World Health Organization

Department of Making Pregnancy Safer

Report

Meeting of Women Parliamentarians Maternal and Newborn Health and Survival

London, United Kingdom
13-14 March 2007

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This publication is a report of a meeting of women parliamentarians in London, on 13-14 March 2007. It does not necessarily represent the decisions or policies of the World Health Organization. The statistics and data presented by the speakers are not necessarily identical to those published by WHO due to different methods of data mining.

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Contents

Meeting of Women Parliamentarians

The *Meeting of Women Parliamentarians* on 13-14 March 2007 in London focused on maternal and newborn health and survival. The WHO Department of Making Pregnancy Safer (MPS) organized this two-day meeting together with the Parliament of the United Kingdom of Great Britain and Northern Ireland (United Kingdom), the Commonwealth Secretariat, and the Royal College of Obstetricians and Gynaecologists (RCOG). They invited key women parliamentarians from 20 developing and developed countries to promote investment and methods that will accelerate progress on maternal and newborn health and survival. The meeting took place the week before British Mother's Day on Sunday 18 March 2007, to highlight the importance of mothers to their families and to society as a whole.

Promoting maternal and newborn health and survival

The meeting provided an opportunity for participants to share their experiences and debate maternal and newborn health issues. It aimed at raising awareness and creating a common understanding of key policies and interventions to improve maternal and newborn health. The central goal was to encourage parliamentarians and government health officials to continue to raise the issue of women's health-care needs at the highest levels and to commit to allocating budget funds and development assistance to meet these needs. The meeting was also meant to build a network for future communication and cooperation.

Discussion among the participants focused on strategies for improving maternal and newborn health and survival. The parliamentarians shared information about maternal and newborn health in their home countries and discussed the quality and availability of and the access to national health care systems. As a key message, the representatives highlighted that maternal health was not only about doctors and medical interventions, but also about politics and investment, since it was essentially influenced by gender politics and budget allocations. As a result of the discussions, the participants jointly urged governments to increase development assistance for maternal and newborn health and survival. They signed a *Global Plan of Action* outlining a six-pronged strategy for improving the health of mothers and their babies.

By working with women members of parliament across the globe, WHO and its partners aim to ensure that women and their newborns get the health care they need during pregnancy and delivery as well as immediately after the birth.

The Global Plan of Action

The participants of the London Meeting, who were members of parliament from all over the world, agreed on a *Global Plan of Action* to reduce maternal and newborn ill-health, among the poor in particular, in order to achieve Millennium Development Goals (MDGs) 4 and 5.

We call for a universal right to health for mothers and their babies by ensuring that…

- **skilled care** is provided for all women during pregnancy, childbirth and the postnatal period;
- **communities** are involved in strengthening health delivery systems and partnerships;
- **global networks** are created to share information on the nature and effects of maternal and perinatal health services;
- **infrastructure** is provided, including buildings, roads, and transport systems as well as human resources, supplies and equipment;
- **safe pregnancy and motherhood** are promoted by reducing unsafe abortion, anaemia, eclampsia, haemorrhage, obstructed labour, HIV/AIDS and malaria in pregnancy; and
- **governments take the lead** in fighting maternal and newborn mortality and morbidity.

Background

Maternal mortality worldwide

Every single day, 1500 women die from complications during pregnancy or childbirth. In the last decade, more than 7 million mothers died. At present, about 300 million women suffer from motherhood-related disabilities. Every year, 3.7 million babies die within the first 28 days of their life and another 3 million are stillborn. Despite this, maternal and newborn health remains a largely neglected public health issue.

Maternal and newborn mortality reflect the global inequity between rich and poor, and the numbers are evidence of limited economic means and deficient health services. But these deaths and disabilities are preventable with evidence-based, affordable and cost-effective interventions. Millions of lives could be saved using the knowledge we have today. The challenge is to transform this knowledge into action.

With the right policies, right strategies, and appropriate investment, maternal and newborn death and illness can be reduced. While there are many solutions, gaps continue to exist in investment and coordination. There is a need to build awareness around interventions that work and maximize the use of resources destined for needy countries. Unless programmes and budget allocations change, the numbers of maternal and newborn deaths will not decrease.

Millennium Development Goals

Local programmes and activities designed to improve the health of mothers and children have existed for decades. Global initiatives however only began to focus on maternal and infant health in the last ten years. The most important of these was the Millennium Declaration. The Millennium Development Goals (MDGs) set internationally agreed development targets to be achieved by 2015.

Three of the eight MDGs are directly related to health: MDG 4 aims at reducing child mortality, MDG 5 promotes improving maternal health, and MDG 6 underscores the priority of combating HIV/AIDS and malaria. Improving maternal and infant health is closely linked to the progress made in the control of these diseases. In recent years, the HIV/AIDS pandemic has caused serious setbacks in the gains made at every level, including the area of maternal and infant health. Without preventive treatment, babies can be infected with HIV through mother-to-child transmission. Malaria infection also poses a major threat to pregnant women and to their unborn children.

Many countries have made good progress in reducing the mortality rate of children under the age of five. Nevertheless, in 43 countries, levels of maternal and newborn mortality have stagnated or even increased. In sub-Saharan Africa in particular, it will take many years to attain MDGs 4 and 5 at the current pace.

Need for joint action

To bring about change, civil society, governments and the international community need to redouble their efforts to promote maternal and newborn health and survival. In order to accelerate the progress towards achieving MDGs 4, 5 and 6, joint action is needed. The task is huge, but not insurmountable.

Day One

Opening and welcome

United Kingdom

Ms Cherie Blair

Wife of Prime Minister Tony Blair

Ms Cherie Blair, wife of British Prime Minister Tony Blair, welcomed the guests to the United Kingdom. As the meeting on maternal health was taking place one week before Mother's Day, it would receive considerable recognition, she said. "As a mother of four, Mother's Day is something I greatly look forward to."

She made a direct reference to the reason for the meeting: "Too many mothers die in childbirth and too many become mothers too early." As a lawyer for international human rights, Ms Blair highlighted the fundamental rights of mothers to health and safe motherhood. She urged the parliamentarians to return to their governments and work on improving the health of women and children. She advocated promoting better and more effective programmes for water supply and hygiene, contraception and education. Ms Blair said that it would not take much to improve the health of women and children.

She closed her plea by wishing the parliamentarians a productive meeting, and a happy Mother's Day to each and every mother in the world.

United Kingdom

Ms Sally Keeble

Member of Parliament

Ms Sally Keeble, Member of the British Parliament, chaired the two-day meeting. She declared that the 2007 Mother's Day campaign would take the message about reducing maternal and newborn mortality all around the world.

The Chair underlined the key objectives of the conference. The governments represented around the table should increase their commitment to maternal and newborn health. Action should be taken to stop the deaths of thousands of mothers and millions of newborns every year.

Ms Keeble made introductions around the table and highlighted the forthcoming Mother's Day. Some of the participants – British ministers, international members of parliament, key representatives of major nongovernmental organizations and various partners – were also mothers themselves. She pointed out that the meeting was an excellent opportunity to improve maternal and newborn

health by working in partnership with donor countries, which were also represented.

WHO

Dr Elizabeth Mason

Assistant Director-General a.i., Family and Community Health Director, Department of Child and Adolescent Health, WHO

Dr Elizabeth Mason, Director of WHO's Department of Child and Adolescent Health, talked about maternal mortality worldwide. Instead of being a time to rejoice, childbirth was a tragedy for more than 500 000 women each year. Every day, 1500 women died in pregnancy or childbirth; every year 3.7 million babies did not survive their first month of life. She stressed that a woman's lifetime risk of maternal death varied widely between countries. In developing countries, 1 in 75 women died from pregnancy-related complications, compared to 1 in 7300 in developed countries, Dr Mason said.

Investment needed

Dr Mason presented a three-pronged strategy for reducing the high numbers of women dying in pregnancy or childbirth every year. First, universal access to skilled care at birth had to be ensured within a continuum of maternal care. Secondly, parliamentarians had to put maternal and child health at the centre of national development plans and demand greater investment from their governments. Thirdly, developed countries had to stick to their promise to allocate 0.7% of their GNP to development assistance. At the moment, many countries were lagging behind, Dr Mason said.

Finally, Dr Mason stressed how important this meeting was for reaching a consensus on key issues of maternal and infant health. It gave an opportunity to women parliamentarians from 20 countries to make a difference. "Mothers and babies are precious. We cannot afford to allow them to die," she said.

Ethiopia

Ms Liya Kebede

WHO Goodwill Ambassador for Maternal, Newborn and Child Health

Ms Liya Kebede, WHO Goodwill Ambassador for Maternal, Newborn and Child Health, thanked Ms Sally Keeble for inviting her to a very special gathering of women parliamentarians. She acknowledged that some participants had come from countries as distant as Cambodia,

Malawi and Tajikistan, and thanked them for taking the time to travel and support the *Global Mother's Day Plan of Action*. She highlighted that parliamentarians were the people who could directly influence governments and they could therefore help to push policies for improving maternal and newborn health in their country.

Ms Kebede reported that, in her role as WHO Goodwill Ambassador, she had travelled around the world. In many places she had seen how essential changes in women's health policies were to the well-being of families, communities and countries. As a mother of two and a native of Ethiopia, she was well aware of the challenges a mother faced when delivering and raising children in a climate of poverty and political instability, she said.

Ensuring skilled care at birth

Ms Kebede highlighted the launch of WHO's global campaign *Make your Mother's Day, every day*, which celebrated the importance of healthy mothers. The Department of Making Pregnancy Safer, through the leadership of its Director Dr Monir Islam, was championing this campaign. The Department was working painstakingly to advance MDGs 4 and 5, which aim at reducing child mortality and improving maternal health. Detailing the campaign, Ms Kebede called for investment in human resources for health. Family planning could thus be promoted and women could be given greater access to skilled care during pregnancy and childbirth. Skilled birth attendants could manage complications before and during the delivery and hence prevent maternal death, she said.

WHO's Global Mother's Day Campaign
Make your Mother's Day, every day

Mother's Day is above all a day to honour the role of mothers. Healthy mothers are the real wealth of societies. Without healthy mothers, there can be no healthy families or communities. However, too many mothers are suffering and dying every year.

Many mothers across the globe still do not have access to basic health care. Many are deprived of skilled care before, during and after delivery. Every minute, somewhere across the globe, a mother dies of complications in pregnancy or childbirth.

Millions of lives could be saved using cost-effective solutions that are already available. The challenge is to transform this knowledge into action. To make a difference, we all must join forces and act. Each one of us has a role to play. Together we can do it.

Investing in human resources for health will promote better family planning. It will give greater access to skilled care during pregnancy and childbirth, which will help to manage complications and to prevent death.

WHO asks you to celebrate this year's Mother's Day in your country. Recognize the importance of our mothers, women who have great impact on our lives. Support us to *Make your Mother's Day, every day.*

Presentations part 1

United Kingdom

Rt Hon. Hilary Armstrong

Minister for Social Exclusion

Rt Hon. Hilary Armstrong, Member of the British Parliament and Minister for Social Exclusion, outlined how social exclusion affected the risk of infant mortality. She presented details of the Government's programme, which has been investigating and addressing social risk factors since May 2006.

Social exclusion affected 1 in 40 people in a context of overall prosperity, Ms Armstrong said. She argued that differing rates of infant mortality were an example of the persistent inequality in British society. She pointed out that it was unacceptable that some babies were more likely to die before their first birthday than others. "We are very fortunate that, in the United Kingdom, infant mortality is low. But even here, there are five infant deaths for every 1000 born – and of course each one is a family tragedy."

Ms Armstrong said that the risk of infant mortality was related to several factors, including geographical place of birth, ethnic family background, age of the mother, and the parents' socio-economic situation. The findings showed that babies born in Birmingham were six times more likely to die than those born in Hampshire, the Minister said. Babies whose mother had been born in Pakistan or the Caribbean were doubly at risk than babies born to mothers originating from the United Kingdom. Babies of teenage mothers were 60% more likely to die in infancy than babies of older mothers. Finally, babies registered by single mothers and those born into families engaging in routine or manual work were also more vulnerable to infant mortality.

Reducing inequalities in health

The British Government was seeking to address the inequality in public health, Ms Armstrong said. It had signed a *Public service agreement target* to reduce health inequalities by 10% by the year 2010, especially those between the different socio-economic classes. Inequality was measured by both infant mortality and life expectancy. Ms Armstrong explained that the Government was pursuing a preventive approach contributing to an overall drive on public health and life expectancy. She mentioned specific targets such as reducing obesity, discouraging smoking, especially in pregnancy, and increasing participation in antenatal care programmes.

In conclusion, Ms Armstrong encouraged participants to discuss the relationship between infant mortality and social exclusion in greater detail and to seek an international perspective on the issue.

United Kingdom

Rt Hon. Don McKinnon

Commonwealth Secretary-General

Rt Hon. Don McKinnon, Commonwealth Secretary-General, talked about maternal health in the Commonwealth. He referred in particular to the shortage of health workers and placed an emphasis on women's rights. The Commonwealth encompassed 53 states, rich and poor, and was home to 1.8 billion people.

Mr McKinnon stated that, although the richer states had brought the number of maternal deaths down to very low levels, 60% of all maternal deaths worldwide occurred in the Commonwealth. The deaths were mainly concentrated in a few states in Africa and South Asia. In many of those countries, the maternal mortality ratio had hardly changed over the last 30 years. In some it had even risen – largely owing to HIV/AIDS and the shortage of health workers.

According to WHO estimates, 4.3 million trained health workers were missing globally. Mr McKinnon stated that the Commonwealth was very concerned about the impact of health worker migration on the health systems of the most vulnerable countries in sub-Saharan Africa. "It is a simple fact that there cannot be any health service delivery without trained health workers."

Strengthening women's rights

Mr McKinnon explained that mothers died not only from a lack of affordable care, but also from a lack of decision-making power within their families and society. He stressed that maternal deaths could be prevented if those causes were addressed through a combination of practice and policy. First, there was a need to strengthen health systems. This concerned equipment and drugs, but mainly the quantity and quality of health workers. Secondly, he called for a policy that would strengthen women's rights, especially their sexual and reproductive rights.

To reduce maternal deaths, the Commonwealth Secretariat was focusing on three key areas, Mr McKinnon explained. First, maternal health was publicly promoted as the central MDG, partly in cooperation with the mass media. Secondly, Commonwealth states received technical support to record maternal deaths and to analyse their causes. Thirdly, the Commonwealth countries were encouraged to share best practices for reducing maternal mortality.

Promoting gender equality

Mr McKinnon also highlighted the Commonwealth's work in promoting women's rights and gender equality. The Secretariat aimed to improve girls' education, allowing them to marry later and to live a more self-determined life. Moreover, it aimed for at least 30% of the parliamentarians to be female, to ensure women's rights were being upheld. Referring to the *Commonwealth plan of action for*

gender equality 2005-2015, Mr McKinnon said that governments should divide their budgets equally between men and women, especially in the areas of health and education.

In conclusion, Mr McKinnon added that parliamentarians had the power to be the voice of millions of women who could not make their voices heard. "Half the people on this planet bear a lot more than half its burdens. They deserve our whole-hearted support."

WHO

Dr Monir Islam

Director, Department of Making Pregnancy Safer, WHO

Dr Monir Islam, Director of WHO's Department of Making Pregnancy Safer (MPS), gave an overview of maternal mortality at global and regional levels. He outlined the main reasons for high maternal mortality ratios and mentioned some countries where action had been taken to tackle these underlying problems.

In his introduction Dr Islam cited the latest statistics and findings from WHO. He explained that every year 80 million pregnancies around the world were unwanted, 50 million were interrupted by induced abortion, and 20 million caused maternal morbidity. Moreover, every year 500 000 women died from complications related to pregnancy or childbirth. In Africa, the numbers of maternal deaths had been increasing. Newborn mortality, Dr Islam explained, was closely related to maternal mortality.

Gaps between rich and poor

A woman's risk of dying in pregnancy or childbirth varied widely between countries, Dr Islam said. It was greatest in Africa and Asia: in Africa, 1 in 26 women died as a result of pregnancy; in Asia, 1 in 120. In Sierra Leone 1 in 8 mothers died compared to 1 in 48 000 in Ireland. But even within countries there were large differences between rich and poor people, and between the urban and rural population.

Dr Islam outlined three delays causing the high numbers of maternal deaths. First, there was a delay in a woman's decision to seek care. Because of their low position in society, women had to ask their husbands for permission and for money. Secondly, there was a delay in accessing health facilities. Within health facilities, there was a third delay in providing care of an adequate quality. Dr Islam emphasized that there were relatively cheap interventions to address these problems.

Cases of successful investment

WHO, through the Department of Making Pregnancy Safer, and other UN agency partners had worked diligently with governments and health-care managers to tackle these issues, Dr Islam said. He pointed out that some countries

had been able to improve maternal health. In Indonesia, there had been great investment in the social sector to combat the above-mentioned problems. Botswana had successfully increased the proportion of deliveries occurring in health facilities to 99% through investment in health and education since its independence in 1966. Bolivia, Costa Rica and Cuba had also made great strides. Those countries had proven that progress was possible, if governments implemented basic interventions, Dr Islam concluded.

The Director of MPS encouraged poor countries to promote maternal health issues in parliamentary debates in order to increase investment in that area. Developed countries could also push key women's health issues to the top of the political agenda. Dr Islam emphasized that 5 million mothers would probably die in the next decade, if the current situation did not change.

United Kingdom

Mr Andrew Lansley

Shadow Secretary of State for Health

Mr Andrew Lansley, Member of the British Parliament, stressed that the British Conservative Party wished to play a part in improving maternal and infant health across the world.

Mr Lansley pointed out that people who worked for the British health system shared their medical experience with people abroad. On the one hand, there was a long tradition of health workers

spending their vacations or sabbaticals abroad to support local health care. On the other hand, there was also a long tradition that people from abroad came over to the United Kingdom to learn and practise medicine. According to Mr Lansley, one in five hospitals across the United Kingdom supported activities overseas, directly or indirectly.

He emphasized that these activities were due to individuals' personal enthusiasm and decisions.

Exploring ways of cooperation

Mr Lansley hoped that the United Kingdom could provide more support in the area of maternal health globally. To that end he encouraged a debate on what steps the United Kingdom should take. "What we have to think about now is how we can systematically give back resources. It is important that we keep on debating with each other on how we can improve health." He was also interested in country-specific aspects of maternal mortality and hoped that discussions could show how to share ideas in a better way.

Country reports

Belgium

Ms Stephanie Anseeuw
Senator

Ms Stephanie Anseeuw, Senator, reported on Belgium's development assistance. She pointed out that her country would have committed 0.7% of its GNP to the developing world by 2010. In 2005, the country had allocated €60 million for basic health care, as well as €2.5 million for reproductive and sexual health. She highlighted that Belgium had worked with African governments to support projects on reproductive health and gender needs. Among them had been projects focusing on HIV/AIDS prevention, for example in Rwanda and Sierra Leone, and on the prevention of sexual violence against women in Côte d'Ivoire.

Sweden

Ms Rosita Runegrund
Member of Parliament

Ms Rosita Runegrund from Sweden focused on gender friendly policies as well as Swedish development aid. She stressed that 47% of parliamentarians in Sweden were women and

underlined that she had seen big changes in policies for working women over the last 40 years. Mothers were now able to stay at home for a year or more to take care of their children.

In addition, Ms Runegrund reported that Sweden gave 1% of its GNP to the developing world. The Government had promised to give the same or even more in 2008. "If every rich country does this, it will be better for world health," she said.

Tajikistan

Ms Galiya Rabieva
Member of Parliament

Ms Galiya Rabieva presented national data on maternal health in Tajikistan. Although the country had increased its commitment since its independence in 1991, maternal and newborn health remained a serious issue, she said. The existing laws were only poorly applied.

She cited recent government statistics that showed an overall decrease in the maternal mortality ratio over the last decade, namely from 125 maternal deaths per 100 000 live births in 1995 to 46 in 2005.

However, in some regions the ratio remained very high, ranging from 120 to 840 maternal deaths per 100 000 live births. Ms Rabieva reported that the Ministry of Health had investigated the causes of maternal death with the assistance of the WHO Regional Office for Europe. The studies showed that mothers were mainly dying due to bleeding, eclampsia, and unsafe abortion.

Poor access to antenatal care

Ms Rabieva said that, in general, pregnant women did not receive antenatal care in her country. Even simple examinations like urine tests or weighing were not provided, meaning that diagnoses of complications were delayed. Ms Rabieva said that the public had little knowledge of antenatal care. In addition, the high abortion rates could be explained by limited access to safe contraceptives.

Ms Rabieva urgently called on donors to assist her country in achieving the Millennium Development Goals. With 60% of its population living below the poverty line, Tajikistan needed support from international partners, she said.

United Republic of Tanzania

Hon. Faida Mohamed Bakar

Member of Parliament

Hon. Faida Mohamed Bakar informed the audience about maternal mortality in the United Republic of Tanzania. She reported that her country was still facing a lot of health problems. Nevertheless, there had been steady progress in the area of maternal health over the last few years. In 2007, 94% of all pregnant women received antenatal care. However, less than half of deliveries were assisted by skilled birth attendants.

Ms Bakar said that the maternal mortality ratio was still too high: 578 maternal deaths per 100 000 live births. She mentioned different reasons, including inappropriate care, ignorance of danger signs and lack of birth-preparedness plans. Weak decision-making power and limited financial means were also contributing factors. In addition, health care services might be difficult to reach or inadequate in quality.

Ms Bakar said that the Government had implemented several interventions to address these problems. It had advanced the national *Road Map for accelerating the attainment of the Millennium Development Goals related*

to maternal and newborn health. It had supported the implementation of activities, increased budget allocations, mobilized resources at all levels and expanded the coverage of services. Nevertheless, there was still a long way to go before achieving MDGs 4 and 5 in her country.

Discussion and debate

Botswana

Hon. Lesego E. Motsumi
Member of Parliament

Hon. Lesego E. Motsumi from Botswana said that the maternal health problems that had been discussed resulted directly from a lack of access to effective medical care. To provide this access many different things were needed, including buildings, roads, clean water and education, especially in rural areas. She encouraged interaction between different ministries to ensure an appropriate environment for quality health services.

Brazil

Ms Ideli Salvatti
Senator

Ms Ideli Salvatti, representing Brazil, talked about newborn mortality. She said that in Latin America one in five mothers had lost a child. In her country, the Government had been able to reduce the shocking number of newborn deaths in the last decade. She emphasized that the differences in the numbers of newborn deaths showed the differences in wealth across the world. "We have to fight this injustice!" she said. She called on countries to pay more attention to family health policies.

India

Smt Prema Cariappa
Member of Parliament

Smt Prema Cariappa from India said that her country was facing a big problem in women's health, because the number of unsafe abortions was increasing.

Kenya

Hon. Charity Kaluki Ngilu
Minister of Health

Ms Charity Kaluki Ngilu from Kenya asked governments from different countries to work together to address the health worker shortage. Developing countries lost their health workers to developed countries because they could not afford to pay as much, she said.

Nigeria

Hon. Patricia Olubunmi Etteh
Member of Parliament

Nigeria's Hon. Patricia Olubunmi Etteh drew attention to the lack of health services in the rural areas of her country. While it had the greatest need for health care, the rural population was offered the least. Doctors did not want to work there because those areas lacked infrastructure and resources, she said.

Sierra Leone

Hon. Janet Mamie Sam-King
Member of Parliament

Hon. Janet Mamie Sam-King from Sierra Leone highlighted the prevalence of sexual discrimination.

She said that the numbers of maternal and child deaths reflected how little her Government cared for women and children.

Reception and dinner at the House of Commons

United Kingdom

Rt Hon. Baroness Hayman
Lord Speaker

Rt Hon. Baroness Hayman highlighted the forthcoming Mother's Day and stressed the importance of maternal and newborn health and survival. She acknowledged the role of women in the House of Lords in putting maternal and child health issues at the top of the Government's agenda. Baroness Hayman also spoke about her personal experience of raising children while being a Member of Parliament.

She spoke of the slow progress in improving maternal and newborn health so far, emphasizing the need for more action, especially in Africa and Asia. Those regions had made the least progress in reducing maternal and newborn morbidity and mortality, she said. Access to emergency care services was lacking. Baroness Hayman also cited her country's efforts to put an end to poor health policies.

Lesotho

Ms Mathato Mosisili

First Lady of the Kingdom of Lesotho

The First Lady of the Kingdom of Lesotho, Ms Mathato Mosisili, echoed Baroness Hayman's calls. She stressed the need for human resource planning for maternal and newborn health care. She asked the donor countries to work on these plans together with developing countries and to increase their contributions to these plans.

She stressed that support was needed to relieve overburdened staff and the thousands of patients they served. She explained that more funding was needed to counteract the current loss of health workers. Increasing human resources was critical to expanding and sustaining maternal and newborn care, as well as HIV/AIDS treatment in her country.

Day two

Site visits and reception

Site visits

On the second day of the meeting, participants had the opportunity to visit several facilities across London to get a picture of maternal and newborn health care in the United Kingdom. They went to *Sure Start Queens Park* children's centre and the Institute for Child Health at the UCL Centre for International Health and Development. They also visited the Royal College of Midwives, Guy's and St Thomas' Hospitals, and the Hurley Clinic. After the site visits, the participants attended presentations at the Royal College of Obstetricians and Gynaecologists (RCOG).

United Kingdom

Ms Sarah Brown

President, Piggy Bank Kids and wife of British Chancellor Gordon Brown

Ms Sarah Brown, a well-known advocate for maternal and child health and the wife of British Chancellor Gordon Brown, welcomed the participants to the

RCOG. Ms Brown founded the charity *Piggy Bank Kids* in 2002, which supports a wide range of projects helping disadvantaged children in the United Kingdom. Having lost her baby daughter Jennifer after childbirth, Ms Brown also set up the *Jennifer Brown Research Fund*, which supports research to save newborn lives and solve pregnancy problems.

Ms Brown introduced herself to each of the participants individually. She said that she was delighted to be involved in such an exciting meeting and was looking forward to hearing views on key issues from different countries. She explained how the British Government could help countries identify key needs.

Presentations part II

United Kingdom

Professor Jim Dornan
Dr Nynke van den Broek
Royal College of Obstetricians and Gynaecologists (RCOG)

The Royal College of Obstetricians and Gynaecologists (RCOG) was represented by Professor Jim Dornan, Senior Vice President for RCOG International Programmes, and by Dr Nynke van den Broek, Director of the RCOG International Office based in Liverpool. The RCOG is an international organization with over half of its fellows and members residing overseas. The college was established in 1929 to address the high maternal mortality ratio in the United Kingdom, which was 750 per 100 000 at that time – as high as in Africa and rural South-East Asia today.

Professor Dornan underscored that the miracle of life sometimes turned into a disaster. Resource-poor countries in particular had very high maternal mortality ratios. Professor Dornan listed the main causes of maternal death: severe eclampsia, haemorrhage, obstructed labour, sepsis, and complications of abortion. He stressed that all these causes were easily treatable.

Building capacity in health care

Dr Nynke van den Broek added that too many women died from complications in childbirth, mainly in sub-Saharan Africa and Asia. She highlighted the importance of the Millennium Development Goals, especially MDGs 4 and 5. She then presented the RCOG International Office's key strategies for achieving these goals. First, maternal and newborn needs had to be identified and prioritized. Then governments had to establish collaboration with medical professionals, especially midwives. The capacities of the health systems had to be increased where effective interventions were known. Implementation had to be enforced by identifying and overcoming barriers. Where effective interventions were not yet known, they had to be developed, pilot-tested and scaled up. Dr van den Broek stressed that these strategies could only be implemented if the RCOG worked in partnership with other organizations as well as politicians.

United Kingdom

Rt Hon. Hilary Benn

Secretary of State, Department for International Development

Rt Hon. Hilary Benn, Secretary of State in the Department for International Development (DFID), focused on women's health as a political issue. He also highlighted the need for gender equality.

Mr Benn started his talk with a flashback to British politics regarding women's health in the late 19th century: at that time, childbirth had been a dangerous experience, he recalled. Mothers had delivered their babies under miserable conditions assisted by untrained women. The maternal mortality ratio had been high. Finally, a small group of pioneering women had become involved in politics and had called for the education of professional midwives. They had overcome the pervasive belief that women could not and should not become professional midwives. In 1881 they had helped to establish the Royal College of Midwives, today the oldest and largest midwifery college worldwide. In 1902 the British Parliament had enacted the Midwives Act to put midwifery on a professional footing. This was a clear example of politics making a difference, Mr Benn concluded.

Examples of successful health politics

Addressing the women parliamentarians in the audience, Mr Benn declared, "You know better than anyone else that women's health is as much political as it is medical or scientific." He cited recent examples of successful politics in the area of women's health. In Honduras a strong political commitment to women's health had cut maternal mortality by 40% in the 1990s. He reported that in Ghana the proportion of deliveries assisted by a skilled birth attendant had increased after the Government had abolished health user fees. In South Africa, political demands to change the abortion law had reduced the casualties from unsafe abortion by 90%. As a last example Mr Benn highlighted that the Government of Pakistan had taken forward a major maternal, newborn and child programme, which DFID had funded with £90 million.

Yet in developing countries more than half a million mothers died every year - a number equivalent to the population of the city of Liverpool, Mr Benn said. The women who suffered most were the poorest, he pointed out. A woman in Sierra Leone was 600 times more likely to die in pregnancy than a woman in the United Kingdom. "There is no greater symbol of discrimination against women than the continued death of women in childbirth, when we have the knowledge – and the power – to prevent these deaths."

Increasing women's representation in parliament

Mr Benn judged gender equality not to be a complicated idea. "It is simple: women must have

the same rights as men and discrimination has to stop." Women's representation in parliaments would be part of that gender equality, the Secretary of State said. He admitted that the United Kingdom was not doing very well, since only a fifth of parliamentarians were women. But in Rwanda it was half, he pointed out, and there the female politicians had urged the Government to increase investment in health and education.

Mr Benn outlined what politicians could do about women's health. First, they had to recognize that improving maternal health was also about gender, power and politics. Secondly, they had to make women's rights a central idea in any planning. Thirdly, politicians should make women's health an election issue. They should listen to women's needs and involve them in the political process. He then closed his speech with a call for action: to make the world a better place for women and children, politics must make a difference.

Upcoming event

Ms Jill Sheffield
President, Family Care International

Announcing the Women Deliver Conference, Ms Jill Sheffield, President of Family Care International, highlighted the importance of women's health to the wealth of nations.

The conference would be taking place from 18 to 20 October 2007 in London. The date marked the 20th anniversary of the Safe Motherhood Initiative. The meeting was being organized by UN organizations, among them WHO/MPS, The World Bank, a number of governments including the British Government, and nongovernmental organizations. Around 2000 world leaders from across the globe had been invited to focus on improving health systems and creating political will to save the lives and improve the health of women, mothers and babies worldwide.

"For women and their families all over the world, we are going to deliver facts, messages and strategies to policy-makers," Ms Sheffield said. She argued that the health of a nation was directly tied to the health of women – politically, economically and socially. Hence, parliamentarians could show policy-makers that they could improve the health of their nation by investing in women, she said.

Accelerating progress on MDGs

Ms Sheffield emphasized that it was high time for the global community to deliver back to women. "There are several things going on that make it just the right time." She highlighted the Millennium Development Goals towards which progress needed to be accelerated. She mentioned that MDG 5, which aims to improve maternal health, was clearly the key issue for women's health policies. She also stressed the importance of reducing child mortality (MDG 4), strengthening HIV/AIDS prevention (MDG 6) for women and girls, ensuring primary education (MDG 2) for girls, and enforcing gender equality (MDG 3). She stated that all these issues were central to the reduction of poverty and the advancement of nations.

Discussion and debate

Bolivia

Ms Paulina Humacata Zarate
Member of Parliament

Ms Paulina Humacata Zarate talked about gender equality and women's access to health services in Bolivia. She reported how she had launched literacy programmes in different municipalities. She explained that these programmes had not only improved women's education, but had also helped to increase understanding of the different languages in the Bolivian rural communities. President Morales had supported the literacy programmes in order to have more female representatives in the governments. Ms Zarate stressed that it was important that men and women worked together. "That way we can achieve an understanding, so that men respect women and women respect men," she said. She emphasized that it was important to teach children the principles of gender equality.

Ms Zarate also reported a low demand for maternal health care in facilities. Before she became a parliamentarian she had worked as a health promoter. She said that one of her problems had been to get the women whom she had wanted to help to seek medical care. She asked for advice regarding the issue. **Dr Nynke van den Broek**, Director of the RCOG International Office, suggested asking women who use health services for help in improving them. "Sometimes we do not even bother to ask them, 'What is it that is not good about the facility?' or 'Why are you not able to come?'" Sometimes no transport was the problem, but other times it was very simple things. The height of the bed could be a reason, or impolite midwives, or perhaps a lack of respect for cultural differences. The feedback could provide important information on how to change services so that women would be happier to come, she said.

Botswana

Hon. Lesego E. Motsumi

Member of Parliament

Hon. Lesego E. Motsumi from Botswana argued that women's health was an issue for both women and men. To her it was important for the health committee and the gender committee to work together in parliament to promote women's health. She added that men needed to be educated that women's health concerned them too. She argued that the very men who made the women pregnant wanted them to stay alive and also wanted the babies. In her opinion, there was no need to increase the number of women in parliament to raise the issue of women's health. In any case, some parliaments would never reach 50% women.

Cambodia

H.E. Ms Ho Naun

Member of Parliament

H.E. Ms Ho Naun from Cambodia said that no funds were available in her country to pay the health user fees for poor people. She stated that support from policy-makers was greatly needed to improve the national health care system.

Indonesia

Dr Mariani Akib Baramuli

Member of Parliament

Dr Mariani Akib Baramuli from Indonesia was especially interested in midwifery. She reported that her country needed training for midwives, since doctors were lacking. So far, she said, there had been no legislation to strengthen midwifery services in Indonesia. She asked Secretary of State **Rt Hon. Hilary Benn** to summarize the British Midwives Act for her. He explained that the aim of the 1902 Midwives Act had been to create and regulate a profession. It had set professional standards and estimated the national need. Above all, the Midwives Act had recognized that women were able to work as skilled birth attendants.

Kenya

Hon. Charity Kaluki Ngilu

Minister of Health

Hon. Charity Kaluki Ngilu from Kenya stated that investment in women's health was a political decision. Ms Ngilu had been Minister of Health

for four years by 2007, and a parliamentarian for 15 years. She reported that the Ministry of Health in Kenya had been under-funded in the past. Obviously, neither the Government nor the donor community had made health issues a priority. So at the beginning of her term of office Ms Ngilu had gone back to the drawing board, identified the needs, declared the health sector to be a priority and successfully increased investment. She reported that she had been able to improve health care: with the support of donors Kenya had increased the number of health workers by 3500 between 2005 and 2007. Equipment had been purchased and people, including women, were being offered more services, she said.

Ms Ngilu also recounted how an ill baby had caused her to cancel the user fees in health facilities. She reported how the mother had been turned away when she had brought her very sick baby to the health facility. The health workers had refused her access to the services, because she had had no money to pay for them. Even when the Minister of Health had accompanied the mother to the hospital, the health workers had still said no. Ms Ngilu had turned around and created a very firm policy to eliminate the user fees. She had driven that policy forward in Government and had finally been given the money to support it.

Ms Ngilu then raised the issue of health workers training abroad. She asked why health workers from Kenya were not allowed to advance their education in the United Kingdom. Secretary of State **Rt Hon. Hilary Benn** referred to a code of practice in the National Health Service. He explained that the National Health Service did not directly recruit from developing countries so as to prevent the drain of skilled and talented health workers.

Malawi

Hon. Olive Masanza

Member of Parliament

Hon. Olive Masanza from Malawi told participants how her commitment to orphans had brought her into parliament. It had been right after her retirement as a civil servant that she had joined the *Save the Children Fund* for Malawi. Since 1997 she had cared for 3000 orphans in her area. That work had made people vote for her in parliamentarian elections. She emphasized that she spoke as much as possible about every subject involving women or children in Malawi. "I feel that the voiceless views should be heard through me," she said.

Ms Masanza encouraged women to vote for women in parliament. "In Malawi, 51-52% of the population are women. Why can we not get 50% of women in parliament?" she asked. "It is because women vote for men, not for fellow women." This way women put each other down, she said. She hoped that Malawi would have at least 30% of female representatives in parliament by 2009. She pointed to her home district of Mulanje, where 65% of the parliamentarians were women.

Netherlands

Ms Chantal Gill'ard
Member of Parliament

During the discussion, Ms Chantal Gill'ard from the Netherlands mentioned oxytocin, an inexpensive drug that should be used to manage the third stage of labour. An oxytocin injection can prevent lethal bleeding and save a mother's life. She wondered why the drug was not used more widely. **Dr Monir Islam**, Director of MPS, replied that although it was well known that oxytocin could save lives, there were problems concerning its administration. For example, in some places syringes were not available. Moreover, the drug needed to be cooled, so a refrigerator and a power supply had to be available. He added that there was a company in the Netherlands that was trying to develop heat-stable oxytocin.

Nigeria

Hon. Patricia Olubunmi Etteh
Member of Parliament

Hon. Patricia Olubunmi Etteh from Nigeria showed great interest in using social workers and volunteers to reach out to women. She was impressed by this work in the United Kingdom, but reported that in her country social workers only worked in offices and did not go out. There were no volunteers at all. She asked Rt Hon. Beverley Hughes for advice on how to integrate such people into the system of her country. Ms Hughes replied that the changes in the United Kingdom had happened over many years. She suggested that it might be useful for Nigerian social workers to meet social workers from other parts of the world.

Sierra Leone

Hon. Janet Mamie Sam-King
Member of Parliament

Hon. Janet Mamie Sam-King from Sierra Leone reported how she had raised the issue of maternal mortality in parliament. Before she went into politics, Ms Sam-King had worked as a nurse in the United Kingdom. She said that she found the

statistics on maternal mortality in her country to be very distressing. In Sierra Leone, the numbers had recently increased to 2000 maternal deaths per 100 000 births. She explained that this was caused by a lack of planning and, where there were plans, a lack of funds to implement them. She said that she had raised awareness of maternal health issues in parliament. In 2005 she had addressed maternal mortality and spoken to people across the country. Ms Sam-King said that the country did not do enough to address the thousands of maternal deaths and called on other nations to help.

Sudan

Hon. Hayat Ahmed Elmahi Hamid
Member of Parliament

Hon. Hayat Ahmed Elmahi Hamid, representative from Sudan, talked about cultural barriers that hindered the implementation of women's health programmes. In Sudan, the main barriers were the leaders' lack of commitment and poverty in general. In addition, women received little education and had no decision-making power within families. To improve women's health these barriers had to be overcome, the parliamentarian said.

Uganda

Hon. Sylvia Namabidde Sinabulya
Member of Parliament

Hon. Sylvia Namabidde Sinabulya from Uganda drew attention to community factors influencing maternal and newborn health. She said that obstetricians and gynaecologists had been well trained. However, only 38% of delivering women in her country were assisted by skilled birth attendants. The rest gave birth in communities in the presence of traditional birth attendants and ran a higher risk of dying from complications in childbirth. Ms Sinabulya concluded that policies had been made, hospitals built, and doctors trained, but the women did not come. She wondered how non-medical professionals could be trained to reach out to women and bring them to the facilities.

Group

During a group discussion, representatives from different countries compared the British maternal health care system with their systems at home. The group agreed that maternal health care issues were quite similar in developed and developing countries. The main difference was that in the United Kingdom there were systems in place to deal with the issues. In

developing countries there were only weak systems or even none at all.

The group also noticed differences concerning the health workers. They highlighted that British health care personnel were very friendly, whereas in some other countries the people working in health facilities did not treat their patients with respect. Furthermore, the group found that in the United Kingdom men were involved in women's health care to a very high degree. In African countries, however, men said that issues of maternal and child health were a women's issue.

Finally the group mentioned that in the United Kingdom programmes were obviously developed to address a need. In the developing countries, they said, programmes were too often developed for their own sake.

Presentations part III

United Kingdom

Ms Christine McCafferty

Member of Parliament
Chair of the APPG on Population, Development and Reproductive Health

Ms Christine McCafferty informed the audience about the work of the All Party Parliamentary Group (APPG) on Population, Development and Reproductive Health in the British Parliament. The group had been formed in 1979 to improve sexual

and reproductive health both in the United Kingdom and throughout the world. The members briefed other parliamentarians on new developments in their area of interest, mainly through meetings and newsletters. They reported for example on family planning, maternal and child health, and HIV/AIDS as well as on political and cultural challenges.

Ms McCafferty had first chaired the APPG in 1997. She said that sexual and reproductive health was an issue that had not been discussed enough in the United Kingdom. "There are a lot of conversations and debates based on misinformation, in my view. A lack of evidence-based information misguides legislators," she said.

Making a case for maternal health

"As parliamentarians, we must continue to make a case for improved maternal and child health services, not only in our own Government but also among foreign governments and donor organizations," she said. She stressed that sustained and increased investment in sexual and reproductive health services was desperately needed in all developing countries. She anticipated

that investment would bring not only tremendous benefits for women, families and societies as a whole, but also for economic growth and gender equality.

Ms McCafferty reported on key hearings the APPG had organized on HIV/AIDS. In her view these had been extremely important in influencing policy-makers both in the United Kingdom and abroad. She reported that the hearings had led the European Parliament to issue a statement on HIV prevention under the British Presidency on World AIDS Day in 2005. Recently, the Department for International Development had received the APPG's report on population growth and the Millennium Development Goals.

Involving nongovernmental partners

The APPG Chair asked parliamentarians to commit themselves to improving sexual and reproductive health. She encouraged them to join national maternal and child health bodies and to support nongovernmental organizations in that particular area. Ms McCafferty suggested asking faith-based organizations to help address maternal and child issues, since they were very powerful in many countries, not least in the United Kingdom. Also, ordinary people should be involved in the decision-making processes, especially vulnerable groups.

Ms McCafferty stated that sexual and reproductive health issues would have a profound effect on the achievement of the MDGs.

United Kingdom

Rt Hon. Beverley Hughes

Minister for Children, Department for Education and Skills

Rt Hon. Beverley Hughes, British Minister for Children, talked about infant mortality in the United Kingdom. Outlining risk factors for infant death, she referred in particular to the unfavourable circumstances of teenage motherhood.

Ms Hughes highlighted the importance of reducing infant mortality worldwide and in the United Kingdom. She added that her Government was making slow progress in reducing infant mortality and improving maternal health. In 2004 the infant mortality rate in the United Kingdom stood at less than five deaths per 1000 births, compared to 5.6 in 1999. However, beneath the surface of these national numbers lay a very complex story, Ms Hughes pointed out. For lower-income families the rate had not decreased as much as for the average. Put simply, a baby was more likely to die if it was born into a poor family.

The local authorities had analysed the disparity between different parts of London, poor ones and rich ones. They had found that if the mortality

rates of the most deprived areas had been the same as those of the most prosperous parts, the overall rate would have been reduced by about four fifths. The authorities had identified seven familial factors that increased a baby's risk of dying: teenage motherhood, smoking, alcohol, drug abuse, poor nutrition, lack of health advice and genetic conditions.

Addressing teenage motherhood

"One of the things we know for sure is that there is a very strong and direct correlation between having a baby as a teenager and increased infant mortality," Ms Hughes said. She explained that babies of teenage mothers were 60% more likely to die in their first year than those of older mothers. The reasons were manifold, the Minister said. Teenage mothers were much less likely to go for antenatal care. They were much more likely to smoke during pregnancy and much less likely to breastfeed their children. Teenage mothers were also more likely to live in poverty.

Ms Hughes said that she had been working very hard to reduce the number of teenage conceptions and births since 1998. She judged her national strategy to have been a real success. In 2007, the conception rate for people under the age of 18 had been at its lowest level for 20 years, she said. The British Government had also increased the number of teenage mothers who resumed education, training or employment, which could protect them from future disadvantage.

United Kingdom

Rt Hon. Rosie Winterton

Minister of State, Department of Health

Rt Hon. Rosie Winterton, British Minister of State at the Department of Health, highlighted the importance of the *Global Plan of Action*, which women parliamentarians from all around the world had signed at the meeting in London. Before being elected Member of Parliament in 1997, Ms Winterton had worked for the Royal College of Nursing.

The Minister of State said how pleased she was to support the global call for action to improve the health of mothers and children around the world. She said that in the United Kingdom 1 in 20 000 women died in childbirth, while in other countries a woman's lifetime risk of maternal death might be as high as 1 in 5. The tragedy was that most maternal deaths could be prevented, and at little or no extra cost, she said.

Action to improve maternal health

Ms Winterton appreciated that the meeting offered an opportunity to discuss how to reduce the global burden of death. Policy-makers and leaders of civil

society could share ideas on improving maternal and newborn health, especially among the poorest. She reiterated the six strategic points as proposed in the *Global Plan of Action*: ensuring skilled care for every woman; strengthening health systems through communities; building global information networks; providing better infrastructure; promoting safe pregnancies; and governments leading action against mortality and morbidity.

Referring to the aim of strengthening health systems, Ms Winterton asked participants to look particularly at the workforce capacity. Talking about her experience during recent visits to Malawi and Zambia, she stressed that only identification and prioritization of the health personnel crisis within a country could ensure the improvement of national health systems.

Ms Winterton joined the other speakers in stressing the importance of the discussions at the two-day meeting. After returning home, the parliamentarians could promote the strategies they had identified in their debates with other politicians from all over the world.

Conclusions

United Kingdom

Ms Sally Keeble

Member of Parliament

Ms Sally Keeble concluded the meeting with an outlook on desirable results and future meetings. She said that participants needed to decide which actions would make a difference considering the experiences that had been discussed over the last two days. "We are just at the beginning of a process," she emphasized. "The effectiveness of this meeting will be judged by the outcomes."

She further declared: "As parliamentarians, we have responsibilities for what happens in our constituencies." She mentioned that often it was women who raised maternal and child health issues most quickly. She stressed the need to create a virtual network to share experiences and opinions. Even very difficult issues, such as female genital mutilation, should be addressed.

Planning future meetings

With regard to future meetings, Ms Keeble asked participants to consider where they should be held and how they should be organized. She suggested devolving to the regional level as well as to the country level, and that the next conference should build on lessons learnt. It should look at strategies that worked rather than listing problems. She hoped that in future meetings, participants would see some real improvements in women's health services and maternal mortality ratios. Ms Keeble also hoped to see that MDGs 4 and 5 had moved up the political agenda.

Finally, Ms Keeble hoped that everyone had had a good time and that participants would meet next year in a developing country. "I hope we can then talk about what has improved," she said.

WHO

Dr Monir Islam

Director, Department of Making Pregnancy Safer, WHO

Dr Monir Islam emphasized that this was not a one-off meeting. He encouraged participants to report on the meeting in their home countries and to promote ideas on improving maternal and child health. He said that he would like to see three results of the meeting. First, he hoped that participants would develop a virtual internet network. Secondly, he asked the women parliamentarians to communicate how they had taken matters forward at home. Thirdly, he announced that similar meetings should be organized in order to empower participants to push the agenda forward.

Group evaluation

Ms Paulina Humacata Zarate from **Bolivia** wished there had been a few more days and more time to share experiences. She said that she would appreciate a similar conference in another country, maybe even in her home country. Since there had been so many achievements in Latin America, she also suggested regional meetings as a way to better focus on regional issues.

Hon. Lesego E. Motsumi said that her country, **Botswana**, needed more time to discuss the issues of maternal health. As national problems had not yet been analysed, she could not share experiences with the other participants. She suggested coming up with tangible strategies in the future. She showed great interest in sharing experiences of which strategies work and which do not.

Ms Ideli Salvatti from **Brazil** said that gender discrimination was still a major problem in South America. She expressed the need to share experience globally and to further develop regional meetings. With regard to the meeting in London, she said that she would have appreciated a more geographically representative attendance.

Hon. Charity Kaluki Ngilu from **Kenya** suggested holding an annual meeting of women parliamentarians on Mother's Day. She suggested that the meeting could take place in developing countries so that participants could go on site visits there. The Minister of Health highlighted the issue of teenage pregnancies. She said that teenage mothers were an important group to support.

Hon. Olive Masanza from **Malawi** said: "Actions speak louder than words!" A lot of decisions taken were not implemented, she argued. Parliamentarians should monitor problems and ensure that things were being taken forward.

Hon. Janet Mamie Sam-King from **Sierra Leone** said that she would appreciate more international forums like the current meeting as well as regional conferences. She suggested holding the meetings in model countries like the United Kingdom or the Netherlands. She added that she had learnt a lot during the two-day conference.

The **Sudan** representative **Hon. Hayat Ahmed Elmahi Hamid** recognized that women's rights were an important part of improving maternal health. The issue had a real political dimension, she said.

Rt Hon. Rosie Winterton, British Minister of State, stressed the importance of working in partnerships in order to learn from the experiences of other countries.

Agenda

Day one (Tuesday, 13 March 2007)

Opening and signing of Mother's Day card

Ms Cherie Blair
Wife of British Prime Minister Tony Blair

Welcome notes

Ms Sally Keeble
Member of British Parliament, Chair of the meeting

Dr Elizabeth Mason,
Assistant Director-General a.i., WHO / Family and Community Health

Ms Liya Kebede, *WHO Goodwill Ambassador for Maternal, Newborn and Child Health*

Presentations part I

Rt Hon. Hilary Armstrong,
Member of British Parliament, Minister for Social Exclusion

Rt Hon. Don McKinnon,
Commonwealth Secretary-General

Dr Monir Islam, *Director, WHO / Department of Making Pregnancy Safer*

Mr Andrew Lansley
Member of British Parliament, Shadow Secretary of State for Health

Country reports

Belgium: Ms Stephanie Anseeuw, Senator

Sweden: Ms Rosita Runegrund, Member of Parliament

Tajikistan: Ms Galiya Rabieva, Member of Parliament

United Republic of Tanzania: Hon. Faida Mohamed Bakar, Member of Parliament

Discussion and debate

Press interviews, photo opportunities, signing Mother's Day cards

Reception and dinner at the House of Commons

Rt Hon. Baroness Hayman,
Lord Speaker of the House of Lords

Ms Mathato Sarah Mosisili
First Lady of the Kingdom of Lesotho

Day two (Wednesday, 14 March 2007)

Site visits

Sure Start Queens Park, children's centre

Royal College of Midwives

UCL Centre for International Health and Development, Institute of Child Health

Guy's and St Thomas' Hospitals, midwifery and women's services

The Hurley Clinic

Royal College of Obstetricians and Gynaecologists

Welcome address

Ms Sarah Brown
President, Piggy Bank Kids

Presentations part II

Professor Jim Dornan
Senior Vice President, RCOG International Programmes

Dr Nynke van den Broek
Director, RCOG International Office

Rt Hon. Hilary Bennn
British Secretary of State, Department for International Development

Ms Jill Sheffield
President, Family Care International

Discussion and debate

Group discussion

Information sharing and country experiences

Presentations part III

Ms Christine McCafferty
Member of British Parliament, Chair of the All Party Parliamentary Group on Population, Development and Reproductive Health

Rt Hon. Beverley Hughes,
British Minister for Children, Department for Education and Skills

Rt Hon. Rosie Winterton,
British Minister of State, Department of Health

Conclusions

Ms Sally Keeble, Member of British Parliament

Dr Monir Islam, Director, WHO / Department of Making Pregnancy Safer

List of participants

Country participants

Belgium
Ms Stephanie ANSEEUW
Senator

Ms Elke ROEX
Member of the Flemish Parliament

Mr Wannes VANDAELE

Bolivia
Ms Paulina Humacata ZARATE
Member of Parliament

Botswana
Hon. Lesego E. MOTSUMI
Member of Parliament

Brazil
Ms Ideli SALVATTI
Senator

Cambodia
H.E. Ms HO NAUN,
Member of Parliament
Chairman of the Commission on Public Health, Social Work, Veteran Youth Rehabilitation, Labour Vocational Training and Women Affairs

H.E. Ms IM RUN
Member of Parliament
Secretary to the Commission on Foreign Affairs, International Cooperation and Information

Ms SOK RACHNITA

India
Smt Prema CARIAPPA
Member of Parliament

Indonesia
Dr Mariani Akib BARAMULI
Member of Parliament
Chairperson of Health Working Group, Commission IX

Ms Maryamah NUGRAHA BESOES
Member of Health Insurance Working Group, Commission IX

Kenya
Dr Tom MBOYA
Technical Adviser to the Minister of Health

Hon. Charity Kaluki NGILU
Minister of Health

Member of Parliament

Lesotho
Ms Nelly Mosebo FELIX
Principal Protocol Officer

Ms Mathato Sarah MOSISILI
First Lady of the Kingdom of Lesotho

Malawi
Hon. Olive MASANZA
Member of Parliament

Netherlands
Ms Chantal GILL'ARD
Member of Parliament

Nigeria
Hon. Patricia Olubunmi ETTEH
Member of Parliament
Deputy Chief Whip and Chairperson Caucus of Female Parliamentarians

Pakistan
Dr Saira TARIQ
Member of Parliament

Sierra Leone
Hon. Janet Mamie SAM-KING
Member of Parliament

Sudan
Hon. Hayat Ahmed ELMAHI HAMID
Member of Parliament

Sweden
Ms Rosita RUNEGRUND
Member of Parliament

Tajikistan
Ms Galiya RABIEVA
Member of Parliament
Member of the Committee
of International Affairs,
Public Associations and Information

Uganda
Hon. Sylvia Namabidde SINABULYA
Member of Parliament

United Kingdom
Rt Hon. Hilary ARMSTRONG
Member of Parliament
Minister for the Cabinet
Office and Social Exclusion
Chancellor of the Duchy of Lancaster

Rt Hon. Hilary BENN
Member of Parliament
Secretary of State, Department for
International Development

Cherie BLAIR
Wife of Prime Minister Tony Blair

Sarah BROWN
President, Piggy Bank Kids

Rt Hon. Baroness HAYMAN
Lord Speaker of the House of Lords

Rt Hon. Beverley HUGHES
Member of Parliament
Minister for Children,
Department for Education and Skills

Ms Sally KEEBLE
Member of Parliament

Mr Andrew LANSLEY
Member of Parliament
Shadow Secretary of State for Health

Ms Christine McCAFFERTY
Member of Parliament

Chair of the All Party Parliamentary
Group (APPG) on Population,
Development and Reproductive Health

Ms Fran McCONVILLE
Health Adviser, Reproductive
and Child Health
Department for International
Development

Ms Veronica OAKESHOTT
Parliamentary Researcher

Rt Hon. Baroness UDDIN
Member of the House of Lords

Rt Hon. Rosie WINTERTON
Member of Parliament
Minister of State, Department of Health

United Republic of Tanzania
Hon. Faida Mohamed BAKAR
Member of Parliament

Nongovernmental organizations and agencies

Christian Aid
Ms Rachel BAGGALEY
Head of the HIV/AIDS Unit

Commonwealth Secretariat
Ms Ann KEELING
Director, Social Transformation
Programmes Division

Rt Hon. Don McKINNON
Commonwealth Secretary-General

Mr Greg PATON
Intern

Ms Peggy VIDOT
Adviser, Social Transformation
Programmes Division
Health Section

Family Care International
Ms Jill SHEFFIELD
President

IPPF
Mr Stuart HALFORD
Advocacy Officer

Maternity Worldwide
Dr Adrian BROWN
Chairman

Dr Shane DUFFY
Director

Ms Susan NEWPORT
Chief Executive Officer

Oxfam UK
Ms Ruth HYDON
Oxfam GB Parliamentary Office

Mr Muhamed Baba TUAHIRU
Oxfam's National Advocacy Officer, Ghana

White Ribbon Alliance
Ms Brigid MCCONVILLE

World Vision
Mr Graham DALE
Head of Policy and Public Affairs

Royal College of Obstetricians and Gynaecologists (RCOG)

Professor Jim DORNAN
Senior Vice President

Ms Binta PATEL
Manager, International Office

Ms Beryl STEVENS
Director, Corporate Affairs

Dr Nynke VAN DEN BROEK
Senior Clinical Lecturer on Reproductive Health
Director, International Office

Ms Catherine WOOD
Administrator, International Office
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Dr Q. Monir ISLAM
Director, Department of Making Pregnancy Safer

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