li> <li>● Support for rest and lower work load</li> <li>● Recognition of dangers signs, including blues/depression</li> <li>● Awareness of signs of domestic and sexual violence and referral</li> <li>● Newborn stimulation and play</li> <li>● Support for women living with HIV including ART</li> <li>● Reporting birth and death (vital registration)</li> <li>● PMTCT follow up for mother and infant where necessary</li> </ul>
FIRST LEVEL HEALTH FACILITY	<p>All of the above plus:</p> <p>(postpartum)</p> <ul style="list-style-type: none"> <li>● Assessment of maternal well-being including maternal nutrition</li> <li>● Prevention and detection of complications (e.g. infections, bleeding, anaemia)</li> <li>● Anaemia prevention and control (iron and folic acid supplementation)</li> <li>● Provision of contraceptive methods</li> <li>● Treatment of some problems (e.g. mild to moderate anaemia, mild puerperal depression, mastitis)</li> <li>● Pre-referral treatment of some problems (e.g. severe postpartum bleeding)</li> <li>● Recording and reporting</li> <li>● Promotion, protection and support for exclusive breastfeeding</li> </ul> <p>(neonatal)</p> <ul style="list-style-type: none"> <li>● Eye infection prophylaxis, immunization, presumptive treatment of congenital syphilis</li> <li>● Treatment of local infections (skin, cord, eye, mouth)</li> <li>● Identification, initial management and referral of a newborn with any sign of severe illness, injury or malformation</li> <li>● Care of premature/low birth weight babies without breathing problems: support for breast(-milk) feeding, Kangaroo Mother Care</li> <li>● Where indicated: HIV and malaria treatment</li> </ul>
REFERRAL FACILITY	<p>All of the above plus:</p> <ul style="list-style-type: none"> <li>● Treatment of all complications (severe anaemia, severe postpartum bleeding, severe postpartum infections, severe postpartum depression)</li> <li>● Tubal ligation and vasectomy/contraceptive implants</li> <li>● Management of a newborn with severe problems, e.g., premature babies with breathing problems or unable to feed orally, severe infection, severe birth asphyxia, severe jaundice, malformations</li> </ul>

## F. Summary of key packages of interventions for MNCH – Infancy and childhood care

Five illnesses and medical conditions are directly responsible for more than 90 per cent of all child deaths (aged 0–5): pneumonia, measles, diarrhoea, malaria and a set of neonatal conditions (related to a child’s experience during pregnancy or birth). The key interventions listed below have been proven to have an impact of scale and can almost all be delivered at community or health facility level. Child health must be linked to interventions that provide early stimulation or protection.

### Indicators:

- Under-five mortality (deaths per 1000 live births) (MDG indicator)
- Three doses of the combined diphtheria, pertussis and tetanus vaccine (percentage of infants aged 12–23 months who received three doses of diphtheria, pertussis and tetanus vaccine)
- Antibiotic treatment for pneumonia (percentage of children aged 0–59 months with suspected pneumonia receiving antibiotics)

Intervention level	Intervention
HOME / COMMUNITY	<ul style="list-style-type: none"> <li>● Promotion and support for: exclusive breastfeeding; appropriate complementary feeding; child stimulation and play; hand washing; sanitation and appropriate disposal of faeces; recognition of signs of illness and timely care-seeking; home care during illness</li> <li>● Provision and promotion of ITNs</li> <li>● Identification and referral of children with signs of severe illness</li> <li>● Identification and management of diarrhoea, pneumonia and malaria</li> </ul>
FIRST LEVEL HEALTH FACILITY	<p>All of the above plus:</p> <ul style="list-style-type: none"> <li>● Immunization</li> <li>● Identification and referral of children with signs of severe illness</li> <li>● Integrated management of childhood illnesses (IMCI) (diarrhoea, pneumonia, fever – malaria and measles, uncomplicated severe acute malnutrition).</li> <li>● Assessment of nutritional status and counselling on feeding</li> <li>● Micronutrient supplementation</li> <li>● Recording and reporting</li> <li>● Where indicated: HIV testing and counselling (early infant diagnosis), cotrimoxazole prophylaxis, ART</li> </ul>
REFERRAL FACILITY	<ul style="list-style-type: none"> <li>● Management of children with severe illness</li> <li>● Management of children with severe complicated malnutrition</li> </ul>

## Summary sheet 4:

### Tracking financial resources – global commitments<sup>28</sup>

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Tracking financial resources provides critical information that helps increase the accountability of governments to their citizens. It shows whether countries have spent funds according to the priority areas budgeted for in national health plans, supports more informed policy-making and enables money spent to be associated with results achieved. Resource tracking also helps to show whether development partners have provided external financial support in line with their commitments.

The Commission on Information and Accountability for Women's and Children's Health was established to support implementation of the Global Strategy for Women's and Children's Health. Its objective is to propose a framework to help countries monitor where resources go, how they are spent and the results achieved.

The Commission has produced three recommendations for national governments working to improve women's and children's health:

#### **Recommendation 1: Monitor financial resources directed to health, and specifically to reproductive, maternal, newborn and child health services by:**

- developing compacts with all development partners wishing to work in a country to ensure they report on externally funded expenditures on health following an agreed template;
- tracking the two aggregate indicators:
  - (i) total health expenditure by financing source, per capita and
  - (ii) total reproductive, maternal, newborn and child health (RMNCH) expenditure by financing source, per capita;
- making this information available nationally, regionally, and internationally to the World Health Organization (WHO) for inclusion in its health expenditure database.<sup>29</sup>

*The Commission states that "Parliaments have an important role to play in holding governments accountable for such reporting". (Commission report, p15)*

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28 [http://www.who.int/topics/millennium\\_development\\_goals/accountability\\_commission/Commission\\_Report\\_advance\\_copy.pdf](http://www.who.int/topics/millennium_development_goals/accountability_commission/Commission_Report_advance_copy.pdf)

29 The information is available at the following WHO databases: global health expenditure database (<http://apps.who.int/nha/database/PreDataExplorer.aspx?d=2>); national health accounts data over time by country ([www.who.int/nha/country/en/](http://www.who.int/nha/country/en/)); country-specific health data (<http://apps.who.int/ghodata/>).

**Recommendation 2: Review resource flows (ideally annually) for overall health spending and spending specific to RMNCH. This spending must be related to:**

- commitments budgeted for in national health plans and by development partners;
- goals of equity and human rights, by disaggregating health expenditure by socio-economic status and other demographic or geographic variables, to measure how far governments are meeting their commitments to ensuring the right to health (see box *Key commitments and resolutions on maternal, newborn and child health*, Section 1 above);
- results achieved (e.g. DPT3 coverage, assisted deliveries, percentage of children receiving vitamin A supplementation) as an indication of whether expenditures are providing value for money.

*The Commission states that “In many countries, parliaments have a mandate to perform these review functions. Efforts to strengthen the capacity of countries to direct resources to women and children should involve parliaments”.* (Commission report, p17)

**Recommendation 3: Ensure that an accountability mechanism is in place by 2015 to oversee resource expenditure. Such a mechanism can increase accountability, acknowledge success and remedy performance.**

*The Commission recommends that one of several potential options to strengthen review mechanisms in countries is to establish a national commission for women's and children's health. This would be chaired by a head of State or government, accountable (and reporting) to parliament, inclusive of all relevant government departments and engaging non-governmental actors. “The highest levels of political authority, including national parliaments, should act to ensure the results of the review inform subsequent national plans, together with commitments on budgets, timelines and further accountability measures.”* (Commission report, p18)

Other possible models to complement the above mechanism include parliamentary reviews, annual health sector reviews, national health assemblies, civil society processes, memoranda of understanding, codes of conduct, etc.). The model should move beyond simple monitoring to critical review (including technical review of data quality) and to implementation of remedial actions that will improve results. To ensure effective accountability, mechanisms should include policy, technical, academic and civil society constituencies.