
1. Africa


   Maternal Death Reviews (MDRs) are not only a key element of accountability but necessary for improving the quality of maternal health care services. MDRs do more than counting maternal deaths; they look beyond the numbers, studying the causes and avoidable factors behind each death, leading to actions to improve quality of care through addressing factors that could have contributed to the death based on the findings. MDRs provide individuals and communities with an opportunity to understand how those with responsibilities have failed to uphold them. Equally, they provide those with responsibilities the opportunity to explain what they have done and why. Where mistakes have been made, MDRs require redress mechanisms. However, MDRs are not essentially a matter of blame and punishment and can be positive instruments to produce changes. They are part of a process that helps to identify what works so it can be replicated and what does not so it can be revised.

   Since 2003, UNFPA and other agencies, including WHO and UNICEF, and other development partners have been supporting African Ministries of Health in Africa to institutionalize MDRs. Five methods were introduced: verbal autopsy, facility-based maternal deaths review, near miss review of severe morbidity, confidential enquiries into maternal deaths and criterion-based clinical audit. “Beyond the Numbers” published by WHO in October, 2004 served as a reference for orientations. The development of national policies and guidelines for MDRs by countries has improved from 35 per cent in 2007 to 65 per cent in 2010, including Comoros, Lesotho, Malawi, Namibia, Rwanda, and Uganda. A review of the Beyond the Numbers’ methodologies in the eastern and southern Africa showed that maternal deaths are a notifiable condition in 65 per cent of countries in the region. By 2010, 50 per cent of countries had set up national committees to plan, coordinate and implement MDR activities. In 2010, 60 per cent of countries had developed guidelines, implementing them in all but one country. While 55 per cent of countries in 2007 reported that maternal deaths were reviewed and analyzed, by 2010, 65 per cent of countries had done so.

   Challenges observed and lessons learned

   According to an internal evaluation conducted by UNFPA, the institutionalization of MDRs requires political commitment, legal and administrative back up, financial support, capacity development, simplified reporting forms and procedures, coordinated support of development partners, involvement of professional bodies, and regular supportive follow up. The establishment of an active advocacy group at the national level is important to ensure civil society engagement. Equally important is the adoption of policies, guidelines and tools for conducting MDRs. Expansion of coverage from pilot to district and national scale is essential to ensure

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sustainability. Involvement of communities in the planning, design, implementation and monitoring and evaluation of the programmes ensure ownership by rights holders.

While the development of national policies and guidelines for MDRs is critical, they do not guarantee that MDRs’ implementation is taken to scale. Dissemination of the guidelines and program support to the program managers at the provincial and district level are essential. A specific budget line for MDRs in the health sector helps to ensure that it is not lost among competing priorities. MDRs are more sustainable when integrated into the maternal and reproductive health programmes (skilled care, emergency obstetric and newborn care, family planning) rather than as a vertical programme. Causes and solutions are then more likely to be related to the availability, accessibility, acceptability and quality of reproductive health services including maternal and newborn health services.

The case of Rwanda

The Health sector in Rwanda has made significant progress in recent years. Reproductive health, including family planning and maternal health is a priority in the Ministry of Health Strategic Plan. The maternal mortality rate has decreased from 750 in 2005 (DHS) to 540 in 2008 (UN estimates) and then to 383, according to the Health Management Information System (HMIS, 2010). Improved surveillance and accountability have played a major role in reducing the maternal mortality rate and increasing the number of assisted deliveries in Rwanda.

Contributing factors to the current rate of maternal deaths include the high percentage of births that take place without skilled medical assistance (63.5 per cent) and the low utilization of basic obstetric care and family planning services (Contraceptive prevalence rate 27 per cent). However, the percentage of women using modern contraceptive methods impressively increased from 10 to 27 per cent in three years -from 2004 to 2007- (Interim DHS, 2007-08) and to 45 per cent in 2010 (HMIS). Moreover, from 2000 to 2007 the infant mortality rate decreased by almost half from 107 to 62 deaths per 1,000 live births. (IDHS, 2007-08)

Currently UNFPA is implementing its sixth cycle of assistance through a country programme that provides support for an integrated package of adolescents sexual and reproductive health, gender equality, women’s empowerment and population issues in five districts.

Applying the human rights principle of accountability: Maternal Audits

In 2008, with UNFPA support, the Rwandan Government developed and adopted a roadmap to accelerate the reduction of maternal and newborn mortality and morbidity, which includes maternal death audits at health facilities and community level. The Ministry of Health chose three methods 1) facility based death audit; 2) confidential enquiry into maternal deaths, and 3) verbal autopsy (community based death audit).

As a result of capacity building from WHO and UNFPA, all district hospitals (43) have trained providers in maternal death audit. Consequently, 256 maternal deaths in 2009 and 221 maternal deaths in 2010 were audited and recommendations formulated to avoid similar deaths in the future.

High Level Advocacy

Under the leadership of the government, several high level advocacy initiatives aimed at improving maternal and newborn health, have taken place in Rwanda. These include the launch of the CARMMA in October 2009.

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3 CARMMA: Campaign to accelerate the reduction of the maternal mortality in Africa. This is an initiative taken by the African Union to stimulate national commitment and advocacy for maternal and newborn health, as complement of the Sexual Reproductive Health Maputo Plan of action (2006).
by the First Lady, and the organization of two International Conferences on Maternal and Child Health in May 2009 and July 2010. These events have reaffirmed the Government of Rwanda’s commitment to addressing maternal mortality and morbidity, and have demonstrated how political will is so important in the reduction of maternal mortality and morbidity.

**Joint UN Action**

Another very important element is the joint UN support. Joint UNICEF, WHO and UNFPA support has increased local resource mobilization (procurement of ambulances, piloting RapidSMS in one district, improving family planning services at the community level). In fact, piloting of RapidSMS in one district has provided evidence of the enormous potential of innovative technology and has empowered community health workers through a tool (telephone) that has allowed them to take action in a short time.

2. Asia

a. The Case of Nepal

The 2006 NDHS data showed that the maternal mortality ratio (MMR) was 281 deaths per 100,000 live births in Nepal. This represented a decrease of 32 per cent over the 2000 figure that stood at 415. A recent survey of eight districts technically supported by UNFPA estimated the MMR to be 229 deaths per 100,000 live births (FHD 2009). This figure is currently used as a proxy for the national figure, and helps to infer significant progress towards the MMR target. Over 90 per cent of all maternal deaths in these eight districts were related to pregnancy complications. It is noted that percentage contributions of eclampsia, abortion related complications, gastroenteritis and anemia to maternal causes have increased. Heart disease accounts for 7 per cent of causes of maternal death.

The MMR was found to vary considerably by age, with the lowest risk amongst women in their twenties, an increased risk for those aged under 20 and 30–34 years, and a significantly increased risk for those aged over 35 years (FHD 2009). There was also significant variation by caste/ethnicity. Muslim, Tarai/Madhesi and Dalit groups did poorly, with an MMR ranging between 273 and 318, which is above the MDG target, while Janajati groups, Brahmin/ Chhetri and Newar did far better, with an MMR between 105 and 207 (FHD 2009). Although women making ante-natal care visits to a skill birth attendant during pregnancy showed an improving trend, it still is below the desired level.

Anemia and malnutrition continue to be major underlying factors in many maternal deaths. Over one third of the women who died from maternal causes suffered from anemia prior to pregnancy and over one fifth from malnutrition. Nearly one quarter of women who died from maternal causes did not want to become pregnant at that time and this proportion increased for older women. Nearly one third of those who had an unwanted pregnancy attempted to abort. Fifty per cent of those who attempted an abortion suffered from at least one obstetric complication. However, the leading cause of death among all women of reproductive age was suicide, at 16 per cent.

Family planning is one of the key pillars of safe motherhood. Contraceptive prevalence rate (CPR) has shown some improvement in recent years but reportedly high levels of migration that separate couples hamper efforts to raise the CPR. According to a recent survey of 40 rural districts, the use of contraceptives among long distance couples is as low as 23 per cent (NFHP 2010).

Adolescent pregnancy and motherhood is a major social and health issue in Nepal. Nineteen per cent of women aged 15–19 years had already given birth or were pregnant with their first child. The percentage of adolescents who had begun childbearing increased rapidly with age, from one per cent for girls aged 15 years to 41 per cent for women aged 19 years.

**Government Efforts**
The Government has recognized that improvement in maternal and neonatal health is a national priority and has recently developed strategies and plans in this area. The importance of improving maternal and reproductive health for poverty reduction is also a government priority. As a result, the Government has formulated policies and strategies on reproductive health, safe motherhood, and newborn and adolescent health.

In January 2005, the Government of Nepal initiated a maternity incentive scheme, later renamed the Safe Delivery Incentive Programme, a demand and supply-side financing scheme designed to promote maternal health and to achieve MDG 5. In January 2009, the ‘Aama programme’ was launched. This program provides free delivery services and cash incentives to cover travel costs as well as financial incentives to health workers for providing safe delivery services at the home of the client. The programme has been endorsed nationwide.

**UNFPA’s Support Programmes**

Nepal’s recent struggle for democracy and more protracted struggle for women’s dignity and rights present new possibilities and lessons. UNFPA has accompanied the people of Nepal for part of this journey, and will remain in Nepal to support the fulfillment of the promise of peace.

UNFPA, Nepal has supported national owned efforts at every level, through a range of partnerships, in various settings, with a variety of tools and processes to bring about results. In this regard, women’s rights and gender equality are addressed across the spectrum of post-conflict, humanitarian emergencies to development. UNFPA’s support during 2011 – 2012 focuses on making MDGs meaningful for the most marginalized with a particular focus on improving availability, accessibility, including financial accessibility, and quality sexual and reproductive health services. This includes supporting the Ministry of Health and Population in operationalizing the remote area guidelines for safe motherhood and designing the national programmes to address obstetric and gynecologic morbidities (uterine prolapse, obstetric fistula and cancer cervix) in the most remote parts of the country through NGOs. In addition, UNFPA has supported the development of the health sector gender and social inclusion strategy (GESI) and development of guidelines for safe motherhood services with strong cross-sector collaboration among ministries, civil society and the external development partners. The GESI strategy helps to establish a common understanding of who the vulnerable groups are including the poor, specific marginalized caste and ethnic groups and vulnerable individuals and communities (based on a composite set of indicators). Moreover, UNFPA is supporting research to identify and address maternal mortality and consequences for policy advocacy, including maternal death audits and confidential enquiries, and documentation of sexual violence during conflict.

Over the last decade, the women and young girls of Nepal have seen a fifty per cent of reduction in maternal mortality and significant rise in the proportion of births delivered by a skilled birth attendant from 17 per cent in 2006 to 29 per cent in 2009. Moreover, it has to be noted that free maternity services targeting women living in poverty and marginalized women have increased.

**b. The Case of Lao PDR**

Despite many efforts in the last decade by the government and development partners to improve maternal and newborn health, maternal mortality ratio (MMR) remains high. The 2005 Census estimate showed MMR to 405/100,000 live births, translating to approximately 800 maternal deaths per year, or two to three maternal deaths every day. Therefore achieving MMR reduction to reach the national target for MDG5 of 260 maternal deaths per 100,000 live births by 2015 will require intensive action by all development partners working in synergy to support the Ministry of Health’s strategy. Moreover, infant and maternal mortality rates among ethnic minorities are higher than national averages, with infant mortality rate reaching 70 per 1000 live births, and maternal deaths 750 per 100,000 live births in some provinces. This is partly because remote villages become cut off during the rainy season making access to antenatal and postnatal care difficult, but also because women often give birth in unsafe conditions without trained birth attendants. Finally,
food insecurity for 4-6 months of the year results in chronic malnutrition.

**Main Efforts done by the Government with UNFPA’s support**

In partnership with UN agencies and NGOs, the Lao Government is committed to bringing the benefits of development to these minorities, and has put in place supportive government policies. There are significant challenges to the realization of the right to health however - not least being that Laos is one of the poorest countries in South East Asia.

UNFPA supported a qualitative research study in 2007 using the PEER\(^4\) approach – a methodology particularly suitable for gathering data amongst hard to reach, non literate people. The research explored perceptions and behaviours related to reproductive health among vulnerable ethnic communities. Local women, trained as researchers, developed their own research questions, interviewed their friends, and reported findings to the research team. They collected detailed qualitative data on risk factors related to maternal health and barriers of access to service. According to the research, despite the existence of many distinct cultural practices between the different ethnic groups, a number of common findings emerged: language barriers were a constraint to understanding health promotion messages, with consequent low levels of knowledge about reproductive health; early marriage and childbearing, from 12 years upwards, is common among a number of groups; sickness and wellbeing are believed to be related to spiritual forces; many women are unable or unwilling to access ante-natal care and maternity services, as pregnancy is perceived to be a ‘normal’ part of life, not associated with ill-health; preference is given to delivery with traditional birth attendants. Following the findings of the research, UNFPA has been supporting the establishment of Health Committees and community motivators in many villages. These village representatives are trained in reproductive health and rights by Health Unlimited staff in partnership with local government officials. The Health Committees include village elders, who play influential roles within their own communities, and voluntary representatives of the Lao Women’s Union. The Committees’ responsibilities include organizing community meetings to discuss health issues, supporting the work of the community motivators, liaising with the authorities, and establishing Village Health Funds as part of birth and emergency preparedness plans.

Each village has four community motivators, two men and two women, of different ages. Using inter-personal communication approaches, such as focus group discussions and collection of testimonials, the motivators’ role is to provide reproductive health education and to be peer educators. They also identify unmet family planning needs, organize visits and support women who want to visit health services, and ensure there are sufficient supplies of condoms and contraceptive pills available in the Village Drug Funds.

Both the Health Committee members and the community motivators are responsible for providing direct feedback to service providers to ensure client satisfaction, and to help address linguistic and cultural misunderstandings. Client exit interviews are also used as a tool to check client satisfaction and quality of services.

These village level support mechanisms have been designed to encourage and assist women to have assisted deliveries in facilities staffed by skilled workers.

**Results and way forward**

Initial results from the programme are encouraging. ante-natal care has increased significantly, with more than twice the number of women attending for a second visit and almost twice as many coming for a third visit (although the total number of women attending for third and fourth ante-natal visits is still only half the number attending for earlier visits.)

\(^4\) Participatory Ethnographic Evaluation and Research
c. The case of the Province of Ifugao in the Philippines

Ifugao is a landlocked province of the Philippines in the Cordillera Administrative Region (CAR) in Luzon. Its capital is Lagawe and borders Benguet to the west, Mountain Province to the north, Isabela to the east, and Nueva Vizcaya to the south. The major ethnic sub-groups of Ifugao are Tuwali, Ayangan, Hanglulo and Kalanguya.

Under the 6th Country Programme, UNFPA is supporting three out of 11 municipalities in Ifugao namely Asipulo, Lagawe and Tinoc; covering 49 out of 175 barangays in these areas.

The total fertility rate of Ifugao in 2006 is 4.6 children per woman, higher than the average of the entire country (3.3) and that of CAR (3.3). Based on the 2006 UNFPA Baseline Survey, the contraceptive prevalence rate for any method is 40 per cent; unmet need for family planning is 20 per cent; and 46 per cent among women who experienced difficulty during pregnancy with complications delivered at home on the average for three pilot municipalities.

To address these reproductive health issues, interventions—framed from a human rights-based, gender-responsive and culturally-sensitive perspective—include policy development for population and reproductive health programs; capacity building for health service providers, social and population workers, teachers, and peer educators; providing equipment to basic emergency obstetric care and birthing facilities, youth centers and women’s centers; advocacy for passage and implementation of Reproductive Health and Gender and Development (GAD) codes; organizing community health teams and livelihood assistance for women’s groups.

Progress made in addressing maternal mortality

In terms of family planning, use of contraception among men in Lagawe and Tinoc increased significantly from 52 to 59 percent and 48 to 58 percent; respectively. In Tinoc, married women who are using a modern contraceptive method increased from 34 percent in 2006 to 47 percent in 2010.

Home deliveries decreased from 62 to 49 percent in Asipulo and from 69 to 44 percent in Tinoc. On the other hand, there was a nine per cent increase in the proportion of birth deliveries with complications in public health centers across all the three municipalities.

<table>
<thead>
<tr>
<th>Deliveries by Skilled Health Personnel (SHP)</th>
<th>2006 Baseline</th>
<th>2010 Endline Surveys</th>
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<tbody>
<tr>
<td>Percent of all deliveries which were assisted by SHP</td>
<td>71.4</td>
<td>74.7</td>
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<tr>
<td>Place of delivery among all births</td>
<td></td>
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<tr>
<td>o Home</td>
<td>61.8</td>
<td>48.5*</td>
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<tr>
<td>o Public hospital</td>
<td>33.2</td>
<td>35.8</td>
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<td>o Public health center</td>
<td>4.2</td>
<td>14.3</td>
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<tr>
<td>Place of delivery among births delivered with complications</td>
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<tr>
<td>o Home</td>
<td>49.4</td>
<td>34.7</td>
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<tr>
<td>o Public hospital</td>
<td>43.7</td>
<td>48.6</td>
</tr>
<tr>
<td>o Public health center</td>
<td>4.6</td>
<td>13.9*</td>
</tr>
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*Significant p < 0.05

These gains were achieved by:
- Enhancing the competencies of medical doctors, nurses and midwives in reproductive health to manage facilities and offer culturally acceptable and gender-responsive services. For instance, 38 per cent of midwives (42 out of 108) underwent Life Saving Skills training for midwives and seven teams (composed of a medical doctor, a nurse and a midwife) were trained on Basic Emergency Obstetric and Newborn Care.

- Accreditation of health facilities: With UNFPA’s support, the equipment and facilities at provincial and rural center centers were upgraded to comply with the accreditation standards of the Philippine Health Insurance Corporation (PhilHealth). The upgrading of facilities and subsequent accreditation are complemented by providing poor families free health services. This has increased the accessibility of pre- and post-natal care and facility-based deliveries for indigenous women.

- Advocacy for the adoption of provincial laws: Ifugao was the first among the provinces receiving UNFPA support to pass a Reproductive Health Ordinance at the provincial level in July 2006. In the absence of a national reproductive health policy, the Ordinance provides a legal framework for the institutionalization of a comprehensive reproductive health and responsible parenthood program not only at the provincial level but also at the municipalities’. The ordinance mandates the appropriation of minimum funds to implement the ordinance’s implementation. The provincial ordinance facilitated the adoption of barangay or village-level resolutions or ordinances encouraging pregnant women to attend a health facility for antenatal care, deliver with a skilled birth attendant, and utilize a health facility for childbirth. For instance, in the community of Boliwong, Lagawe, deliveries by skilled birth attendants has improved to 95 per cent in 2009. In the first two months of 2010, 100 per cent of deliveries were assisted by skilled birth attendants.

- Establishment of community-based health teams: Community Health teams were conceived as partners at the grassroots level to achieve better health outcomes and ultimately contribute to reducing maternal mortality ratio. The teams, chaired by the barangay (village) captain and the rural health midwife, have contributed to raise awareness of couples about the importance of family planning and quality maternal and child health services. The teams list and track pregnant women in the barangay; assist couples in the preparation of birth plans, and advocated for birth delivery in health facilities. They are also responsible for reporting maternal and under-five deaths to the municipal health office.

**Eastern Europe and Central Asia**

**d. The case of Armenia**

Armenia is a small landlocked country with population of around 3.2 million people\(^5\). Armenia’s population includes 1.32 million women ages 15 years and older\(^6\). Maternal mortality rate in Armenia is 28.5, which is almost five times higher than the European average (6)\(^7\). There was an unprecedented decline in absolute number of maternal deaths in 2010 – it dropped from average 12-15 deaths to 4 (12 in 2009).

The major causes of maternal deaths are indirect causes (31 per cent), obstetric bleeding (27 per cent), hypertensive disorders (25 per cent), abortions (3 per cent), sepsis (8 per cent), and other (6 per cent)\(^8\). Since 2005, no cases of maternal death resulting from unsafe abortion have been documented and this trend has continued in 2010.\(^9\)

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\(^5\) Source: National Statistical Service.


\(^8\) Source: Ministry of Health, 2010.

There is a clear government commitment to increased access to and quality of health-care services. Ante-natal coverage is very high with 93 per cent of women receiving professional assistance during pregnancy\(^{10}\) and an estimated 71 per cent participating in at least four antenatal visits\(^{11}\). There is a slight disparity between urban and rural populations, 94 per cent and 83 per cent respectively\(^{12}\). The 2005 Armenia Demographic and Health Survey (DHS) indicated that the vast majority of deliveries are within health facilities (97 per cent) and are attended by a doctor; the proportion of home births declined from 9 percent in 2000 to 2 per cent in 2005.

**Adolescent health**

Adolescent health is currently identified by the Ministry of Health as a priority area for public health interventions with three important challenges that need to be addressed: fostering of more positive attitude in the society regarding sexual and reproductive health education and counseling of young people; improvement of the knowledge, communication and counseling skills of teachers, educators and health providers on issues related to sexual and reproductive health education; and increased access for young people to sexual and reproductive health information, education, youth-friendly counseling and care, as well as affordable health services. Sexual and reproductive health education is included in 8-9th grades of the school curriculum as part of healthy lifestyle course. Since 2010 with UNFPA support, sexual and reproductive health education is also integrated into 10-11\(^{th}\) grades.

The reproductive health situational analysis report conducted by the Ministry of Health in 2009 indicates that the number of teenage (underage 19) pregnancies has decreased since 1990. According to the Ministry of Health records, the adolescent birth rate declined from 69.1 (in 1990) to 23 (in 2009) among girls aged 15-19 per 1,000 live births.

In 2008, to improve access to and quality of maternal and newborn care, the Government of Armenia almost doubled financing of perinatal services and introduced the system of birth aid state certificates which guarantee free birth-related services to women. For each woman who delivers a baby, the government allocates approximately US$350 to a health facility; 60 per cent of this sum can be used for staff salaries. This system has motivated health personnel to improve the quality of services and has increased access of pregnant women to health care. These monetary incentives to service providers have also reduced informal payments by patients. This initiative had a positive impact on making maternal health services more accessible. However, barriers to access to health care still exist and primarily include poverty and geography, the latter for women who live in mountainous regions. The lack of reproductive health services including maternal health care provided at the primary health level forces women from rural areas to travel to district and regional centres to receive reproductive health and maternal care. As a result women may experience problems associated with cost and availability of transport.

**Traveling Gynecologist Teams**

In order to improve the access of women particularly those belonging to the poor and disadvantaged groups such as women from remote and borderland rural communities with poor infrastructures to antenatal care services, and to contribute to the reduction of maternal mortality rate, since 2002 UNFPA has supported the Government of Armenia for the establishment of traveling gynecologist teams for hard-to-reach and remote rural areas of Armenia.

A traveling gynecologist team consists of highly qualified and trained medical personnel (a gynecologist and a sonographist). Each team operates a vehicle that is fully equipped with necessary medical equipment (mobile ultrasound machine, portable doppler and cardiotocograph machine) and supplies.

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10 Source: Demographic and Health Survey, Armenia, 2005
11 Source: WHOSIS, 2005
12 Source: Demographic and Health Survey, Armenia, 2005
Currently traveling gynecologist teams cover five regions: Ararat, Armavir, Gegharkunik, Shirak, and Lori. From their base locations they are being called to hard-to-reach and remote rural areas whenever there is a difficult case of woman giving the birth. The traveling gynecologist teams are providing antenatal services to approximately 1,200 women annually.

Emergency Obstetric Care Teams

In addition, since 2001, three emergency obstetric care mobile teams work to reduce the number of preventable maternal deaths across the country. One team covers capital city of Yerevan and neighboring regions, the other two cover Northern (Gyumri) and Southern (Goris) regions of the country including remote and poor areas of Armenia.

Each emergency obstetric care team consists of a gynecologist, an anesthesiologist/reanimatologist, and a neonatologist (if necessary). Since their establishment, the teams have been performing approximately 60-70 visits per year - whenever the life of the woman is endangered.

Establishment of traveling gynecologist teams and emergency obstetric care teams in the country for hard-to-reach and poor areas has contributed to the drastic decline of the number of maternal deaths from a peaking 25 deaths in 2000 to 4 in 2010, and the decrease of maternal mortality ratio from 43.2 per 100,000 live births for 1999-2001 to 27.6 in 2008-2010. However, there is still a long way to go to reach the maternal mortality reduction target (11.5 by 2015) completely.\(^\text{13}\)

e. The Case of Turkey

Reducing Maternal Mortality in Turkey

With an estimated maternal mortality ratio of 20 deaths per 100,000 live births and significant regional variation, maternal death remains a priority for the Government of Turkey. As there are disparities in access to maternal health care within the country, the Health Strategy includes targets for reducing the gaps, in addition to national targets. Despite a young population, with 25 percent between the age of 10-24, Turkey is experiencing a decline in fertility rates and the current total fertility rate is 2.16 children per woman.

As of 2010, 76 per cent of the population was living in urban areas. Delivering basic social services in rural areas is a challenge. Improved registry systems and maternal death audits have enabled the provision of reliable data on maternal deaths during the last three years.

The right to health in Turkey is enshrined in the Constitution. The State promotes the right to health care and accessibility of health services. The government initiated an ambitious and much-needed reform strategy called the Health Transformation Programme in 2006. The main areas of action envisaged in the programme were clearly priorities for reducing inequality in the health status of the population and increasing access to basic health services. The Ministry of Health is responsible for providing health-care services throughout the country with a focus on primary health care. The responsibility for delivering the services and implementing programs is shared by various General Directorates. Health directorates are responsible for the health-care system at provincial level.

The 2008 DHS results indicate that 92 per cent of pregnant women received antenatal care from a health professional, more than 80 per cent received care from a doctor and more than 50 per cent received antenatal

\[^{13}\text{Source: Ministry of Health.}\]
care at least four times (the WHO recommendation). Ninety one per cent of deliveries are realized by skilled birth attendants.

**Maternal audits (applying the human rights principle of accountability)**

Following the “Turkey Maternal Mortality Study 2005”, the General Directorate decided to establish a mechanism in order to monitor maternal mortality. The comprehensive monitoring system involved new mechanisms at central, provincial and service centers levels. Starting from each health facility responsible health staff is identified, who directly report each maternal death to the provincial health directorates, where Provincial Committees consider each case, compile all the information obtained, prepare a report on each case and eventually forward the file to the Ministry of Health. At the central level, the “Maternal Mortality Review Commission” convenes each week and discusses each case, examines the circumstances leading up to any maternal death and, if deemed necessary, submits the case to the “National Maternal Mortality Audit Committee”. The Audit Committee convenes quarterly (or monthly when necessary), further examining each case and reaching a final decision. For all the cases submitted, the Committee prepares a report and sends feedback to the Provincial Committee and to the health facility where the maternal death took place. If the confirmed maternal deaths is related to the fourth delay (delay in receiving care according to WHO’s four delay model\(^\text{14}\)), Ministry of Health officials go to the health facility, and review and discuss any problem regarding the facility, supplies, and personnel and capacity building needs.

In addition to the establishment of this accountability mechanism, UNFPA has supported the establishment of a comprehensive maternal mortality registration. This new system was launched countrywide and supported by a training programme for all health personnel.

### 3. Latin America\(^\text{15}\)

Indigenous peoples, and particularly indigenous women, have the worst socio-demographic indicators and the largest inequalities in terms of access to social services in the Latin American region. Indicators of poverty as well as maternal and infant mortality are systematically higher amid indigenous peoples than non-indigenous populations. Among indigenous peoples, women face triple discrimination linked to gender, ethnic and socio-economic factors.

Nonetheless, in the last 15 years this situation has started to change and empowered indigenous women leaders, organizations and networks in Latin America are playing an influential role. Today, in many countries in the region, empowered indigenous women leaders have organized and are networking using their own life experiences as part of their advocacy efforts in order to demand their right to health.

In some countries of the region, more effective social and health policies are starting to address the conditions of poverty and discrimination that indigenous women face, although they must still be scaled up. Policies that support indigenous women's reproductive rights have the goal of making reproductive health services more accessible, available financially and geographically and also culturally acceptable.

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\(^{14}\) The first three delays are on the demand side: the first one has to do with the woman recognizing that something is not working with her body; the second delay is about the decision to go to the health center; the third delay is in arriving at the health center. The fourth delay, from the supply side, is related with the quality and cultural appropriateness of the service offered.

Culturally sensitive reproductive health policies, programmes and norms are starting to be enacted and enforced in health systems, especially at the sub-national levels. Health services are being adapted and expanded with the inclusion of symbolic and meaningful cultural elements and practices that, without jeopardizing quality of care standards, contribute to enhance indigenous women's access to adequate health care.

For indigenous peoples, the concept of health is a complex one; not only does it consider an individual's physical and mental well-being but also his or her balance with nature, with the collectivities of which he or she is a part and with the rich and complex spiritual realm to which he or she is connected. The world view or "cosmovision" of indigenous peoples is intrinsic to their well-being and their concept of health needs to be understood within a social and cultural context. In the Western world, health is generally related to physical health. In the indigenous world within the Americas, the concept is associated with a state of well-being or Buen Vivir (good living).

Governmental health systems are beginning to understand and engage indigenous peoples' notions of health and illness, and the traditional medicinal knowledge that links their biological, spiritual and emotional lives. Nevertheless, it will require concerted negotiations to find a true common understanding between Western health principles and practices and the traditional knowledge of indigenous peoples. In order to carry out the changes that will definitively enhance indigenous women's access and use of reproductive health services, health systems need to recognize indigenous peoples' rights, including their right to cultural continuity, health and particularly to life.

f. The Case of Panama

The Comarca Ngäbe-Buglé is the largest of six indigenous territories in Panama occupying 6,814.2 km² (nearly 10 per cent of the national territory). It is home to two of the seven indigenous ethnic groups in the country, Ngäbe and Buglé. In Panama, the so-called Comarcas enjoy a high degree of administrative autonomy, exercised by the traditional authorities. According to the 2010 Population and Housing Census, there are 260,058 Ngäbe and 24,912 Buglé in Panama, of which 51 per cent are women.

Over the last 12 years, UNFPA has been working with national and regional authorities of the Ministry of Health and the Association of Ngäbe Women, ASMUNG, to reduce the four delays\(^\text{16}\) that cause maternal mortality in the Comarca Ngäbe-Buglé. The strategy is to increase and strengthen demand from the rights-holders by facilitating women’s empowerment and promoting community organization in support of pregnant women, while at the same time addressing the need for quality health services by developing the intercultural skills of healthcare personnel and providing equipment and supplies.

History – In its first phase (1996-2000), the programme reached 32 communities in two districts. Since then, it has grown to 41 communities in five districts. In the second phase (2000-2005), interventions focused on setting up the Emergency Obstetric Care Center in Hato Chamí, with the help of a Canadian NGO and a private hydroelectric company with presence in the area. In December 2004, UNFPA along with WHO/PAHO, UNICEF, UNIC, the Embassy of Canada and the Government made an alliance aimed at reducing maternal and perinatal mortality and morbidity. In 2006, the first National Action Plan to Reduce Maternal Mortality and Morbidity was signed. IFAD has been an important contributor to the Programme. The Government of Japan has facilitated the purchase of much needed equipment.

Intervention Strategies

\(^{16}\) The first three delays are on the demand side: the first one has to do with the woman recognizing that something is not working with her body; the second delay is about the decision to go to the health center; the third delay is in arriving at the health center. The fourth delay, from the supply side, is related with the quality and cultural appropriateness of the service offered.
The support that UNFPA has the following strategies:

- Using participatory mechanisms to engage community leaders;
- Engaging traditional and local authorities in all phases;
- Empowering communities and particularly women through constant training;
- Incorporating men through masculinity training;
- Providing reproductive health commodities;
- Facilitating equipment purchase and donations for Health Centers.

Achievements

Over 70 community male and female community leaders deliver cultural adapted information on human rights, maternal health, gender equality, masculinity, and intra-family violence prevention to women, men and families. Now women and communities are demanding sexual and reproductive health services and have developed a heightened sense of solidarity and commitment to making every pregnancy safe. Moreover, as local health providers have been trained on the importance of providing services with an intercultural approach, indigenous women have reported increased care and respect when accessing services.

Additionally, there is a maternal shelter or “waiting home” established for indigenous women that live very distant from comprehensive obstetric care. Waiting homes are critical in reducing the fourth delay” that cause maternal mortality. In the next phase of the programme, UNFPA will provide technical support to establish four new maternal shelters.

Most importantly, prenatal care visits increased from 800 at the start of the intervention to over 20,000 and maternal deaths decreased, from 17 in 2005 to 8 in 2010.

g. The Case of Bolivia

Bolivia has gone through a long process, from the struggles to vindicate indigenous people's rights, initiated in the early 90’s to the promulgation of the new political constitution of the plurinational state. In this process there have been important achievements, but also challenges and the different social actors' capacity for dialogue has generally prevailed. Several electoral processes occurred, including a constituent process that resulted in the new constitution, supported by 60 per cent of the population through a national referendum.

The constitution currently in effect incorporates interculturality as the core articulating principle of the democratic and cultural movement taking place in Bolivia. In this context, a policy is being developed that recognizes native rural indigenous justice systems, which benefit the Bolivian people and their 36 nations. In the sphere of public health, new rules, norms and protocols have been developed from an intercultural perspective.

The new constitution guarantees the right to a universal and free health care system that respects worldviews and traditional practices.

Decreasing Maternal Mortality: A National Priority

Decreasing maternal deaths is a priority for the state. In 2006, the Ministry of Health's Resolution No. 0348 established adequate cultural protocols for motherhood and newborn care, including the following recommendations:

- To be accompanied by a family member;
- To deliver the placenta to the family;
- To determine their own body position for labor;
- To allow the consumption of liquids and food during labor; and,
- To avoid unnecessary practices, such as enemas, shaving and cutting.
Another important breakthrough at the policy and normative level has been the inclusion of quality evaluation criteria in service accreditation parameters established in the 2006 Guidelines for the Intercultural Health Policy of the Vice Ministry of Traditional Medicine and Interculturality.

These accreditation parameters include the following:

- Obligatory intercultural training of health staff;
- Use of local indigenous languages;
- Intercultural offices;
- Cultural markings;
- Architecture approved by consensus;
- Indigenous participation in the management of services;
- Local food-based nutrition;
- Community hostels or waiting homes;
- Respectful dialogue with traditional doctors;
- Use of traditional plants;
- Humanized and intercultural childbirth;
- Use of local equipment (hammocks, leather, etc);
- Flextime;
- Spiritual and religious support facilities

The family, community and intercultural healthcare model (SAFCI) created by Supreme Decree No. 29601 of July 11th 2008, currently in effect, places great emphasis on health promotion in the community and considers access to institutional care to be an urgent need. This new model aims at reinvigorating native indigenous rural medicine and ensuring its linkage and complementarity with Western medicine. It is intended to provide health services that take the person, the family and the community into consideration by accepting, respecting, appraising and articulating indigenous rural peoples' biomedical and traditional health knowledge.

UNFPA support

Within this context, UNFPA supports both the SAFCI and the creation of sexual and reproductive health clinics in male-predominant and women-based indigenous organizations, linking them to the health care network. UNFPA also supports the intercultural adequacy of health norms and regulations. UNFPA Bolivia and the NGO Causananchispaj, in partnership with the municipal health care network Vitichi and with the participation of social and institutional workers, designed the municipal strategy for sexual and reproductive health and maternal health care” which takes a culturally contextualized approach. This strategy validates and is built upon the SAFCI, taking into account the need to promote and integrate health at three levels: the family, the community and the health services. For each level, there is a list of health-care related actions that need to be taken.

As a result of this process, culturally pertinent health-care procedures regarding sexually transmitted infections, uterine cervical cancer and family planning were developed for the SAFCI. These procedures are being implemented throughout the country. A key requirement of the model is working with local actors, interacting with representatives of the community and using the support of the regulatory authority of the Ministry of Health.

As part of its future work in Bolivia, UNFPA will continue supporting the implementation of the SAFCI, as well as the inclusion of intercultural approaches in the national norms and the unified health insurance plan, *Su Salud*.

**h. The Case of Ecuador**
In 1984, in the midst of the land and culture reclamation struggles of the Peasant and Indigenous Federation of Imbabura (FICI), the Jambi Huasi Health House was founded in the city of Otavalo.

This initiative is aimed at integrating indigenous and western health systems by utilizing the strengths of both and adapting them to the specific needs of indigenous peoples. The Jambi Huasi experience was the starting point for progressing from a non-governmental initiative to an institutional programme, bringing an intercultural reproductive health approach to a public hospital, the San Luis Hospital of Otavalo.

The political events that began in 2006 brought about changes in the Ministry of Health, and subsequently in Otavalo. An indigenous doctor was appointed as Director of the San Luis Hospital for the first time, signaling an important commitment to increasing indigenous peoples' access to health services.

Key factors that contributed to the successful integration of an intercultural approach at San Luis Hospital were the municipality's support under the leadership of an indigenous mayor and ongoing strengthening activities at the provincial and regional levels of the Ministry of Health.

Within this framework and with continued support from UNFPA, work began on the creation of a model for reproductive health care in the hospital. In order to have baseline information against which to understand and monitor the changes that needed to take place, an analysis of the perceptions and practices of indigenous women and of health providers regarding the reproductive health process was undertaken.

The results of this qualitative study revealed that in order to respond to its peoples' health-care needs, Ecuador must understand the diverse, multi-cultural concepts of health and well-being that exist among them and recognize the variety of different cultural practices that affect their health. Policy makers were challenged to integrate an inclusive concept of health into public policies and guidelines. The San Luis Hospital in Otavalo addressed this challenge by creating a "Model of Reproductive Health with an Intercultural Approach".

In implementing this model, the main changes achieved to date are as follows:
- Aggregating birth registry data by ethnicity;
- Teaching health providers the basics of Kichwa;
- Posting signs in Kichwa to indicate the hospital's services;
- Training and instructing health personnel in intercultural health and culturally correct delivery;
- Creating a culturally correct delivery room that allows the woman to decide what position she wants for her delivery.

Aspects of the intercultural reproductive health model that are contributing to increased access to the hospital's services include:
- The participation of traditional birth attendants in the hospital during delivery and the redefinition of their role as key cultural brokers between worldviews;
- The change from white clothing and nudity to the use of dark and warm colors in the delivery room;
- The provision of food according to the patient's customs; and allowing the use of traditional plant infusions;
- The establishment of a community network for the reduction of maternal mortality;
- The creation of a maternity home where indigenous women can go a few days prior to their delivery; and,
- Making it possible for husbands, family members and traditional birth attendants to be present during labor.

This new model of reproductive health care is expanding its services to indigenous and rural communities through the creation of operative units led by traditional birth attendants or midwives. In coordination with the hospital, these traditional midwives map all pregnant women to better monitor their pregnancies and provide them with information on possible obstetric risks. This model is proving to have a positive impact on the empowerment of indigenous women, acting upon cultural and gender determinants, and increasing effective use of medical services. The main challenge of this model is to achieve its implementation and institutionalization.
with its concomitant improvement of health standards and incorporation of lessons learned, while at the same
time replicating the experience in other indigenous districts' health centers.

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i The Sixth UNFPA programme of assistance to the Philippines covers the period 2005-2009. In 2009, the Executive Board
approved the extension of the CP for further two years (2010-2011) in response to a request of the Philippine Government
to harmonize planning cycles.

ii http://www.nscb.gov.ph/ruca/rfnf_ifugao.htm

iii In 2009, Ifugao became one of the pilot sites of the Joint Programme on Maternal and Neonatal Health (JPMNH) with the
United Nations Population Fund (UNFPA), United Nations Children’s Fund (UNICEF), and the World Health Organization
(WHO). With funding from this joint programme, the assistance was extended to the other eight (8) municipalities. The
Joint Programme aims to improve the provision of a continuum of quality services from pre-pregnancy, antenatal, intra-
partum, post-natal and neonatal care based on agreed national standards adapted to local conditions; to increase equitable
access to and utilization of reproductive health/maternal and newborn information, goods and services in the JPMNH
priority areas; and to enhance the effectiveness of national and sub-national support to local planning, implementation, and
monitoring of the maternal, neonatal, and child health and nutrition (MNCHN) strategy.

iv The total fertility rate is for the period 1-36 months prior to interview (UNFPA Endline Survey Report, 2010).

v Through the establishment of health programs that shall ensure efficient and effective delivery of information and services
on maternal and child health, family planning, STD/HIV/AIDS, prevention and management of abortion complications,
adolescent sexual reproductive health, sexuality education and violence against women.