

## Maternal Health in the Pacific - An NGO Perspective

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organisations working with and for communities and individuals. In the Pacific we have partners in nine Pacific Island countries namely Cook Islands, Fiji, Kiribati, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu. In these countries, we work with non-government organisations who are offering services including ante natal care, counselling regarding maternal health contraceptives available and general information on reproductive health issues.

Most of these countries are geographically spread out and accessibility to sexual and reproductive health services is a challenge for non-government organisations due to high travel costs incurred. In the Cook Islands alone, to get to the northern most part of the island, IPPF's partner in the country works very closely with the government of the Cook Islands to share costs to charter a flight to the island for about NZ\$16,000.00 for a round trip. This type of trip can be carried out only once a year and the weeklong activity is co-ordinated between the government and NGO in order to maximise the impact it could make while on the island. The team would include a doctor, nurse and a community educator. The partnership demonstrates IPPF's work to ensure sexual and reproductive health services is made available and accessible to the underserved, poor, marginalised and socially excluded communities.

<sup>1</sup>Health is a human right and cornerstone of social and economic development. No one should die or suffer from preventable causes because they lack basic health services. Women are drivers of development - the poorest women pay the highest price with their health, well being and ultimately with their lives.

In recent available data, out of the 515,000 maternal deaths that occur every year, 99% takes place in developing countries. Women die unnecessarily. In many

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<sup>1</sup> Dr. Gill Greer – Speech at the ESC Annual Ministerial review July, 2009

instances these deaths could have been prevented through the availability of high quality accessible, affordable and timely medical care. Women in the developing world have 1 in 78 chances of dying from pregnancy related causes, while the ratio in developed countries is 1 in 1,800. For every woman who dies, another 30-50 women suffer injury, infection or disease. In developing countries, pregnancy related complications are among the leading causes of death and disability for women ages 15 - 49. Of all human development indicators, the greatest discrepancy between developed and developing countries is in maternal health.

We all know the key interventions to improve maternal health and reduce maternal mortality. They include complementary, mutually reinforcing strategies, mobilising political commitment and an enabling policy environment, investing in social and economic development such as female education at all levels, poverty reduction and improving women's status, offering family planning services, providing quality ante-natal care, skilled birth attendants and availability of emergency obstetric services for pregnancy complications and strengthening the health system and community involvement. We must remind ourselves that the right to health is universal and health systems need to be funded or allotted adequate funding, be accessible and ultimately accountable to all. The challenge has been to implement these interventions in environments where political commitment, policies and institutions and health systems have been weakened due to the global economic crisis and unstable political systems as experienced here in the Pacific.

In the news a few days ago, rich nations are moving heaven and earth to save banks and corporations on the brink of financial meltdown in a meeting in London. At the same time, a child dies every three seconds of preventable disease somewhere in the world, and every minute a woman dies in childbirth or pregnancy."

<sup>2</sup>The World Health Organisation estimates that about 73 per cent of maternal deaths result from five main causes which are largely preventable: infection, haemorrhage (severe bleeding) eclampsia and other emergencies associated with excessively high blood pressure, prolonged or obstructed labour, and complications of unsafe abortion.

Data available on maternal mortality ratio for the Pacific island countries shows changes both positive and negative among Pacific islands. For example, in 1995

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<sup>2</sup> Amnesty International – Dying too Young

Kiribati recorded 225 deaths and in 2005 this has increased to 284 showing an increase of 38 percent. In 1990 in Tonga, 40 deaths were recorded and in 2006 a total of 113 maternal health related deaths - indicating an increase of more than 150 percent. At the same time, there is some ray of hope for some islands where the figures have shown great reduction in maternal mortality ratio. One such country is Samoa who in 1991 recorded 140 related deaths and in 2005 has reduced this to 22 with a similar picture shown by the Solomon Islands where in 1992, it recorded 550 deaths and in 2006 recorded 142 maternal deaths.

The amount of funds available to plan, implement and monitor programmes relating to maternal health is becoming a concern. Few donors provide funds specific to maternal mortality. According to the Bangkok statement of Commitment,<sup>3</sup> funding for family planning, the first line of defence against maternal mortality, has dropped from 55 percent of total population funding in 1995 to nine percent today. One of the reasons for this drastic change is the shift in funding to deal with rising incidence of HIV /AIDS over the past decade. Samoa was able to secure funds for maternal mortality from Global Fund in the 2003 - 2007 periods. As a result, maternal mortality rate dropped from 19.6 / 100,000 live births in 2002 to 10.7 in 2003 and 3.0 in 2005-2006. This example illustrates that getting budget to implement the essential interventions that will produce desired adequate results in reducing maternal mortality.

In a vast majority of the Pacific Island countries, for instance; in Papua New Guinea many deliveries are still conducted by unskilled traditional birth attendants at home under unhygienic conditions such as cutting the cord with a broken bottle, shell or knife. This increases the chances of infection of mother and her newborn. Many of these births are not recorded and are not followed by health personnel. Hence there should be training available for the mid-wives and birth attendants so that they can become skilled birth attendants. They should also be educated on the importance of reporting births and maternal deaths to the relevant government authorities.

To reduce the number of maternal deaths further and achieve the MDG 5 or even to move beyond the target, there is a need to understand the profound injustice of grave disparities in maternal deaths and the urgency to advocate for and work with donor countries to honour funding commitments. At the same time effective

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<sup>3</sup> Bangkok Statement of Commitment; 2008

monitoring and accountability mechanisms need to be put into place to ensure that donor funding is directed to the interventions that evidence has shown will save women's lives.

Saving women's lives will need resources; globally this is calculated at US\$6 billion dollars a year in order to be on track to achieve the Millennium Development Goal 5 target and reduce maternal mortality by 75 percent from 1990 levels by 2015. We have only 5 years to achieve this target and the Pacific island countries will need to get their act together to achieve the target. The global annual indicative planning figure for essential activities that can save women's lives when giving life is a pretty small amount, and can save hundreds of thousands of women's lives and prevent other social and economic problems that may arise with the loss of a mother.

In all Pacific societies caring for children is primarily the women's responsibility and a mother's death can significantly undermine the care and education of children. A maternal death is not only a tragic waste of life but also imposes a heavy burden to the woman's family and community. A newborn, whose mother dies, is 3-10 times more likely to die by the age of two than one whose mother survives.<sup>4</sup> The World Health Organisation views the survival of new-borns as integrally linked to the survival of their mothers. In addition, a mother's death can have consequences for the older children she leaves behind. In many cases, girl children are encouraged to step into the empty space to manage the household giving up education which limits their own future, becoming malnourished and simply not surviving. Undeniably, a mother's death affects the entire family, including family income and productivity which also impacts on the broader community in which they live.

Not only is maternal mortality and morbidity a global health emergency, but it produces and intensifies cycles of poverty that cause generations of suffering and despair. The ways to prevent these deaths and disabilities are well understood, are relatively simple and mostly low-cost. The four pillars for saving women's lives:

- Family planning and other reproductive health services (includes prevention and treatment of STI's, treatment of septic or incomplete abortions and the provision of safe abortion services consistent with national laws.

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<sup>4</sup> Guttmacher Policy Review - Spring 2009

- Skilled care during and immediately following pregnancy and childbirth
- Emergency obstetric care when life threatening complications develop and
- Immediate postnatal care for mothers and newborns.

It is imperative to note here that because pregnancy is not seen as a disease, governments have not seen it as an issue that needs investing of resources. One of the most effective interventions to reduce maternal mortality involves sex and the politics of sex. Most women do want to have children or want to space their pregnancies at some point in their lives. However, so many possess neither the power nor the means to time, space and limit their pregnancies to enhance their and their family's health and well being. Women need to be treated with respect and dignity, they need to be healthy and they need to be able to plan the number timing and spacing of their pregnancies. In the Pacific, the right to maternal health and child health care and access to services are critical for women and their families but women may not have capacity or the skills to articulate this well to policy makers.

Fourteen years ago at the Fourth World Conference on Women, the then First Lady Hillary Clinton declared that women's rights are human rights. If this is so, the question we may need to ask ourselves is why are women dying when giving life? For some quarters of society, the response would be forward - women's lives are not valued because their voices are not listened to, because they are continuously discriminated against and excluded in their communities especially in decision making processes, and importantly health care systems may fail to prioritise the needs of women in sexual and reproductive health.

Right to health is a human right and it is the right to the highest attainable standard of health. In June 2009, the UN Human Rights Council passed a landmark resolution that recognises preventable maternal mortality and morbidity as a pressing human rights issue that violates a women's right to health, life, education, dignity and information. This is very important news for all of us because a human-rights approach to maternal health places specific legal and ethical obligations on states, in particular, and non-state actors. The resolution which is welcomed by the health communities signals an increasing trend by human rights community to take health issues as seriously as they have taken issues such as torture, the death penalty and the right to a fair trial. With the increased attention to maternal health and hopefully with the appropriate resources, a human rights approach to maternal

health can strengthen policies and programmes and make them more equitable. These will not only need the support of medical professions but communities and society as a whole so that giving life will not be a death sentence for any woman.

Health communities in the region must be willing to learn about human rights, focus on common ground, and work with human-rights professional as respectful and practical partners to work together and address the unacceptable high number of maternal deaths that occur each year in all the countries. The vision for a rights based approach to reducing maternal mortality has been around for more than 15 years and we believe that what is needed are diverse, wide scale actions to be implemented urgently. With this resolution in place, it is hoped that it can be used as a tool to advance the work on maternal health for greater accountability. In the words of the Kyung-wha Kang, Deputy High Commissioner for Human Rights, “if we are serious about reducing maternal mortality and morbidity, a human rights approach must be adopted by all of us, no matter what role we offer to play”.

One of the core priorities of IPPF is to build the capacity of service providers for the provision of high quality services that address the needs of clients that visit the member associations’ clinics. Capacity building is an on-going programme for IPPF - not only with our member associations but encouraging the importance of educating and supporting community initiatives especially in the area of family planning.

In Papua New Guinea and the Solomon Islands, community based educators and distributors are trained within their community and become community advocates for sexual and reproductive health and rights. Training for the group focuses on the importance of communication with people at community level especially with the many dialects that exist in each country. IPPF has been supporting such initiatives because it believes that transformation, if it has to take place, needs to begin from the ground where communities are taking ownership of the programmes thus ensuring some form of sustainability.

For Papua New Guinea, the Member Association of IPPF utilises most of its core budget to conducting their community based educators and distributors programmes. Considering the geographical make up of the country with mountainous terrain compounded by the cost of travelling, it is important that training programmes are organised in a comprehensive manner. The education programme includes training for

traditional birth attendants in safe delivery and in early recognition of danger signs of maternal and neo-natal complications and also organising community support in terms of transportation and communication in an emergency situation. Activities such as these has shown some breakthrough in services where there is an increase in the number of women who have passed through training who are enlightened and empowered to support the work of member associations in sharing and making information on sexual and reproductive health matters accessible to the many women as they speak their dialect and are from the same community. Due to costs, this may take place in only a few areas in a year.

#### **Recommendations:**

- Capacity Building of health service providers on health as a human rights issue
- Gender training for health planners and service providers
- Increase support for better data collection system where information is shared by all stakeholders to ensure a realistic picture of the situation of maternal health in each of the Pacific island countries.
- Annual training for nursing personnel and clinicians on new technology and new protocols for management of delivery emergency site nations.
- Increased funding support to government and NGO's working in the field in the areas of awareness raising, training for community educators and distributors of sexual and reproductive health services and information.

To conclude, the right to the highest attainable health can be achieved if women are healthy because only then families will be healthy and the community at large will be healthy. In May, 2007 Mary Robinson (former Commissioner of Human Rights) in commemorating the International day of Action for Women's Health notes that "Universal access to health is not a myth or a dream. It is a human right. We cannot implement that human right without effective health systems. There is a need for a worldwide movement led by women to make this simple message stick.

Providing appropriate resources to maternal health initiatives in our aim to reverse the trend and save the lives of women, we need to work hand in hand. This is very important in the face of prevailing global economic crisis that threatens to adversely affect development gains, albeit small, and the achievement of the Millennium Development Goals, especially Goal five that is related to maternal health by 2015

As the Chinese proverb says - women hold up half of the sky, it is therefore important to re-look at women as individuals who have rights that need to be respected in order for them to be able to look after their reproductive responsibilities for the sake of humankind.

As articulated eloquently by the IPPF Western Hemisphere Region statement of belief and I believe the same sentiment applies throughout the Federation, as the basis of our work with partners is towards a <sup>5</sup>“world where women, men and young people everywhere have control over their own bodies and therefore their destinies. A world where they are free to choose parenthood or not; free to decide how many children they will have and when; free to pursue healthy sexual lives without fear of unwanted pregnancies and sexually transmitted infections including HIV. A world where gender or sexuality are no longer a source of inequality or stigma.

We will not retreat from doing everything we can to safeguard these important choices and rights for current and future generations.”

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<sup>5</sup> IPPF Western Hemisphere Region - Statement of Belief