The State of

Maternal and Newborn Health

In OIC Member Countries

ORGANISATION OF ISLAMIC COOPERATION
STATISTICAL ECONOMIC AND SOCIAL RESEARCH AND
TRAINING CENTRE FOR ISLAMIC COUNTRIES (SESRIC)

The State of Maternal and Newborn Health in OIC Member Countries

Introduction

Maternal and Newborn Health (MNH) basically refers to health of women and babies during pregnancy, childbirth and after childbirth. Provision of quality care during this period is very critical for the health and very survival of mother and infant. According to the latest estimates, around half a million maternal and about four million newborn deaths are mainly caused by the lack of quality antenatal care, safe and clean delivery and post-natal care for mother and infant.

Maternal and newborn health is of serious concern in the OIC member countries. Every year around 0.2 million women and 2.4 million babies die from preventable causes related to pregnancy and childbirth in OIC member states. Majority of these deaths are occurring in member countries located mainly in Sub-Saharan Africa and Asian region. According to the latest estimates, these two regions accounted for 90 percent of maternal and 80 percent of neonatal deaths (dying within first four weeks of life) in OIC member countries. The higher prevalence of maternal and newborn mortality in these regions reflects inequities in access to health services across the OIC groups and underlines the gap between high income and low income member countries.

Provision of good MNH services is emphasized in the Millennium Development Goals (MDGs). Over the years, many OIC member countries made great progress to achieve these targets; however some members especially in Sub-Saharan Africa and South Asia are still lagging behind in increasing coverage of MNH. According to the research findings, most of the maternal and newborn deaths are preventable by ensuring proper care and counseling before and after pregnancy, at the time of delivery and after child birth. Therefore, member countries must take all necessary measure both at national and intra-OIC level, to ensure safe and secure motherhood and childhood across the OIC region.

In this short report, we will investigate the progress on maternal and newborn health in OIC member countries. To achieve this objective, we will analyze the maternal and newborn mortality trends and progress on some specific measures to improve MNH. At the end, we will discuss the OIC level cooperation to improve MNH and formulate some policy measures to further enhance the pace of efforts to achieve the goal of safe and healthy motherhood and childhood in all OIC member countries.

Maternal Health

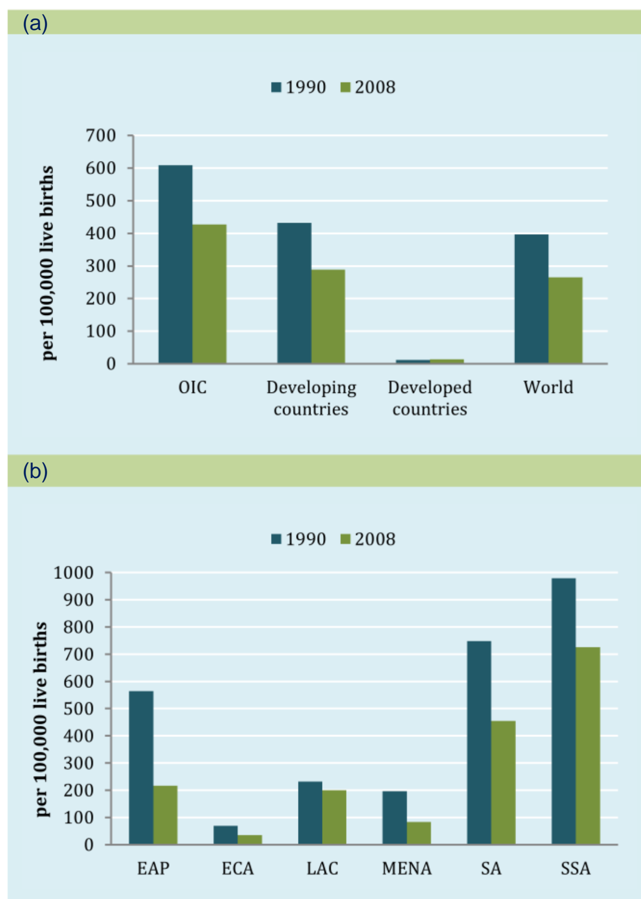
Under the MDG 5, countries are committed to reducing maternal mortality by three quarters between 1990 and 2015. Pregnancy and childbirth related complications remained the leading cause of death and disability for women age 15-49 especially in developing countries. According to the latest estimates (WHO, 2011), globally nearly a half million women die during and following pregnancy and childbirth. About 99.5 percent of these maternal deaths are occurring in developing countries especially in Sub-Saharan Africa and Asia.

In OIC member countries, about 0.2 million women die from preventable causes related to pregnancy and childbirth. This corresponds to 50 percent of the world total maternal deaths in 2008. Majority of the maternal deaths in OIC countries occurred in SSA and SA region and these two regions accounted for about 90 percent of the total maternal deaths (i.e. 66 percent and 23 percent respectively) in 2008. Health experts are of the view that almost all of global maternal deaths are preventable through timely prenatal and postnatal care, skilled birth attendance and the availability of emergency care to deal with complications.

Over the years, world has made some progress to control the maternal deaths and maternal mortality rate (MMR) has declined from 397 deaths per 100,000 live births in 1990 to 266 deaths in 2008, corresponding to a decrease of 33 percent (Figure 2.25). A similar trend can be observed for the developing countries as well. The situation in developed countries was quite the opposite where maternal mortality witnessed an increasing trend. Nevertheless, despite the increase, MMR in developed countries remained comparatively negligible at 14 deaths per 100,000 live births. OIC member countries also witnessed some improvement in maternal health conditions and MMR declined from 609 deaths in 1990 to 427 deaths in 2008,

corresponding to a decrease of 30 percent. However, compared to other groups, OIC member countries recorded higher MMR in 2008.

Figure 1: Maternal Mortality Rate



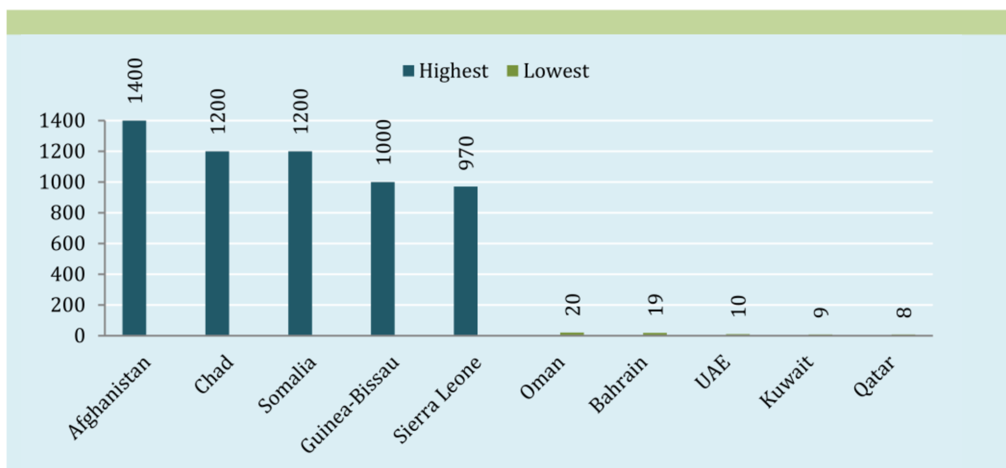
Source: Annex Table A.1

During the period 1990-2008, maternal mortality rate has declined across the OIC regions. As shown in Figure 2.26, in 2008, MMR ranged from a low of 35 and 83 deaths per 100,000 live births in ECA and MENA respectively to a high of 725 and 455 deaths in SSA and SA respectively. Among other OIC regions, the average MMR remained 200 deaths per 100,000 live births in LAC and 216 deaths in EAP. Between 1990 and 2008, OIC member countries in EAP region witnessed the highest decrease in MMR (62 percent) followed by MENA (58 percent), ECA (49 percent), SA (39 percent), SSA (26 percent) and LAC (14 percent). With the exception of SSA and SA region, MMR for OIC regions remained below the world, developing countries and OIC averages in 2008.

At the individual country level, as shown in Figure 2, Afghanistan recorded the highest MMR (1400 maternal deaths per 100000 live births) in OIC region, closely followed by Chad (1200 deaths), Somalia (1200 deaths), Guinea Bissau (1000 deaths) and Sierra Leon (970 deaths). Among these countries, Afghanistan is ranked 1st with respect to highest MMR in the world, Chad and Somalia are ranked 2nd, Guinea Bissau is ranked 3rd and Sierra Leon is ranked 6th. In contrast, Qatar recorded the lowest MMR in OIC region (8 maternal deaths per 100,000 live births)

followed by Kuwait (9 deaths), UAE (10 deaths), Bahrain (19 deaths) and Oman (20 maternal deaths). Between 1990 and 2008, 30 member countries registered more than 40 percent decrease in MMR. In these 30 member countries, 13 are from MENA, 7 from SSA, 5 from ECA, 3 from SA and 2 from EAP region. The member countries with highest decline in MMR from SSA region are as follow: Benin, Gambia, Togo, Senegal, Mozambique, Guinea and Niger. On the other hand, three member countries namely: Kyrgyzstan, Somalia and Suriname witnessed 5 percent, 9 percent and 19 percent increase in MMR respectively [see Annex Table A.1].

Figure 2: Member Countries with Highest and Lowest Maternal Mortality Rates, 2008



Source: Annex table A.1

Newborn Health

According to the latest estimates (WHO, 2011), around 134 million babies are born every year. And about 99% of these births are occurring in developing countries. Mainly due to the lack of maternity care and poor health conditions, 2.5 million babies are stillborn whereas 3.2 million die within first four weeks of their life (neonatal deaths). In 2009, both stillborns and neonatal deaths accounted for 96 percent (42 percent and 54 percent respectively) of total infant deaths across the globe. Almost all of these deaths are occurring in low income developing countries,

including several OIC member countries located mainly in South Asia and Sub-Saharan Africa.

In OIC member countries, more than 41 million babies are born every year, corresponding to 31 percent of the world and 34 percent of the developing countries total. In 2009, about 1.1 million were stillborns whereas 1.3 million died within first four weeks of their life. About 44 percent of world total stillborns were registered in OIC member countries whereas 40 percent of world total neonatal deaths occurred in member countries in 2009.

In line with the global trends, infant mortality situation has been improved in the OIC member countries and infant mortality rate (IMR) exhibited a down ward trend since 90's. As shown in Figure 3 (a), the average IMR in OIC countries has declined from 87 deaths per 1000 live births in 1990 to 58 in 2009, corresponding to a decrease of 33 percent. However, despite this impressive progress, IMR in member countries remained quite higher than the developing countries and world averages. In 2009, one in every 17 children died before their first birthday in OIC countries compared to one in 22 children in developing countries, one in 24 children in world and one in 218 children in developed countries.

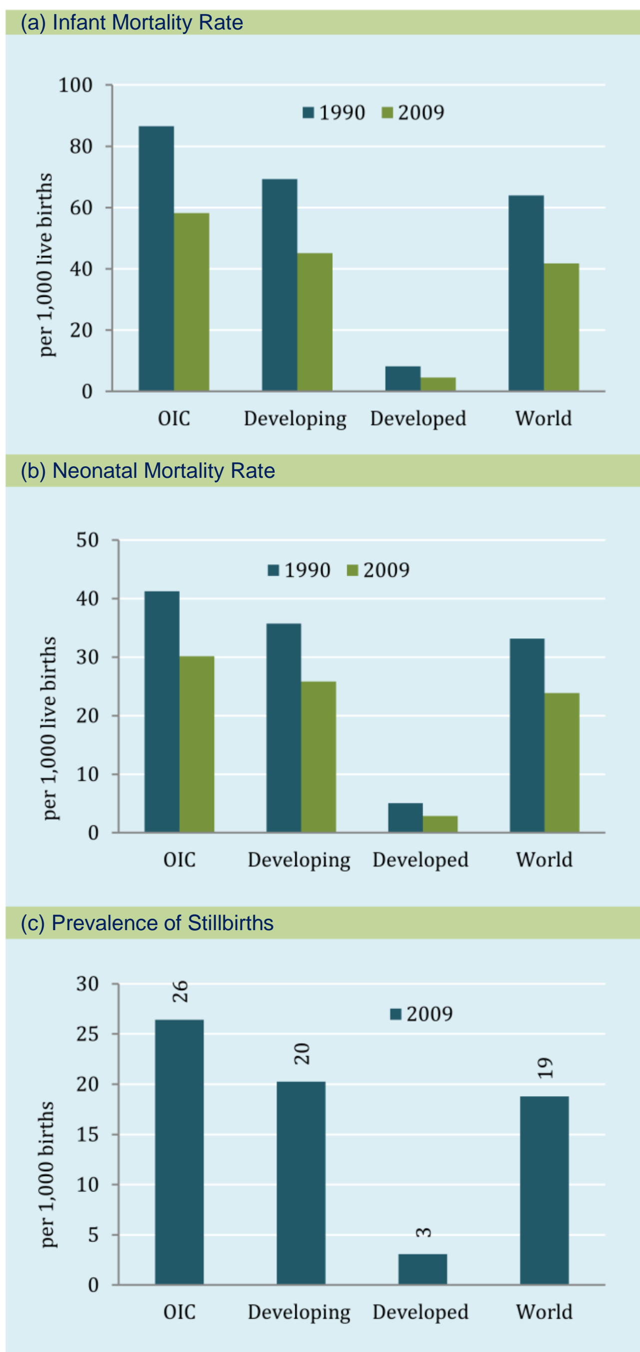
A similar trend can be observed in case of neonatal mortality rate (NMR) as well. As shown in Figure 3 (b), average NMR in OIC countries has declined from 41 deaths per 1000 live births in 1990 to 30 in 2009, corresponding to a decrease of 18 percent. However, despite this positive trend, NMR in member countries remained higher than the other regions. In 2009, one in every 33 newborns died within first four weeks of birth in OIC countries compared to one in 39 newborns in developing countries, one in 42 newborns in world and one in 349 newborns in developed countries.

The prevalence of stillbirths also remained comparatively higher in OIC region. And in 2009, OIC member countries recorded 26 stillborns per 1000 births compared to 20 stillborns in developing countries and 19 in the world (Figure 3 (c)). This means that one in every 38 newborns was stillborn in OIC member countries whereas this ratio was one in 49 newborns for the developing countries, one in 53 newborns for the world and one in 325 newborns for the developed countries.

At the OIC regional level, both births and newborns deaths remain highly concentrated in few regions. In 2009, more than 61 percent of total births and 75 percent of total infant deaths in OIC countries were recorded in SSA and SA region whereas these two regions accounted for 81 percent of total stillborns and 79% of total neonatal deaths in OIC member states.

During the period 1990-2009, infant mortality rate has declined across the OIC regions. Yet, substantial differences exist among the regions. As shown in Figure 4 (a), in 2009, average IMR ranged from a low of 26 deaths per 1000 live births in EAP, ECA and MENA region to a high of 86 and 58 deaths per 1000 live births in SSA and SA respectively. Average IMR was recorded at 27 deaths per 1000 live births in LAC. Between 1990 and 2009, member countries in ECA region witnessed the highest decrease in IMR (61 percent) followed by MENA (53 percent), EAP (49 percent), SA (43 percent) and LAC (41 percent). On the other hand, SSA where a bulk of OIC infant deaths occurs has registered only 26 percent

Figure 3: Newborn Mortality



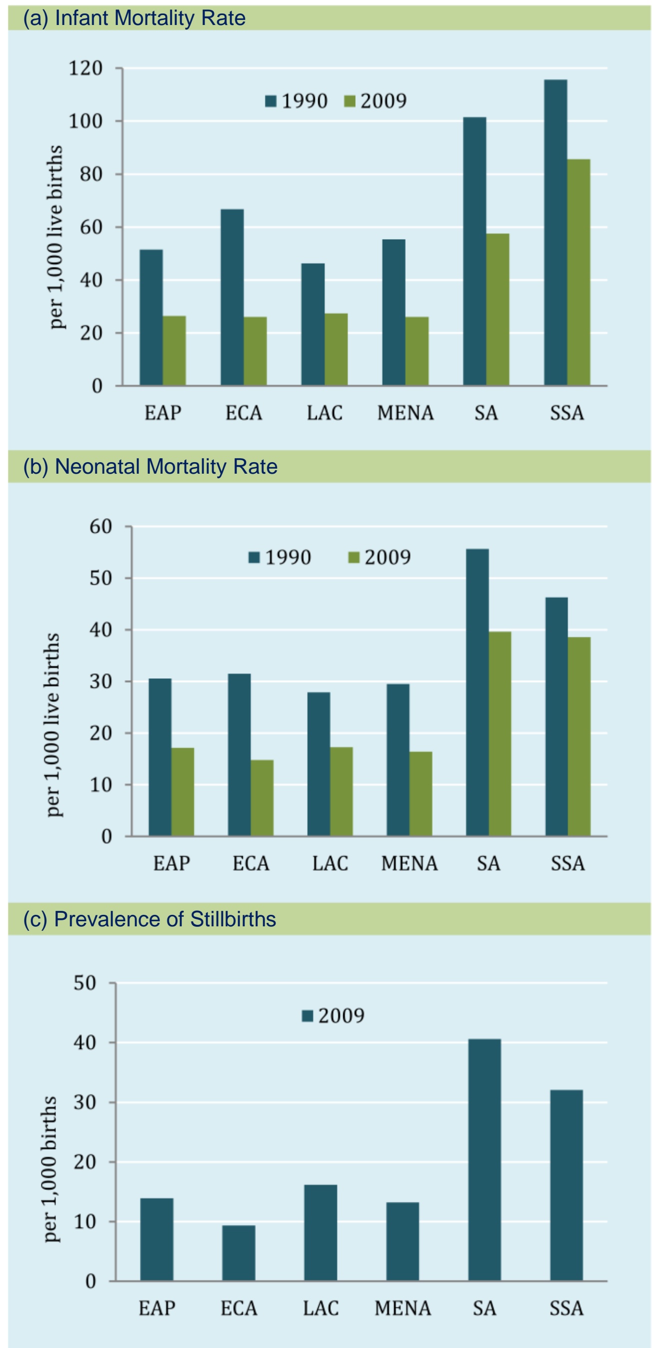
Source: Annex Table A.1

decrease in IMR during 1990-2009. In 2009, average IMR for member countries in EAP, ECA, LAC and MENA remained below the OIC and developing and world averages (58, 45 and 42 deaths per 1000 live births respectively).

A similar trend can be observed in case of neonatal mortality rate as well. As shown in Figure 4 (b), NMR remained highest in SA and SSA [i.e. 40 and 39 deaths per 1000 live births respectively] whereas all other OIC regions recorded NMR between 15 to 17 deaths per 1000 live births in 2009. NMR in SA and SSA regions remained higher than the OIC, developing and world averages whereas it was significantly lower in all other OIC regions. In case of stillborns, as shown in Figure 4 (c), once again member countries in SA and SSA regions witnessed the highest prevalence with 41 and 32 stillborns per 1000 births respectively. On the other side of the scale, member countries in ECA region registered the lowest prevalence of stillborns followed by MENA, EAP and LAC.

At the individual country level, IMR in OIC member countries ranges from a low of 5 deaths per 1000 live births in Brunei

Figure 4: Newborn Mortality in OIC Regions

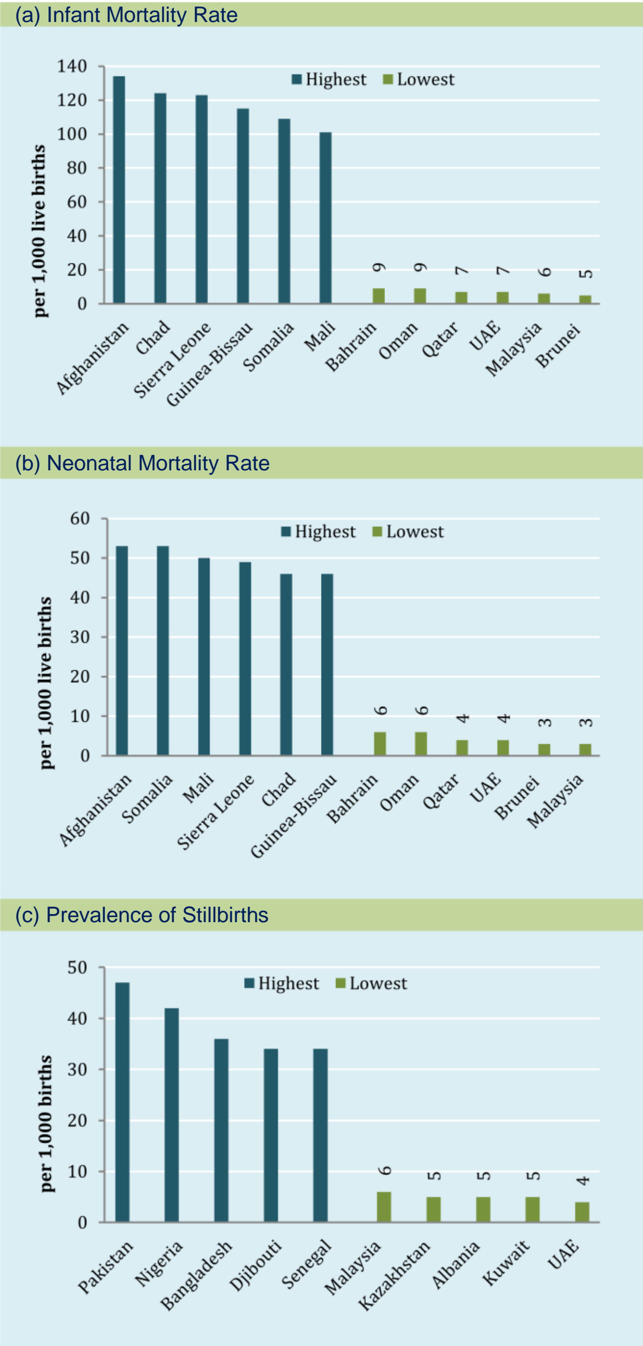


Source: Annex Table A.1

Darussalam to a high of 134 in Afghanistan (Figure 5 (a)). Four member countries from MENA region registered the lowest IMR, ranging from nine to seven deaths per 1000 live births. On the other hand, five member countries from SSA and one from SA region registered IMR of over 100 deaths per 1000 live births. At the global level, these six countries are ranked among the top ten countries with highest IMR. In 2009, IMR ranged between 64 to 96 deaths per 1000 live births for 16 member countries (14 of them from SSA region). In six of these countries (all from SSA), IMR was equal or greater than 80 deaths per 1000 live births. On the other hand, 28 member countries registered IMR ranging from 11 to 52 deaths per 1000 live births. In ten of these 28 countries, IMR remained equal or lower than 20 deaths per 1000 live births.

In 2009, as shown in Figure 5 (b), Afghanistan and Somalia recorded the highest NMR (53 deaths per 1000 live births) in OIC region, closely followed

Figure 5: Member Countries with Highest and Lowest IMR, NMR and Stillbirths



Source: Annex Table A.1

by Mali (50 deaths), Sierra Leon (49 deaths), Chad and Guinea Bissau (46 deaths per 1000 live births). Among these countries, Afghanistan and Somalia are ranked 1st with respect to highest NMR in the world, Mali is ranked 4th, Sierra Leon is ranked 5th, and Chad and Guinea Bissau are ranked 6th. In contrast, Malaysia and Brunei recorded the lowest NMR in OIC region (3 deaths per 1000 live births) followed by UAE and Qatar (4 deaths) and Oman and Bahrain (6 deaths per 1000 live births) [see Annex Table A.1].

A similar trend can be observed in case of prevalence of stillbirths in OIC member countries. As shown in Figure 5 (c), Pakistan registered the highest prevalence of stillbirths (47 stillborns per 1000 births) followed by Nigeria (42 stillborns), Bangladesh (37 stillborns) and Djibouti and Senegal (34 stillborns per 1000 births). In 2009, 16 member countries are included in the top 20 countries with highest prevalence of stillbirths in the world. In these 16 countries, 13 are from SSA region whereas two are from SA and one from MENA region. On the other hand, 26 member countries registered less than 20 stillborns per 1000 births whereas 16 out of these 26 member countries recorded equal or less than 10 stillborns per 1000 births. In these 26 countries, 15 are from MENA region whereas 8 from ECA and 2 from EAP region [see Annex Table A.1].

Progress on some Selected Measures to Improve MNH

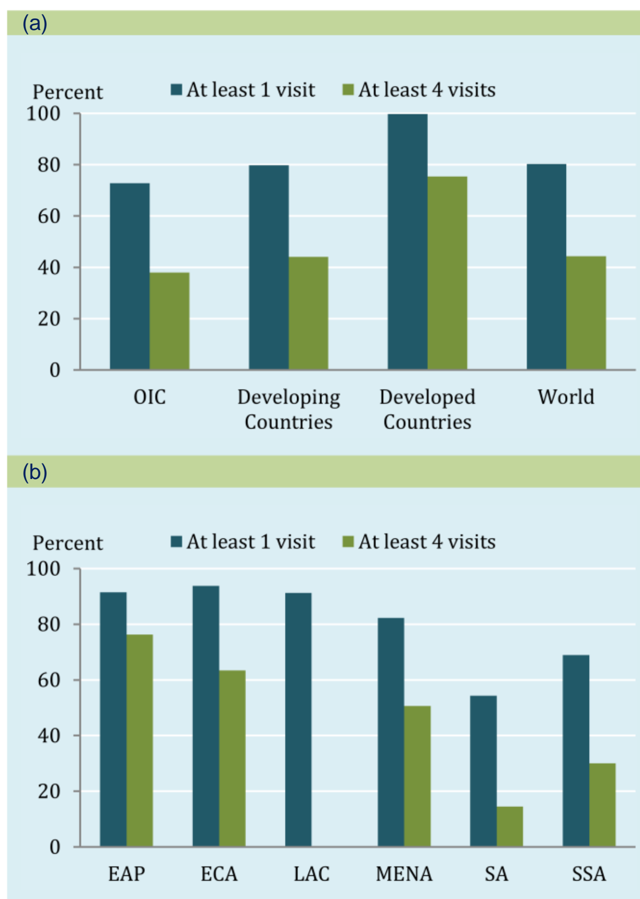
Health experts are of the view that some small and affordable measures can play a significant role to reduce the health risks that women and babies face during pregnancy, delivery and after childbirth. Therefore, most maternal and newborn deaths are avoidable by ensuring quality antenatal care during pregnancy, skilled care during childbirth, and care and support in the weeks after childbirth. In this section, we will evaluate the performance of OIC member countries with respect to some selected interventions to improve MNH conditions.

Antenatal Care

Antenatal care and counselling is the entry point to the formal health care system and provides a solid base to monitor and improve the mother-baby health by identifying and preventing/controlling antenatal complications at the earliest stage (WHO, 2010). Antenatal Care Coverage (ANCC) measures the proportion of total pregnant woman aged 15-49 who visited a skilled health professional for reasons

related to pregnancy. For the quality and effectiveness of ANCC, number of visits and their timing are also considered very important. In this regard, WHO recommends at least four antenatal visits for uncomplicated pregnancies and advises first visit at a very early stage of pregnancy followed by the second from 24-28th weeks, the third at 32nd weeks and the fourth around 36th week.

Figure 6: Antenatal Care Coverage



Source: Annex Table A.2

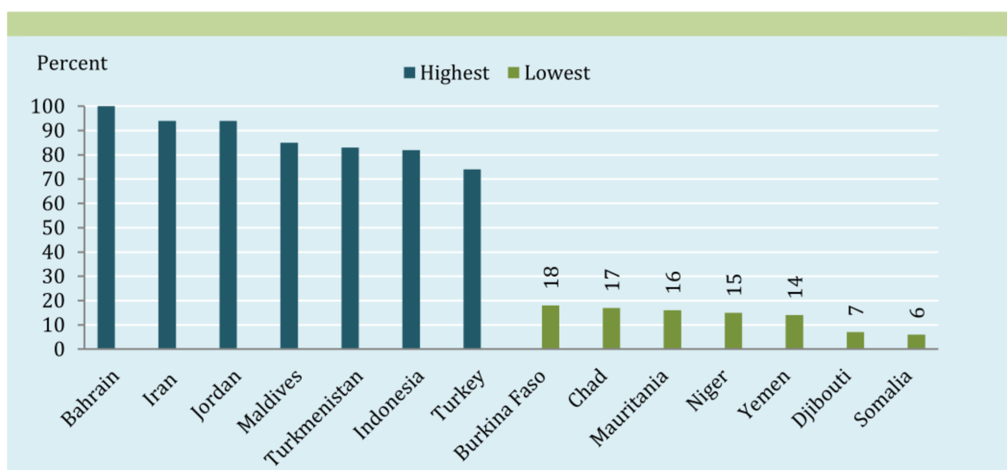
The provision of quality ANCC is a major concern in the OIC member countries. During the period 2000-2010, around 73 percent of total pregnant women in member countries used antenatal care services at least once during the pregnancy whereas 38 percent of total pregnant women benefited from recommended four antenatal checks up. In both cases, OIC average remained below the average of the developing countries and world.

At the OIC regional level, both in terms of at least one and at least four antenatal visits, ANCC remained comparatively very low in SA and SSA regions. As shown in Figure 6(b), in SA and SSA region only 15 percent and 30 percent pregnant women went for four antennal checks up whereas this share was 54 percent and 69 percent in case of one antenatal visit respectively.

At the individual country level, more than two thirds (67 percent to 100 percent) of total pregnant women visited a health clinic at least four times for antenatal checks

up in 10 member countries. Out of these 10 countries, Bahrain, Iran and Jordan remained at the top with ANC Coverage rate of over 90 percent (Figure 7). Among others, 7 member countries registered ANC coverage rate of 50 percent to 66 percent. 6 out of these 7 countries are from SSA region, namely: Gabon (63 percent), Benin (61 percent), Cameroon (60 percent), Sierra Leon (56 percent), Mozambique (53 percent) and Guinea (50 percent). In contrast, 18 member countries registered ANC coverage rate of less than 50 percent. Out of these 18 members, ANC coverage remained less than 20 percent in 7 countries (see Annex Table A.2). The situation remained worse in Djibouti and Somalia, where even less than 10 percent of total pregnant women actually benefitted from WHO recommended four antenatal visits during the period under consideration (Figure 7).

Figure 7: Antenatal Care Coverage (at least 4 visits) in OIC Member Countries



Source: Annex Table A.2

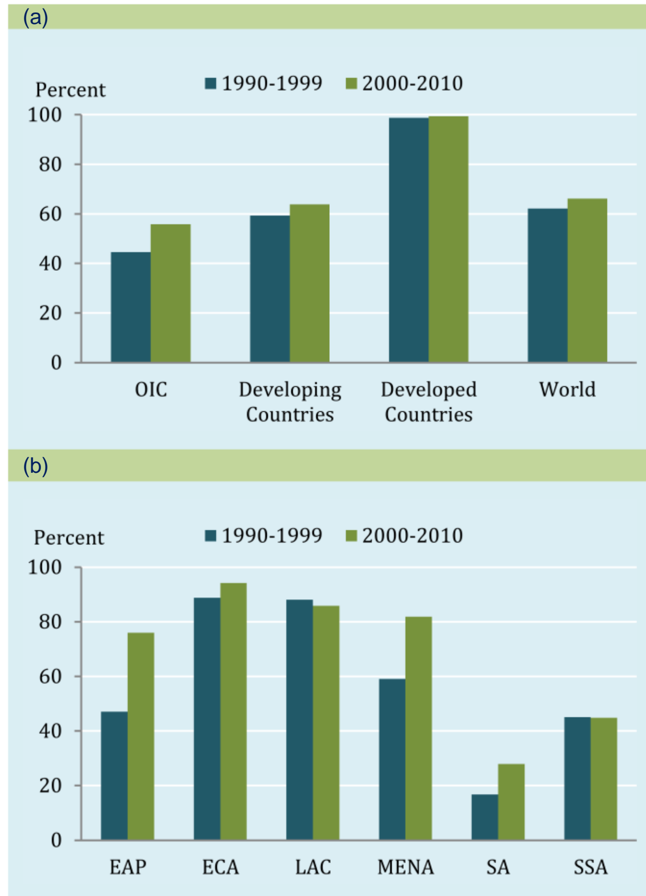
Births Attended by Skilled Health Personnel

Skilled health care and assistance at the time of delivery are very critical for the health and very survival of both mother and baby. According to the WHO estimates (Countdown Report, 2010), lack of proper health care during labor and child birth is the major cause for about 2 million maternal and newborn deaths

every year. Most of these deaths could be prevented by ensuring assistance of skilled health personnel - a doctor, nurse or midwife- during the birth.

In the last two decades, OIC member countries have exerted great efforts to increase the proportion of total deliveries attended by skilled health personnel. These noble efforts have actually paid off and the proportion of total births attended by skilled personnel increased from 45 percent in 1990-1999 to 56 percent in 2000-2010, corresponding to an increase of 11 percentage points which remained quite higher than that for world (four percentage points) and developing countries (five percentage points). However, despite this positive trend, OIC averages remained well below the world, developed, and developing countries averages during the period under consideration (Figure 8 (a)).

Figure 8: Births Attended by Skilled Personnel



Source: Annex Table A.2

Since 1990s, the coverage of skilled personnel attendance at the time of delivery has improved in all OIC regions except in LAC where the coverage rate has slightly declined. Like ANCC, the situation remained quite alarming in member countries located in SA and SSA regions where majority of the births (72 percent and 55 percent respectively) are still taking place without any skilled health care and assistance at the time of delivery (Figure 8 (b)).

At the individual country level, majority of OIC members managed to improve the coverage of skilled health attendants at the time of delivery during the period 1990-2010. According to the latest estimates, in 24 member countries more than 90 percent deliveries were assisted by skilled health personnel in 2000-2010. In 11 of these countries (Brunei, Kazakhstan, Kuwait, Libya, Malaysia, Oman, Qatar, Saudi Arabia, Turkmenistan, UAE and Uzbekistan) all births (100 percent) were attended by skilled health personnel. In contrast, less than 50 percent of total pregnant women received skilled health care during birth in 14 OIC member countries (see Annex Table A.2). In three of these 14 countries, namely: Afghanistan, Bangladesh and Chad, less than 30 percent of total births were attended by a skilled health personnel during 2000-2010 (Figure 9).

Figure 9: OIC Members with Less than 50 percent Births Attended by Skilled Personnel

Source: Annex Table A.2

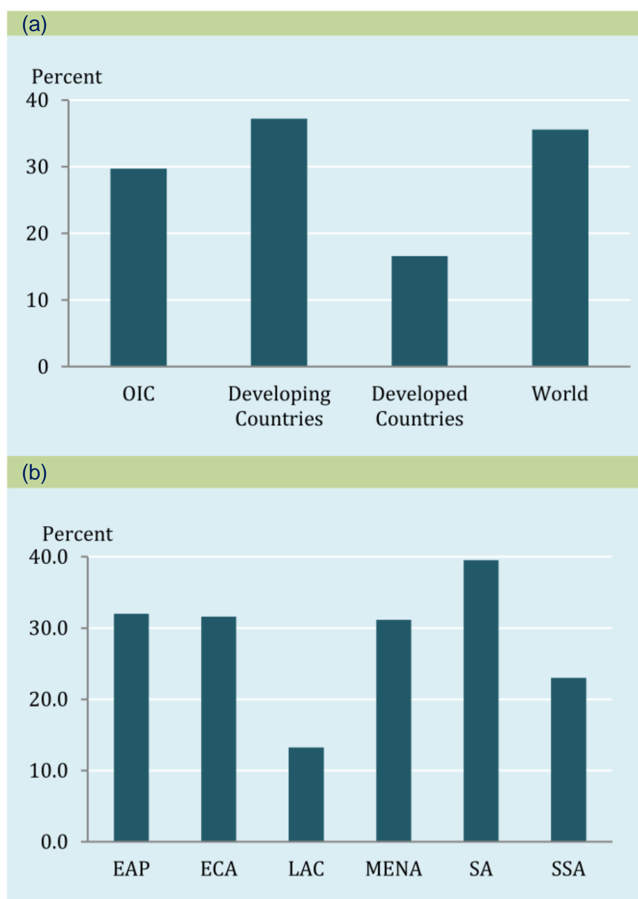
Infants Exclusively Breastfed

Globally, every year about four million babies die during the very first week of life mainly due to poor neonatal conditions. According to the UNICEF, one of the best measures to prevent most of these deaths is an early initiation of breastfeeding. Breast milk is fundamental to child health, growth, development, and survival. As it not only provides newborns with nutrition but also protects them from diarrhea

and acute respiratory infections, stimulates their immune systems and improves response to vaccinations. Keeping in view these benefits of breast milk, health experts are of the opinion that exclusive breastfeeding from the birth to six months could help to reduce neonatal mortality by 20 percent (Niles. C, 2010).

However, in spite of its crucial importance for the healthy survival of a newborn, a vast majority of mothers don't exclusively breastfeed their children for the first six months of life. As shown in Figure 10, worldwide slightly more than one third (36 percent) of newborns were breastfed during 2000-2010. In developing countries where bulk of neonatal deaths occurs about 37 percent of newborns were exclusively breastfed. While in OIC member countries, 30 percent of newborns were exclusively breastfed for the first six months of their life.

Figure 10: Infants Exclusively Breastfed, 2000-2010



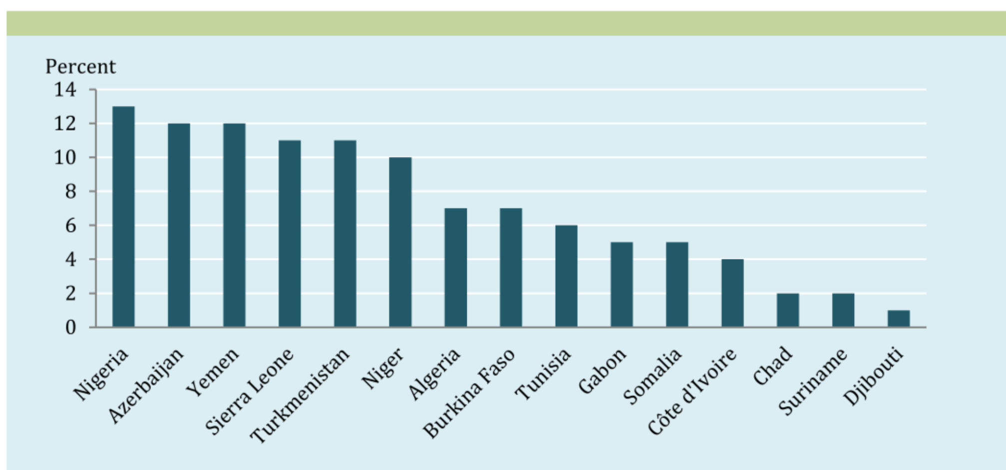
Source: Annex Table A.3

At the OIC regions level, prevalence of exclusive breastfeeding for the first six months was highest in SA and EAP where 39.5 percent, 32 percent of newborns were exclusively breastfed respectively (Figure 10). In contrast, breastfeeding was lowest in LAC and SSA where only 13.2 percent and 23 percent of newborns were exclusively breastfed respectively. Among other regions, over 31.6 percent of newborns in ECA and 31.1 percent in MENA were exclusively breastfed in 2000-

2010. Prevalence of exclusive breastfeeding in SA region remained higher than the world, OIC and developing countries averages.

At the individual country level, prevalence of breastfeeding ranged from a low of one percent in Djibouti to a high of 60 percent in Uganda. Among the 45 OIC member countries with available data, breastfeeding rate remained higher than the developing countries average of 37 percent in 11 member countries (see Annex table A.3). In contrast, prevalence of breastfeeding remained less than 15 percent in 15 member countries. In 9 of these 15 countries, it remained even less than 10 percent. As shown in Figure 12, member countries with lowest prevalence of breastfeeding include Algeria (7 percent), Burkina Faso (7 percent), Tunisia (6 percent), Gabon (5 percent), Somalia (5 percent), Côte d'Ivoire (4 percent), Chad (2 percent), Suriname (2 percent), and Djibouti (1 percent).

Figure 11: OIC Member Countries with Lowest Prevalence of Breastfeeding



Source: Annex Table A.3

Adolescent Fertility

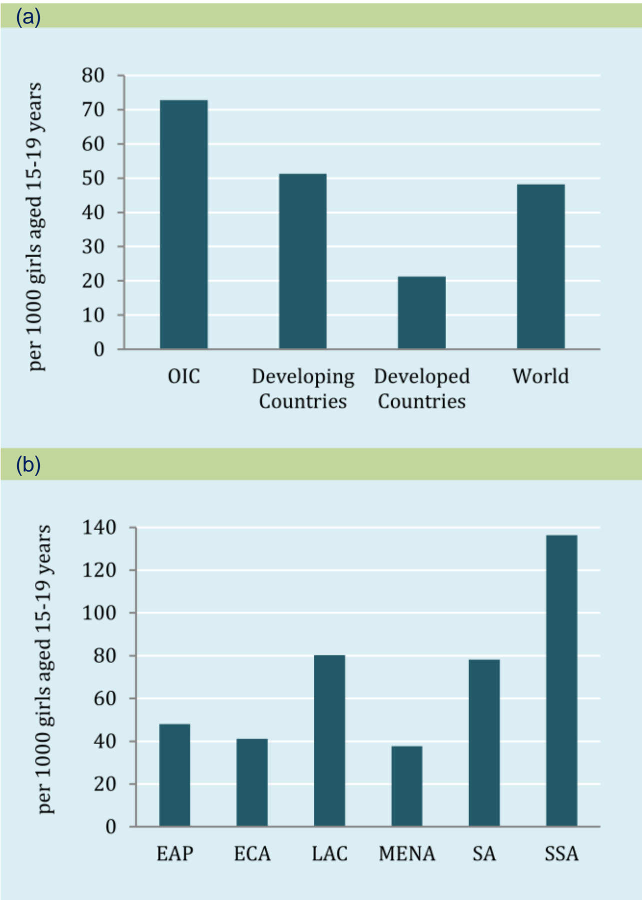
According to the WHO estimates, about 16 million girls aged between 15 to 19 years give birth every year. This accounts for about 11 percent of total births worldwide. Majority of these teenage mothers (more than 90 percent) live in developing countries (Factsheet No: 345, August 2010). Provided the fact that adolescents are more likely to experience complications during the pregnancy and delivery, both mothers and babies are at a greater risk of mortality.

During 2000-2008, global adolescent mortality rate (AFR) was 48 births per 1000 girls aged 15–19 years. This means, on average, one in 21 girls aged between 15 to 19 years gave birth during this period. The adolescent fertility rates remained distinctively different in developed and developing countries. As shown in Figure 12 (a), AFR in developed countries was just 21 births per 1000 girls aged 15–19 years compared to 51 in developing countries. This means that one in 47 girls aged between 15 to 19 years gave birth in developed countries compared to one in 19 in developing countries.

In 2000-2008, AFR in OIC member countries remained much higher than that for world, developed and developing countries. As shown in Figure 12 (a), AFR in OIC was 73 births per 1000 girls aged 15–19 years which means one in 14 girls aged between 15 to 19 years gave birth during 2000-2008. Among others, early age marriages especially in rural areas remained the leading cause of higher AFR both in OIC and developing countries.

Significant disparities existed among the OIC regions as AFR ranged from a low of 38 births per 1000 girls aged 15–19 years in MENA to a high of 136 in SSA during 2000-2008 (Figure 12 (b)). This means that one in 27 girls aged between 15 to 19 years gave birth in MENA region compared to one in 7 in SSA. Member countries in SA and LAC region recorded AFR

Figure 12: Adolescent Fertility Rate, 2000-2008

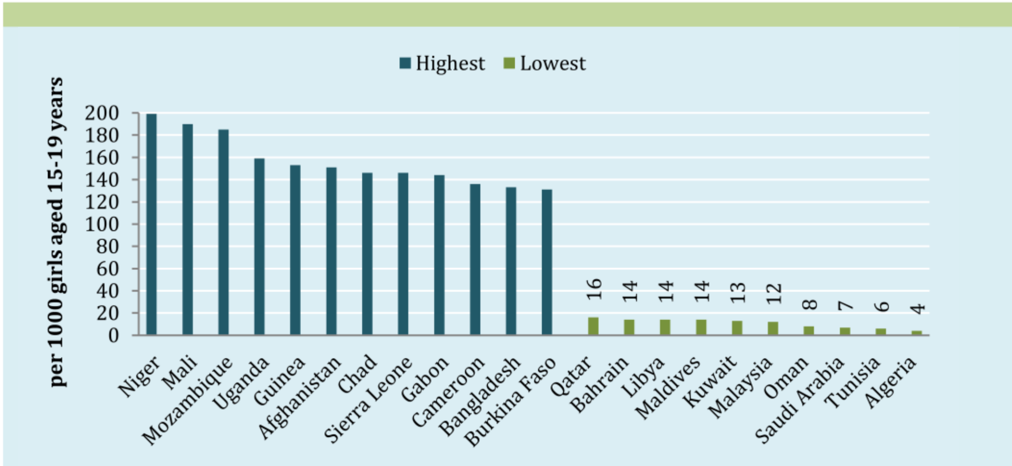


Source: Annex Table A.3

of 78 and 80 births per 1000 girls aged 15–19 years respectively whereas it was 41 and 48 births per 1000 girls aged 15–19 years in ECA and EAP respectively.

At the individual country level, AFR in OIC member countries ranged from a low of four births per 1000 aged 15-19 years in Algeria to a high of 199 in Chad (Figure 13). Eight member countries from MENA region registered the lowest AFR, ranging from 16 to four births per 1000 girls aged 15-19 years. On the other hand, 15 member countries from SSA region registered AFR of over 100 births per 1000 girls aged 15-19 years. Out of these 16 member countries, 12 were among the top 20 countries with highest AFR in the world. In 2009, Niger and Mali were ranked 1st and 3rd with respect to AFR in the world followed by Mozambique (ranked 4th), Uganda (ranked 7th), Guinea (ranked 8th) and Afghanistan (ranked 9th). In contrast, AFR remained less than 50 births per 1000 girls aged 15-19 years in 25 member countries. In 13 of these 25 countries, AFR remained even less than 20 births per 1000 girls aged 15-19 years. In general, 31 member countries registered AFR lower than the OIC average of 73 births per 1000 girls aged 15-19 years. In 25 of these 31 countries, AFR remained lower than the developing and world averages of 51 and 48 births per 1000 girls aged 15-19 years, respectively [see Annex Table A.3].

Figure 13: Members with Highest and Lowest Adolescent Fertility Rate, 2000-2008



Source: Annex Table A.3

Major Challenges and Policy Recommendations

Provision of adequate and quality MNH services is a must to overcome the loss of precious lives during pregnancy, childbirth and after childbirth. Over the years, a lot of progress has been made to improve the MNH conditions worldwide; however these gains mostly remained concentrated in developed regions. Many developing countries, including some OIC member countries are still suffering from high prevalence of maternal and newborn deaths. The MNH situation remained alarming especially in member countries located in SA and SSA regions. The poor MNH performance in these regions, among other factors, is mainly attributed to the lack of adequate and sustainable financial resources, poor health infrastructure and insufficient trained health workforce. In this section, we will give an overview of health financing and workforce situation in OIC member countries; and will also make some recommendations to improve it.

Health Financing

Health financing is a critical component of health systems. There is global evidence that to achieve the goal of universal health coverage it is necessary to generate a significant amount of financial resources for health through prepaid and pooled contributions like tax-based financing, social health insurance and private health insurance; whereas the share of direct out-of-pocket spending on health should be reduced (WHO, 2005).

Out-of-pocket health spending is considered as the most regressive way of health financing and has variety of harmful consequences especially for the low income and poor households. However, despite its negative impacts on accessibility of heath care services, it remained the most widely used method to pay for health services in many OIC member countries. In 2009, only 6 member countries recorded out-of-pocket expenditure as a percentage of total health expenditure of less than 15 percent. Provided the fact that more than 15 percent share of out-of-pocket spending in total health expenditure not only increase the financial vulnerability of low income people but also discourage them to use needed health care services (Countdown Report, 2000-2010), prevalence of poor MNH conditions in many member countries could easily be explained. The gravity of situation could also be explained with the fact that out-of-pocket spending accounted for more than 50 percent of total health expenditure in 22 member countries. Out of

these 22 countries, 10 are from SSA, 5 from MENA, 4 from ECA and 3 from SA region (SESRIC, 2011).

In this regard member countries need to consider following points:

- Reform health financing system to enable wider access. The reforms require continued increasing investment and public spending on health, reducing out-of-pocket spending and increasing pre-payment and risk-pooling, which may include tax-based financing, compulsory social insurance and other types of health insurance.
- Increase the budgetary allocations for health sector and establish an accountability mechanism to ensure transparent and efficient use of these funds.
- Take necessary measures to facilitate Intra-OIC investment in health sector.
- Collaborate with international agencies like WHO, UNICEF and World Bank to benefit from their expertise and financial contribution to build health infrastructure.
- Start prepayment and risk pooling based health financing schemes like Seguro Popular in Mexico, New Rural Cooperative Medical Scheme in China and Social Health Insurance Scheme in Mali to overcome financial barriers to MNH care access especially in rural areas (WHO Countdown Report, 2000-2010).

Health Workforce

Health workforce is the back bone of health care system in a country. It is a well-established fact that the size, composition and distribution of health workers play an important role for prompt and efficient delivery of health care services. Over the years, among others, shortage of well-trained health workforce remained the most basic reason behind limited outreach of primary health care and high maternal and newborn mortality in the developing countries (WHO, 2006).

Being a substantial part of the developing world, OIC member countries are no exception. According to the latest estimates, health workforce shortages are especially serious in member countries located in South Asia and Sub-Saharan

Africa region. In these regions, density of health workers (i.e. the number of doctors, nurses and midwives per 10,000 people) remained below the 23 threshold level for considering a country/region to be facing a health workforce crisis. At the individual country level, only 28 OIC member countries meet the critical threshold, of 23 doctors, nurses and midwives per 10,000 people, generally considered necessary to deliver essential health services. Out of these 28 countries, 14 are from MENA, 8 from ECA and 3 from EAP; whereas in SSA and SA where majority of maternal and newborn deaths are occurring, only Gabon and Maldives meet the threshold (SESRIC, 2011).

Keeping in view this state of affairs, following recommendations can be made:

- Establish a health service commission for training, recruitment and management of health workforce both at national and Intra-OIC level.
- Enhance cooperation both at national and Intra-OIC level, to increase investment in health education and training institutions.
- Launch scholarship programs to attract more students in health professions.
- Ensure mutual recognition of medical diplomas, certificates and degrees.
- Take necessary measures to integrate teaching and learning with clinical practice.
- Motivate the health workers through financial and non-financial incentives to work in underserved rural and remote areas.
- Collaborate with NGOs and international bodies to train and deploy health workers at community level (like community midwives in Indonesia and Leady Health Visitor (LHV) program in Pakistan) to provide MNH services in rural areas.

OIC MNH Initiatives

The domain of health constitutes an important element among the extensive range of mandates which emanate from the Ten Year Program of Action. This is based on the realization of the fact that health is central to overall human development and reduction of poverty.

The 11th Islamic Summit Conference, held in Dakar in 2008 called upon the OIC General Secretariat and the IDB to step up their activities, with the involvement of relevant international organizations, such as the WHO, in the area of combating diseases and epidemics. It also appreciated the establishment of contact between the OIC and the US Department of Health and Human Services and their agreement to formalize their relations. Subsequently, the OIC and the US Government signed a Cooperation Framework on "Reaching Every Mother and Baby in the OIC Emergency Care" on 1st December 2008.

The 35th, 36th and 37th sessions of the Islamic Council of Foreign Ministers (ICFM) adopted resolutions in the area of health which, inter alia, underscored the importance of cooperation in the field of health related Millennium Development Goals and requested the OIC General Secretariat to explore with relevant international organizations and specialized UN agencies such as WHO, UNICEF, UNFPA and UNAIDS the possibilities of elaboration and implementation of feasible regional health projects. The 37th ICFM appreciated the efforts of the OIC General Secretariat to coordinate with Global Polio Eradication Initiative and Roll Back Malaria Partnership. It requested the General Secretariat to expedite the implementation of the project "Reaching Every Mother and Baby in the OIC with Emergency Care" under the OIC-US Cooperation Framework signed in 2008.

The 1st Islamic Conference of Health Ministers (Kuala Lumpur, June 2007) adopted Resolution No.KLOICHMC-1/2007/2.5 on Mother and Child Health. The 2nd Islamic Conference of Health Ministers (Tehran, 1-4 March 2009) under the theme "Health Equity in Islamic Ummah" issued Declaration that encouraged the international organizations to assist the OIC Member States to expand national immunization programs to reach all unvaccinated children. It requested the OIC, WHO and other relevant international organizations to cooperate to foster health capacity building programs in the OIC Member States to promote health equity. The 2nd Conference also approved establishment of a Steering Committee on Health to monitor the implementation of the decisions of the Health Ministers Conferences. The Steering Committee functions under the authority of and is guided by the Islamic Conference of the Ministers of Health.

OIC-US Cooperation on MNH

In pursuance of the resolution of the 1st Islamic Conference of Health Ministers, the OIC General Secretariat with the assistance of the Center of Disease Control and

Prevention (CDC) of US prepared a project entitled "Reaching Every Mother and Baby in the OIC Emergency Care". The OIC and the US Government signed a Cooperation Framework on 1st December 2008 to implement the project.

The project has the followings specific objectives to:

- reach up to one million women and their babies annually;
- train midwives to achieve the required numbers of care providers for mothers and babies;
- ensure basic emergency care in primary care centers and obstetric surgical units with specialized services;
- equip computerized/palm pilot/internet based surveillance and monitoring capacity in primary and specialized center.

The 36th CFM requested the OIC General Secretariat to fully implement the project entitled "Reaching Every Mother and Baby in the OIC with Emergency Care ".

The President of the United States in his speech delivered in Cairo on June 4, 2009, inter alia, committed to expand partnerships with Muslim communities to promote child and maternal health under the action to be taken in the Science and Technology domain.

In August 2010, a delegation of USAID and US State Department visited OIC Headquarters in Jeddah to discuss the implementation of US-OIC project on Mother Child Health. It was decided to pilot the project in two OIC countries namely Bangladesh from the Asian region and Mali from African region.

The OIC and USAID delegations visited Bamako, Mali on 1 – November 2010 and met with the Government of Mali on the implementation of the project. The meeting identified causes of high mortality rate for mother and infants and recommended various actions towards reducing the rate to meet the commitment of the government of Mali at the UN GA in September 2010. The partnerships between OIC-US Government and Government of Mali to reduce mortality rate of mother during delivery and infant for first 4 weeks was launched on 4 November 2010. The implementation of the project will involve religious and community leaders, women groups, civil societies and a number of international partners and expected to commence in 2011.

Conclusion

Over the years, many OIC member countries witnessed significant improvement in maternal and newborn health care coverage. As a result, maternal and newborn mortality rates have witnessed declining trends and life expectancy at birth has been improved. However, despite these positive trends, OIC member countries are still lagging behind the world and developing countries averages. The MNH situation is particularly alarming in South Asia and Sub-Saharan Africa region. The poor MNH care coverage is strongly related with the lack of adequate and sustainable financial resource, poor health infrastructure and insufficient trained health workforce. However, the nature and magnitude of these key challenges varies greatly across the OIC member countries and therefore no single solution suits them all. However, in general, there is a need for long term commitment of the member countries governments to put MNH higher on their national development agendas and collaborate, both at regional and international level, to build necessary health infrastructure and train workforce. There is also need for embarking on health financing reforms by initiating prepayment and risk pooling based financing schemes to improve the accessibility and affordability of MNH care services. Furthermore, there is also need for involvement of all stakeholders: clients, health providers and community leaders, to develop, execute and evaluate national MNH programs in OIC member countries.

References

Niles, C., 2010, UNICEF: World Breastfeeding Week.

< http://www.unicef.org/childsurvival/index_55388.html >.

SESRIC, 2011. OIC Health Report 2011.

WHO, 2011. World Health Statistics 2011:

WHO, 2010. Countdown to 2015 Decade Report (2000–2010): Taking Stock of Maternal, Newborn and Child Survival.

WHO, 2006. The World Health Report: Working Together for Health.

WHO, 2005. Achieving Universal Health Coverage: Developing the Health Financing System.

Annex Tables

Table A.1: Maternal and Newborn Mortality

	MMR per 100,000 live births		IMR per 1000 live births		NMR per 1000 live births		Stillbirth per 1000 total births
	1990	2008	1990	2009	1990	2009	2009
Afghanistan	1700	1400	167	134	60	53	29
Albania	48	31	41	13	20	7	5
Algeria	250	120	50	29	27	17	11
Azerbaijan	64	38	78	30	31	15	12
Bahrain	25	19	14	9	8	6	9
Bangladesh	870	340	102	41	58	30	36
Benin	790	410	111	75	42	32	24
Brunei Darussalam	28	21	9	5	6	3	6
Burkina Faso	770	560	110	91	41	37	26
Cameroon	680	600	91	95	36	37	26
Chad	1300	1200	120	124	45	46	29
Comoros	530	340	90	75	41	36	27
Côte d'Ivoire	690	470	105	83	45	39	27
Djibouti	370	300	95	75	41	35	34
Egypt	220	82	66	18	33	11	13
Gabon	260	260	68	52	30	25	17
Gambia	750	400	104	78	41	32	26
Guinea	1200	680	137	88	53	40	24
Guinea-Bissau	1200	1000	142	115	52	46	30
Guyana	310	270	47	29	32	21	17
Indonesia	620	240	56	30	33	19	15
Iran	150	30	55	26	31	17	13
Iraq	93	75	42	36	26	23	9
Jordan	110	59	32	22	21	15	13
Kazakhstan	78	45	51	26	27	15	5
Kuwait	10	9	14	11	9	7	5
Kyrgyzstan	77	81	63	32	29	17	10
Lebanon	52	26	33	11	19	7	9
Libya	100	64	32	17	18	11	10
Malaysia	56	31	16	6	8	3	6
Maldives	510	37	80	11	40	8	13
Mali	1200	830	139	101	57	50	23
Mauritania	780	550	81	74	43	41	27
Morocco	270	110	69	33	37	20	20
Mozambique	1000	550	155	96	53	41	28
Niger	1400	820	144	76	48	35	23
Nigeria	1100	840	125	86	49	39	42
Oman	49	20	37	9	20	6	7
Pakistan	490	260	101	70	53	42	47
Qatar	15	8	18	7	10	4	8
Saudi Arabia	41	24	35	18	20	11	8
Senegal	750	410	73	51	41	31	34
Sierra Leone	1300	970	166	123	59	49	30
Somalia	1100	1200	109	109	53	53	30
Sudan	830	750	78	69	40	37	24
Suriname	84	100	44	24	20	12	15
Syria	120	46	30	14	16	8	12
Tajikistan	120	64	91	52	37	24	12
Togo	650	350	89	64	41	32	25
Tunisia	130	60	40	18	23	11	10
Turkey	68	23	69	18	34	12	11
Turkmenistan	91	77	81	41	33	20	13
Uganda	670	430	111	79	38	31	25
United Arab Emirates	28	10	15	7	10	4	4
Uzbekistan	53	30	61	32	29	17	6
Yemen	540	210	88	51	43	29	23
OIC	**609**	**427**	**87**	**58**	**41**	**30**	**26**
Developing	**432**	**289**	**69**	**45**	**36**	**26**	**20**
Developed	**12**	**14**	**8**	**5**	**5**	**3**	**3**
World	**397**	**266**	**64**	**42**	**33**	**24**	**19**

Source: WHO, World Health Statistics 2011.

Table A.2: Antenatal Care Coverage and Births Attended by Skilled Personnel

	ANCC (%), 2000-2010		Birth Attendance (%)	
	At least 1 visit	At least 4 visits	1990–1999	2000–2010
Afghanistan	36	…	…	14
Albania	97	67	89	99
Algeria	89	…	77	95
Azerbaijan	77	45	100	89
Bahrain	100	100	98	97
Bangladesh	52	21	14	18
Benin	84	61	64	78
Brunei Darussalam	99	…	99	100
Burkina Faso	85	18	42	54
Cameroon	82	60	55	59
Chad	39	17	12	21
Comoros	74	…	52	62
Côte d'Ivoire	85	45	45	57
Djibouti	92	7	…	93
Egypt	74	66	46	79
Gabon	94	63	…	87
Gambia	98	…	…	57
Guinea	88	50	31	46
Guinea-Bissau	78	…	…	39
Guyana	92	…	93	83
Indonesia	93	82	43	73
Iran	99	94	…	97
Iraq	84	…	…	80
Jordan	99	94	97	99
Kazakhstan	100	…	100	100
Kuwait	100	…	98	100
Kyrgyzstan	97	…	98	98
Lebanon	96	71	89	98
Libya	93	…	94	100
Malaysia	79	…	81	100
Maldives	99	85	…	95
Mali	70	35	40	49
Mauritania	75	16	40	61
Morocco	68	31	40	63
Mozambique	92	53	44	55
Niger	46	15	18	33
Nigeria	58	45	42	39
Oman	100	…	91	100
Pakistan	61	28	19	39
Palestine	...	...	...	...
Qatar	100	…	99	100
Saudi Arabia	97	…	91	100
Senegal	87	40	47	52
Sierra Leone	87	56	…	42
Somalia	26	6	34	33
Sudan	64	…	85	49
Suriname	90	…	80	90
Syria	96	42	76	95
Tajikistan	89	49	81	88
Togo	84	…	51	62
Tunisia	96	68	81	95
Turkey	92	74	81	91
Turkmenistan	99	83	…	100
Uganda	94	48	38	42
United Arab Emirates	100	…	99	100
Uzbekistan	99	…	98	100
Yemen	47	14	22	36
OIC	**73**	**38**	**45**	**56**
Developing Countries	**80**	**44**	**59**	**64**
Developed Countries	**100**	**75**	**99**	**99**
World	**80**	**44**	**62**	**66**

Source: WHO, World Health Statistics 2011.

Table A.3: Infants Exclusively Breastfed and Adolescent Fertility Rate (AFR)

	Infants Exclusively Breastfed (%)	AFR per 1000 girls aged 15–19
	2000–2010	2000–2008
Afghanistan	...	151
Albania	39	17
Algeria	7	4
Azerbaijan	12	42
Bahrain	...	14
Bangladesh	43	133
Benin	43	114
Brunei Darussalam	...	31
Burkina Faso	7	131
Cameroon	21	136
Chad	2	146
Comoros	21	95
Côte d'Ivoire	4	111
Djibouti	1	27
Egypt	53	50
Gabon	5	144
Gambia	41	104
Guinea	48	153
Guinea-Bissau	28	...
Guyana	21	90
Indonesia	32	52
Iran	44	35
Iraq	25	68
Jordan	22	28
Kazakhstan	17	31
Kuwait	...	13
Kyrgyzstan	32	29
Lebanon	...	18
Libya	...	14
Malaysia	...	12
Maldives	48	14
Mali	34	190
Mauritania	19	61
Morocco	15	18
Mozambique	37	185
Niger	10	199
Nigeria	13	123
Oman	...	8
Pakistan	37	20
Qatar	...	16
Saudi Arabia	...	7
Senegal	34	96
Sierra Leone	11	146
Somalia	5	123
Sudan	34	...
Suriname	2	66
Syria	29	75
Tajikistan	25	27
Togo	48	...
Tunisia	6	6
Turkey	42	56
Turkmenistan	11	21
Uganda	60	159
United Arab Emirates	...	22
Uzbekistan	26	26
Yemen	12	80
OIC	**30**	**73**
Developing Countries	**37**	**51**
Developed Countries	**17**	**21**
World	36	48

Source: WHO, World Health Statistics 2011.

SESRIC

Kudüs Caddesi No 9, Diplomatik Site:

06450 Çankaya, Ankara, Turkey

Tel: +90-312-468 6172 (4 Lines) Fax: +90-312-467 3458

E-mail: oicankara@sesric.org Web: www.sesric.org