Standing Committee
for Economic and Commercial Cooperation
of the Organization of Islamic Cooperation (COMCEC)

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Proceedings of the 14th Meeting of the COMCEC Poverty Alleviation Working Group

"Child and Maternal Mortality in Islamic Countries"

COMCEC COORDINATION OFFICE
November 2019

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PROCEEDINGS OF THE 14TH MEETING OF THE COMCEC POVERTY ALLEVIATION WORKING GROUP ON

"Child and Maternal Mortality in Islamic Countries"

(November 6th 2019, Ankara, Turkey)

COMCEC COORDINATION OFFICE
November 2019

For further information please contact:

Mr. Mehmet Akif Alanbay, Expert

COMCEC Coordination Office
Necatibey Caddesi No: 110/A
06100 Yücetepe
Ankara/TURKEY
Phone : 90 312 294 57 10
Fax : 90 312 294 57 77
web : www.comcec.org
e-mail : poverty@comcec.org
malanbay@comcec.org

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Introduction

The 14th Meeting of the COMCEC Poverty Alleviation Working Group was held on 6 November 2019 in Ankara, Turkey with the theme of "Child and Maternal Mortality in Islamic Countries".

The Meeting was attended by the representatives of 16 Member States, which have notified their focal points for the Poverty Alleviation Working Group namely, Afghanistan, Algeria, Azerbaijan, Benin, Egypt, Gambia, Indonesia, Iraq, Morocco, Niger, Oman, Pakistan, Palestine, Qatar, Tunisia and Turkey. Representatives of COMCEC Coordination Office, SESRIC, World Health Organization (WHO) Country Office in Turkey, UNICEF Ankara Office and Doctors Worldwide have also attended the Meeting.[1]

The Meeting began with a recitation from Holy Quran. Afterwards, Mr. Deniz GÖLE, Director at COMCEC Coordination Office (CCO), and Mrs. Juldeh CEESAY, Deputy Permanent Secretary of Ministry of Finance and Economic Affairs of the Gambia, as the chairperson of the Meeting, made their opening remarks. Afterwards, the representative of the CCO made a presentation on "COMCEC Poverty Outlook". The presentation informed the participants about the state of poverty and human development as well as the overall health situation in the world and in the OIC Member Countries.

The Meeting continued with the presentation of the research report titled "Child and Maternal Mortality in the Islamic Countries" which was prepared specifically for the 14th Meeting to enrich the discussions.

The afternoon session began with a policy debate session. The policy recommendations on reducing child and maternal mortality in the member countries were discussed by the participants. The Room Document, which was prepared by the CCO in light of the findings of the aforementioned research report as well as the answers of the Member Countries to the policy questions, was considered.

Following the moderation session, representatives of Benin, Indonesia, Morocco, Oman, Palestine and Turkey shared the experiences in maternal and child mortality in their respective countries.

Finally, the participants listened to the representatives of World Health Organization (WHO), UNICEF and Doctors Worldwide to learn about their experiences in contributing to reduction of maternal and child mortality.

[1] The list of participants is attached as Annex 4.

1. Opening Session

In line with the tradition of the Organization of the Islamic Cooperation (OIC) and the COMCEC, the Meeting started with the recitation from the Holy Quran. Afterwards, Mr. Deniz GÖLE, Director at the COMCEC Coordination Office welcomed all participants. Thereafter, Mr. GÖLE briefly mentioned about the COMCEC and its activities. He also explained the details of the programme of the Meeting.

Afterwards, Mrs. Juldeh CEESAY, Deputy Permanent Secretary of Ministry of Finance and Economic Affairs, as the chairperson of the Meeting, welcomed all the participants to the 14th Meeting of the Poverty Alleviation Working Group. After introducing herself, Mrs. CEESAY invited Dr. Güneş AŞIK, Consultant at the COMCEC Coordination Office, to make her presentation on Poverty Outlook in the OIC Member Countries.

2. COMCEC Poverty Outlook

Prof. Dr. Güneş AŞIK, Sector Adviser from the COMCEC Coordination Office presented the key findings of the COMCEC Poverty Outlook.

In her presentation, Dr. AŞIK explained the state of poverty in the world and in the OIC Member Countries by highlighting key indicators on monetary and non-monetary poverty and gave insight about human development and health outcomes in the OIC. Dr. AŞIK emphasized that poverty goes beyond monetary terms and none of the indicator alone is capable of revealing the true dimension of poverty. Poverty arises not only when people do not have enough monetary resources but it also arises when people are deprived of basic rights such as education, health and security which limit their ability to lead a dignified life.

Dr. AŞIK stated that the most frequently used methods to define poverty are US$1.90 a day poverty line of the World Bank (in monetary terms), or the value of a minimum calorie requirement. Poverty headcount ratio at $1.90 a day is the percentage of the population living on less than $1.90 a day at 2011 international prices.

Then, she briefly informed the participants about the indexes used in the Outlook. The Human Development Index (HDI), produced by UNDP since 1990, measures the achievements in key dimensions of human development: a long and healthy life, being knowledgeable and have a decent standard of living. The HDI is a composite index obtained from life expectancy at birth, mean and expected years of schooling and Gross National Income (GNI) per capita. She added that the Multidimensional Poverty Index (MPI) is also a composite index obtained from health, education, and standard of living indicators but includes additional deprivation measures. MPI was also generated by UNDP in 2010 and it reflects the multidimensional nature of poverty such as sanitation, access to electricity and food. Furthermore, the Global Hunger Index (GHI) is designed to measure and track hunger globally, by country and by region as well as calculated each year by the International Food Policy Research Institute (IFPRI). The GHI highlights successes and failures in hunger reduction and provides insights into the drivers of hunger obtained from undernourishment, child wasting, child stunting and under-five mortality rate indicators.

Dr. AŞIK continued her presentation with poverty situation in the world. The last three decades witnessed a significant global poverty reduction. The global poverty headcount ratio fell to 10% in 2015 from 35.9% in 1990. Regarding income groups, while this ratio was 41.8 percent for upper-middle income countries, 44.8 percent for lower-middle income countries and 60.6 percent for low-income countries in 1990, these ratios fell to 1.7 percent, 13.9 percent and 43.9 percent for these income groups respectively in 2015.

With regards to non-monetary poverty indicators, she first touched upon the HDI. Dr. AŞIK expressed that human development category is strongly correlated with income per capita. 50 out of 58 "very high human development" countries are high-income countries, and the "high human development" category is dominated by upper-middle-income countries. Similarly, "medium human development" category is dominated by lower-middle income countries. In the "low human development category", all of the countries are from low income or lower middle-income groups. Regarding the 2019 Global Multidimensional Poverty Index (MPI), she stated that the index was calculated for 101 countries. Trends in MPI show that poverty is on decline, however there is still significant need for progress. Almost 1.3 billion people in these countries live in multidimensional poverty.

Since 2000, significant progress has been made in the fight against hunger. The 2000 Global Hunger Index (GHI) score was 30 for the developing world, while the 2018 GHI score was 20.9. Despite the lower hunger level reflected by the 2018 global GHI score, the number of hungry people in the world remains unacceptably high. According to GHI, 52 countries are still in serious, alarming or extremely alarming situation.

Dr. AŞIK continued her presentation with the state of poverty in the OIC. She pointed out that the OIC represents a highly diverse group in terms of GDP per capita, which varies from 1048 dollars to 126,598 dollars (i.e. Niger and Qatar). The GDP per capita in upper-middle OIC Countries has a diverse pattern. While this indicator is $8,569 in Guyana, it reaches to $31,698 in Malaysia. Malaysia, Turkey and Kazakhstan have high GDP per capita values compared to the rest of the group. In the lower-middle income group, GDP per capita levels vary between $2,828 and $13,057. In the low-income group, GDP per capita levels vary between $1,048 and $3,444. 6 of these countries have GDP per capita levels which are lower than $1,800, namely, Niger, Mozambique, Sierra Leone, Gambia, Togo and Guinea-Bissau. Similarly, the poverty headcount ratio varies remarkably among the OIC Member Countries. In terms of monetary poverty, there is no poor in the high-income countries. The poverty rate is generally low in the upper-middle income countries. Lower-Middle income countries display a highly diverse picture and poverty headcount ratio ranges from 0.3% in Tunisia to 53.5% in Nigeria.

As to the 2019 Global Multidimensional Poverty Index, Dr. AŞIK stated that according to Human Development Report (HDR), among the OIC Member Countries, for which multidimensional poverty headcount ratio is calculated, this ratio is highest in Niger and lowest in Turkmenistan.

She continued her presentation with the GHI values of the Member Countries, which range between under 5 and 45.4. None of the OIC member countries experiences an extremely alarming hunger

situation and 3 member countries are in an alarming situation while 21 countries are in a serious situation. On the other hand, 13 member countries are in moderate hunger situation and 9 countries are in low hunger situation.

Furthermore, Dr. AŞIK expressed that the world human development index (HDI) average has increased from 0.598 to 0.728 between 1990 and 2017. For the same period, the OIC average rose from 0.505 to 0.632 and remained significantly below the OECD and world average. OIC's HDI values are only higher than those of LDCs. On the other hand, the gap between the OIC and developing countries has enlarged in the last 25 years. In 1990, it was only 0.010 points whereas it has risen to 0.049 points in 2017 implying a more rapid progress in developing countries.

In terms of the components of HDI, Dr. AŞIK stated that in terms of life expectancy and expected years of schooling, OIC's index values are slightly below upper middle income countries and higher than low income and lower middle income countries. However, an important point to note is that the HDI ranking of OIC is not improving as rapidly as the GNI of OIC, meaning that the rise in incomes in OIC is not sufficiently translated into development outcomes. Put differently, HDI score of OIC is lower than what its income per capita implies.

Dr. AŞIK summed up status of the poverty indicators in the OIC region as follows; Monetary poverty is significant in the member countries; however, non-monetary poverty is a bigger problem. Nearly a quarter of the population in the OIC member countries live under multidimensional poverty. She added that progress in the human development varies significantly among the member countries. There is an improvement over time; however, a faster progress is needed.

Finally Dr. AŞIK provided information on the improvements in key health outcomes. Health expenditures as a percent of GDP show significant variation across OIC countries, with high income OIC members exhibiting lower expenditures as a share of GDP on average and lowest income countries on average having higher shares. Dr. AŞIK suggested that this reflects the fact that maintaining a certain level of health expenditures exhausts more of the available resources in low income countries. Across OIC countries, Sierra Leone has the highest health expenditures as a percent of GDP with 18.3% and Brunei Darussalam has the lowest, with expenditures equaling 2.6 percent of GDP.

Dr. AŞIK stated that maternal mortality rates were more than halved in most income groups across the World, but there is still need for significant progress to meet the Sustainable Development Goal (SDG) of 70 maternal deaths per 100,000 live births by 2030. Low income OIC members were able to reduce maternal deaths from 915.3 per 100,000 live births in 1990 to 501.5 in 2015. The reduction in lower middle income OIC countries was from 479.7 per 100,000 live births to 270 during the same period. Dr. AŞIK stated that upper middle income OIC countries is just about to meet the SDG target, with 75.3 maternal deaths while high income OIC countries have already met the target with 12.9 maternal deaths per 100,000 live births.

As for under 5 mortality rate, SDG is 25 deaths per 1000 live births by 2030. High income and upper middle income OIC countries have already met the target with child mortality rates equal to 8.5 and

19.2 per 1000 live births in 2018. On the other hand, while recording significant reduction, low income and lower middle income OIC countries still lag behind the targets and the world average with under five child mortality rates equal to 83.2 and 50.6 per 1000 live births. Dr. AŞIK suggested that the improvements across OIC members are encouraging, however, current trends point out that more efforts are clearly needed to improve the health outcomes in low income and lower middle income OIC countries.

3. Child and Maternal Mortality in Islamic Countries

3.1. Overview of Child and Maternal Mortality in the World and the OIC

Dr. Saifuddin Ahmed, Professor, Johns Hopkins University Bloomberg School of Public Health, presented the findings of the research study titled "Maternal and Child Mortality in Islamic Countries".

In his first presentation, Dr. Ahmed provided the situation of maternal and child mortality in the world and contrasted the progress made by the Organization of Islamic Cooperation (OIC) countries towards the MDG targets. Maternal mortality has declined substantially in OIC countries between 1990 and 2015. However, the extent of mortality decline was much lower than the global average. Similarly, the under-five child mortality rate decline was also lower in OIC countries, compared to non-OIC countries. Almost half of the world's under-five child deaths occur in OIC countries. He emphasized the significance of maternal and child mortality in relation to poverty, which is both the cause and consequence. He thanked the COMCEC for timely undertaking the study in the contexts of SDG's 2030 deadline so that countries may take actionable strategies and implement plans to achieve the goals in the next 11 years. He explained the child survival intervention programs that are advocated by the UNICEF since the early 1980s for reducing preventable child deaths. Although GOBI (growth monitoring, oral rehydration solution, breastfeeding, and immunization) strategy has been very successful in reducing child mortality, increasingly there is recognition of the importance of female education, birth spacing and food supplementation for accelerating the progress. Currently, the world's half of under-five child deaths occur in the neonatal period, which will require different sets of interventions around peripartum and immediate postpartum periods. A high proportion of neonatal deaths are related to maternal causes and occur during delivery or immediately after delivery, which also underscores the significance of maternity care for reducing both maternal and neonatal mortality. Treatments are available for all direct causes of maternal mortality but still in many OIC countries maternal mortality ratio levels are similar to the situations that prevailed in early1900s in developed countries, such as the USA and UK. High maternal and child mortality rates reflect egregious failure of the health system of these countries.

Dr. Ahmed then presented the study objectives and research methodology. He illustrated the data sets that were analyzed for the study and explained the qualitative surveys that were undertaken in the four case study countries. He then explained the definitions of the key impact and process indicators of maternal and child mortality that were used in the study report. He also presented the

conceptual framework of the study and explained the linkages of the proximate and direct determinants of child and maternal mortality and their possible causal pathways.

Dr. Ahmed then discussed the country specific analytical results of the situations of maternal and child mortality and health care utilization patterns in OIC countries. Globally, the under-five mortality rate (U5MR) was 39 deaths per 1,000 births in 2017. In 26 of 57 OIC countries, the U5MRs were higher than the global average rate. In 13 OIC countries, the U5MRs were more than twice than that of the global average. These 13 countries are located in the sub-Saharan African region. These countries are Benin, where under-five mortality rate (U5MR) was 98 deaths per 1,000 live births, Burkina Faso with U5MR of 81, Cameroon with U5MR of 84, Chad with U5MR of 123, Cote d'Ivoire with U5MR of 89, Guinea-Bissau with U5MR of 84, Mali with U5MR of 106, Mauritania with U5MR of 79, Niger with U5MR of 85, Nigeria with U5MR of 100, Sierra Leone with U5MR of 111, and Somalia with U5MR of 127. In Asian region, Afghanistan and Pakistan have exceedingly high U5MRs, where U5MRs are 68 and 75 deaths per 1,000 live births, respectively.

Based on the data from the Global Burden of Diseases and IHME, Dr. Ahmed then presented the prospects of achieving the SDG goals of 3.1 to reduce maternal mortality ratio (MMR) to less than 70 deaths per 100,000 live births in 38 OIC countries, which are members of the COMCEC Poverty Alleviation Working Group. Of these 38 countries, 22 countries are projected to have higher than MMR of 70 by 2030 and unlikely to attain the level of the SDG 3.1 target. In 20 countries, maternal mortality ratios are expected to be two times higher than the targeted rate in 2030. The prospects of achieving the SDG 3.2 to reduce under-5 mortality to at least as low as 25 per 1,000 live births and neonatal mortality to at least as low as 12 per 1,000 live births by 2030 for 38 OIC countries are slightly better. However, of the 38 OIC countries, 19 are unlikely to achieve SDG 3.2 by 2030 at the current rate of mortality reduction. These countries are Afghanistan, Benin, Cameroon, Chad, Cote d'Ivoire, Gabon, Gambia, Guinea, Mauritania, Mozambique, Niger, Nigeria, Pakistan, Sierra Leone, Somalia, Sudan, Suriname, Togo and Uganda.

Dr. Ahmed also presented the results of the under-five mortality rates by wealth quintiles of family and suggested that children in the poorest families had almost two times higher risk of deaths by 5-year compared to children in richest families in most countries. A similar disparity in U5MR was found by the education level of mothers. Children in rural areas have a much higher level of U5MR compared to urban areas. An exception was Mauritania, where U5MR was higher in the urban area. The country has very large urban populations living in slum areas, which may explain the cause of higher U5MR in urban areas.

Antenatal care (ANC), delivery care with skilled birth attendants, postpartum care and family planning are recognized as the four pillars of safe motherhood programs since the 1st Safe Motherhood Initiative meeting in 1987 at Nairobi. Dr. Ahmed presented the distributions of these maternal health care utilization indicator results by socioeconomic status of family, education level of mothers, and urban-rural residence. Most countries show large disparity in maternal health care utilizations by these variables. Among the reasons of why women do not deliver at a health facility, the most frequently cited factors were the lack of money and distance of nearest facilities. Lack of

permission, availability of female providers and lack of knowledge were the major social and cultural barriers for delivering at the health facilities.

A similar pattern of disparity was also evident for the child health care utilization indicators. Immunization coverage for individual vaccine or for the first dose of DPT or Polio was high in OIC countries but the completion rate of all the recommended doses of eight child vaccinations by 1 year of age was much lower. Dr. Ahmed emphasized on the significance of immunization compliance and the challenges of completing all the recommended vaccination doses. The countries need to identify the socioeconomic and cultural barriers and to develop appropriate culturally sensitive interventions for improving basic immunization schedule compliance. Immunization coverage was lowest among the children of women with no education and of poorest families. Receiving treatments for acute respiratory infection (ARI) and diarrheas was lower among the children in rural areas compared to the children in urban areas.

Maternal mortality ratio is the key indicator for tracking progress in maternal deaths reduction. However, the measurement of MMR is difficult in most of the OIC countries due to the lack of complete vital registration system. In the absence of death and birth certificate data, most estimates of the MMR are based on statistical models developed by the MMEIG (Maternal Mortality Estimation Interagency Group) and IHME/GBD (Institute for Health Metrics and Evaluation/Global Burden of Disease) group. These estimates often vary substantially between the two groups, which make it difficult for the government officials to reliably track progress. Moreover, the MMR estimates are not available at subnational level, which is also challenging for targeting high risk areas and populations. Dr. Ahmed emphasized the importance of improving the birth and death certificates for reliably measuring the MMRs at national and subnational levels.

Comments:

Comment: It was emphasized that aggregated data is important for the effective following the evidence practices.

Answer: Maternal mortality is high despite almost all mothers give birth in a health facility in some countries. So, there is a quality problem that needs to be pursued closely. Therefore, each evidence should be investigated in detail.

Comment: The review of maternal mortality with hospital-level studies is significant to reveal the problems that mothers face. Furthermore, the cultural reservations by mothers can be the main risk factor sometimes.

Comment: The participants also discussed some measures for reducing health care inequity among poor families, low educated women and in rural areas. Improving access to health insurance and reducing sociocultural and religious barriers were the some suggestions put forward.

3.2. Lessons Learnt from the Selected Case Studies and the Policy Options

In the second presentation, Dr. Ahmed provided the key analytical results and lessons learnt from the four case study countries. He provided the rationales for selecting these countries. Then he describes the study methodology with primary focus on the descriptions of the in-country interviews of country stakeholders and their selection procedures. The stakeholders were identified from government officials in the Ministry of Health and Ministry of Planning/Finance, in-country UN/WHO, World Bank/USAID/Developmental Agency, university/research institutions, and Non-Governmental Organizations. Dr. Ahmed provided an overview of demographic and health status of each study country, followed by the presentations of results from the trends analysis of maternal and under-five child mortality.

The study team interviewed the key stakeholders to get their perceived opinion on MNCH situations and health system challenges in respective countries. The study utilized the World Health Organization's (WHO) framework of health systems challenges, which contains six core components or "building blocks". These are service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership/governance. On the question of perceived least functional health system building blocks, the stakeholders in Bangladesh ranged the ranking of these six components from an average of scores 2 (somewhat functioning) to 3 (functioning well). When inquired on the barriers to accessing MNCH care, the majority stakeholders identified the quality of care as the most significant barrier, in comparisons to other barriers such as accessibility to health care services, physical accessibility, adequacy of the number of health staff, supply of essential drugs, and financial affordability. Only one-fifth of the respondents consider that the country's health information system is well developed while the vast majority opined that the HMIS system is functioning well but needs improvement. Surprisingly, the results were very similar in other countries. In all countries, the quality of care was identified as a major barrier and challenge. The stakeholders emphasized on training the health providers on the recommended delivery care practices and to establish a monitoring system for tracking the use of recommended practices at health facilities on an ongoing basis for the sake of improving the quality of care.

In Bangladesh, the majority of health financing is covered by the out-of-pocket expenses, which is also showing an increasing trend in the recent period. In contrast, the out-of-pocket expense was showing decreasing trends in Indonesia and Cote d'Ivoire in the recent period. These countries are known for promoting health insurance. Iraq is showing an alarming trend of rapidly increasing out of pocket expenses for medical care in the recent period while the government expenditure is decreasing. Dr. Ahmed also discussed the relevance of these findings in relation to the catastrophic costs of delivery and child care, poverty, and the challenges of access to care among poor families.

At the later end of the presentation, Dr. Ahmed presented a set of actionable policy recommendations based on the findings of the study. These recommendations are to (1) improve health system functioning and quality of care through accountability, training, practice of recommended standard of care protocols, regular monitoring of standards, and good governance; (2) to reduce inequity in maternal and child health care and reduce barriers to accessing care

through targeted intervention programs for reaching vulnerable, poor, less educated and rural populations; (3) improve FP access and contraceptive use through an integrated approach, especially in sub-Saharan African OIC countries, where maternal and child mortality levels are high despite high rates of facility deliveries; and 94) improve health information management systems through investment and appropriate policies on improving routine data collection, systematic timely reporting, full coverage, and data utilization. As a long term recommendation, Dr. Ahmed also emphasized on improving female education level, considering that large inequity in child mortality and MNCH care was observed by women's education level in all countries. Meanwhile, countries should consider improving women's knowledge of life-threatening maternal and child complications, treatment availability, and needs of preventive care through information dissemination, counseling, and educational programs.

Comments:

Comment: Multi-sectoral cooperation is very important as maternal and child mortality cannot be tackled in isolation.

Answer: Integrating different aspects into maternal health care requires additional financing. Moreover, universal health care is another important way of integrating various dimensions of maternal and child care and ensuring the multi-sectoral collaboration.

Comment: The importance of measuring mortality rates at the subnational level was also underscored by the delegates. Engaging relevant stakeholders was highlighted for removing social and cultural barriers to access medical care.

4. Policy Discussion Session

The session was moderated by the Dr. Jumana AL ABDUWANI, Head of Child Health Section at Ministry of Health of Oman.

At the beginning of the session, Mr. Selçuk KOÇ, Director at the COMCEC Coordination Office (CCO), made a brief presentation on the responses of the member countries to the policy questions on child and maternal mortality which were sent to the Poverty Alleviation Working Group focal points by the CCO. He also presented the policy recommendations provided in the room document.

After the presentation, Dr. AL ABDUWANI gave the floor to all delegations asking their opinions and comments for each policy recommendation. The participants shared their comments on the policy recommendations given in the room document. Based on the intensive deliberations, the participants have highlighted the following policy recommendations:[2]

- Developing a strategy/policy to improve access to maternal, neonatal and child health (MNCH) care, and to provide equitable distribution of health providers,
- Improving health system functioning and quality of MNCH care through training and practice of recommended standard of care protocols, and regular monitoring of standards,

[2] The Room Document is attached as Annex 3.

- Improving continuum of maternal, neonatal and child health care for assuring uninterrupted services before and during pregnancy, delivery and postpartum period through among others developing specific conditional cash transfer programs
- Developing/Improving integrated health information management systems for monitoring MNCH care level and reporting births and deaths, including maternal deaths, nationally and locally
- Developing sustainable educational programs on women and child health care delivered to community with a view to eliminating the inequities linked to low education levels

(Annex 3: Room Document)

5. COMCEC Project Funding

Mr. Deniz GÖLE, Director at COMCEC Coordination Office delivered a presentation on utilizing the COMCEC Project Funding (CPF) for the poverty-related projects of the member countries as well as the OIC institutions.

In the beginning, Mr. GÖLE informed the participants about the essentials of COMCEC Project Funding. He explained the two instruments of COMCEC Strategy, namely Working Groups and Project Funding. Then, he stated the relationship between Ministerial policy recommendations, Strategy's principles and objectives. He gave details about the activity-based projects and research projects. Lastly, main characteristics of COMCEC Project Funding such as membership to the WGs, partnering with at least two member countries and satisfying the Project Preparation and Submission Guidelines were touched upon.

Mr. GÖLE emphasized the importance of sectoral themes, which should also be considered while submitting project proposals, published on the COMCEC website. He enumerated the supported topics in poverty alleviation cooperation area as followings:

- Increasing quality of teachers
- Increasing teaching and learning effectiveness through adoption of information and communication technologies
- Promoting better early-childhood learning opportunities through accessible and affordable pre-primary schooling
- Ensuring progressive universalism for closing the rich-poor gap in learning outcomes
- Involving parents in the monitoring of their children's education and intensifying the parent-teacher interaction
- Improving access of poor students and youth to vocational education through reducing school fees, offering monthly scholarship schemes and providing adequate facilities
- Improving facilities of TVET institutions as well as establishing a training center inside an industrial area
- Matching the skills taught in TVET institutions with the industrial requirements through job-oriented and demand driven curriculum update
- Increasing the quantity and quality of teachers in TVET sector through professional development programs and industrial attachment
- Increasing awareness on TVET and creating new job opportunities for skilled graduates
- Developing strategies and policies for a well-designed payment and health insurance schemes to achieve universal health coverage

- Strengthening primary healthcare services particularly in poorer areas through encouraging skilled health staff to work in rural and remote areas
- Enhancing integrated health promotion and prevention interventions
- Promoting the engagement of private sector in provision of safe and quality healthcare
- Encouraging the development of integrated health information management systems
- Allocating required resources to health IT infrastructure and strengthening multi-sectoral coordination mechanism
- Decreasing child and maternal mortality
- Eradicating urban poverty
- Enhancing decent housing opportunities for the poor

Mr. GÖLE continued his presentation with the implementation statistics, both yearly and in sectoral basis, for the last 5 years. Also, he gave the details of the contents and activities of the poverty alleviation projects being implemented in 2019 by Afghanistan, Nigeria, Suriname, Turkey and SESRIC.

Lastly, Mr. GÖLE gave general information about the relevant pages of the COMCEC Project Funding website and mentioned about the timeline for the project submission. He indicated the relevant reference materials in the Online Project Submission System to be used during the project submission period.

6. Member State Presentations

In this section, the representatives of Benin, Indonesia, Morocco, Oman, Palestine and Turkey made presentations to inform the participants about policies and programs conducted in their respective countries for reducing maternal and child mortality.

6.1. Benin

Dr. Kodjo Rodrigue KOHOUN, Health District Manager at Ministry of Health, made a presentation about the situation related to child and maternal mortality in Benin.

In the beginning of his presentation, Dr. KOHOUN pointed out that financial barriers are the major obstacle for health care accessibility in low-income countries. User fees constitutes as the barriers for using health care by the poorest and the disadvantaged households and are one of the main reasons of high rates of maternal and child mortality in Benin. In order to reduce maternal and under five child mortality ratio, pregnancy women and children under five years benefitted from user fees exemption since 2000. He expressed that relevant policies and strategies aim to build strong health system and increase the quality of care to achieve the SDG targets.

Dr. KOHOUN emphasized that the main issue in financing health care is the high level of out of pocket health expenditure which remained 43% of national health expenditure. He pointed out that even if health indicators have improved between 2006 and 2017, some indicators have remained at a critical level, particularly the maternal and under five mortality ratio which are 391 per 100 000 live births and 96 per 1000 live births respectively.

Dr. KOHOUN continued his presentation by expressing that Benin is enhancing reforms in health sector to reduce maternal and child mortality, build a strong health system, to achieve universal

health coverage by reducing inequity, protecting disadvantaged household and the poorest. He stated that significant strategies have been developed to increase health care availability and to improve the quality of care. He expressed that Benin adopted and scaled up an integrated maternal, neonatal and nutrition health plan. To fight against maternal and infant death, audit of maternal and neonatal death is systematized and there is increasingly the policy commitment to monitor maternal and neonatal deaths.

Dr. KOHOUN informed the participants that private sector provided 60% of health care in Benin. Since 2017, government of Benin has been accelerating control and regulation of private facilities. Accordingly, all non-qualify private facilities were closed. There is also the private involvement in monitoring and evaluation of the quality of care in health private facilities.

In addition to reinforcing health centers and hospitals with medical equipment Benin is building national and regional hospitals of great reference. He added that Benin began implementing the pilot phase of national health insurance this year. It targeted the poorest and addressed a large package of health care, particularly for the maternal and under five years. This national insurance scheme is exclusively financed by national income and it's planned to be scaling up in less than 9 months.

In the last part of the presentation Dr. KOHOUN stated that Benin is accelerating reforms in health sector to improve the quality of care and reduce maternal and under five mortality ratio. These reforms aim to achieve the universal health coverage and the Sustainable Development Goals.

6.2. Indonesia

Ms. Eni GUSTINA, Secretary at Ministry of Health, made a presentation on the situation about maternal and child mortality in Indonesia.

In the beginning of her presentation, she emphasized the according to Population Survey in 2015, Maternal mortality rate in Indonesia was 305 per 100,000 live births. This status is still high compared to the target that must be achieved in 2024; 183 per 2 per 100,000 live births and SDGs Target 2030; 131 per 100,000 live births. The major direct causes of maternal death are hypertension disorders 34%, hemorrhagic 27%, non-obstetric complications 16%. 77% of maternal death occurred at hospital. While Indonesia thrives to reduce maternal mortality rate, we also struggle to reduce Neonatal mortality rate from 15 per 1000 live births to 8.6 per 1000 live birth by 2030. The major direct causes of neonatal death were intrapartum complications 28.3%, respiratory and cardiovascular disorders 21.3%, and LBW and premature 19%. Same as maternal death, neonatal death also occurs mostly at hospital. Currently, we are studying the causes of this issue.

She continued with by stating that Indonesia has established several regulations on maternal and child services. They covers promotive and preventive services throughout the life cycle such as antenatal care, distribution of Fe tablet to pregnant women, breastfeeding counselling, immunization, family planning counselling, etc. Also include in these regulation adolescence health services to prevent maternal and child death such as health screening, health education including about reproductive health. We realize the importance of health services for adolescence.

Adolescence are prone to free sex, anemia, unhealthy behavior, making it as the most critical period in life cycle for intervention so that we can prevent the direct causes of maternal and neonatal death.

She mentioned that maternal and neonatal death cannot be reduced without cooperation among programs and sectors at all levels. To strengthen the implementation of those regulations at province and district level, Indonesian government has established a regulation on minimum standard of services in health sector including minimum standard of maternal and child health services. It urges local government to provide health services to all community and their performance would be assessed by looking at their achievement in giving the services. In other words, provision of minimum health services becomes the responsibility of the head of local government.

Finally, she touched upon to increase the quality of health services, Indonesian government has conducted an accreditation of primary health care facilities and hospital especially the national, province and regional referral hospital. The program called Nusantara Sehat or Healthy Archipelago conforms health workers team consist of a doctor, a dentist, a nurse, a midwife, a community health worker, a nutritionist, a pharmacist, to fulfil the necessities of health workers especially in remote area. In addition, to increase the access of maternal and child health services, community health workers in public health center conduct home visits to make sure that community including mother and children, receives appropriate health services.

6.3. Morocco

Ms. Fatiha BARKATOU, Executive at the Division of Maternal and Child Health, Ministry of Health shared the experience of Morocco in maternal and child health with a presentation.

She began her presentation with a short outline of demographic and socio-economic conditions of Morocco. She also introduced the international and national context in which strategies and actions of Morocco in maternal health and infantile are worked out and set up.

Then, she presented the situation of infantile and maternal health in Morocco from the description of progressive tendency in the course of last two decades of the indicators of impacts and the indicators of performance of programs allocated to infantile and maternal health which showed a favorable evolution manifesting efforts approved by the Ministry of Health. Nevertheless, these results hide inequality between group of persons and territories

Afterwards, she explained the main achievements of the Ministry of Health in promotion, protection and improvement of infantile and maternal health.

She concluded her presentation by putting the emphasis on the approach that Morocco adopted to achieve efficiently the SDG and on importance to reinforce the sustainability of this progress by strengthening the international collaboration notably with OIC member countries.

6.4. Oman

Dr. Jumana AL ABDUWANI, Head of Child Health Section at Ministry of Health of Oman, made a presentation maternal and childhood mortalities in Oman.

At the outset, Dr. AL ABDUWANI stated that the Sultanate of Oman has accomplished great achievements in the health sector over a short period of time. These achievements have been widely recognized and acclaimed by various international organizations, including the World Health Organization (WHO), The United Nations Children's Fund (UNICEF) and the United Nations Development Program (UNP). Health indicators such as infant, less than five and maternal mortality rates continued to show progressive and consistent reduction in the Sultanate over the past 4 decades. Several diseases have been eliminated and life expectancy at birth has reached levels comparable to those in developed countries. An extensive network of modern health facilities providing full range services is made available and easily accessible to the entire Omani population. The WHO documents the Oman's glaring health successes in its WHO Worlds Health Report of 2000, which was devoted to measuring performance of health systems worldwide. Oman's health system was rated the first among more than 190 national health systems in its attainment of higher goals over a short period of time and at reasonable cost.

Dr. AL ABDUWANI continued her presentation by stating that women and children were one of the main target populations of health care since early seventies. This was reflected by the number of adopted health programs targeting these groups and integrating these programs at different health care levels with a focus on the wide-network of primary health care. This strategy in addition to working with other sectors responsible for mothers and child health locally and internationally succeeded in improving maternal and child health indicators. Nearly all children in Oman are immunized against common preventable infectious diseases, under five mortality rate in Oman considered one of the lowest mortality rate in the world, child health system within the primary health care is in concordance with international recommendations, as it offers surveillance for physical malformations, developmental assessment, feeding assessment, immunization and accident prevention in addition to screening for anemia and autism. Antenatal care coverage reach more than 99% and 98% of mothers delivered under supervision of skilled personal. The package of care for MCH takes a concept of life cycle with services starting from pre-conception till menopause.

She emphasized the reduction of maternal death is a key international development goal. Implementation of Surveillance of maternal deaths system enhanced the efforts of Oman to achieve this goal. The system of reporting maternal deaths was adopted in Oman in 1991 with a ministerial decree to notify all maternal deaths. In 1992, national maternal mortality committee was issued to identify causes of death before, during, or after delivery.

Lastly, Dr. AL ABDUWANI highlighted key interventions in MCH, described maternal death surveillance system, including data of maternal death surveillance from 1991 till 2017.

6.5. Palestine

Dr. Hadil ALI-MASRI, Consultant Doctor, Ministry of Health, presented the experiences of Palestine in maternal and child mortality.

Dr. ALI-MASRI started her presentation mentioning that Palestine is under constant restriction of movement and access to health facilities due to the Israeli occupation. She indicated that there are approximately 5 million Palestinians living in the areas under the Palestinian control (The West Bank and Gaza). Women of the reproductive age contribute to 25% of the population and is basically among the most vulnerable.

She pointed out that the history of reporting and documenting maternal and child mortality is quite recent in Palestine.

She expressed that most cases of maternal mortality occur in the postpartum period and the main direct causes are postpartum hemorrhage, pulmonary embolism, infection and preeclampsia.

She informed the participants that available reports show that maternal mortality has been reduced by more than 50% from 2009 to 2018 (from 38 to 16.7 per 100 000 live birth). She explained these figures by the awareness of this problem and the interventions taken to mitigate it. She added, however, obstacles to further reduction still exist. She touched upon some examples such as lack of equipment, shortage of necessary medications, insufficient skilled healthcare providers, low morale and poor communication among healthcare providers and limited scientific clinical research.

Dr. ALI-MASRI concluded her presentation by stressing that the reduction in under five child mortality between 2009 and 2018 seems to be less significant (15 to 13.4 per 1000 live birth). Infant mortality rate is the most plausible explanation of the relatively unchanged under five child mortality rate. The vast majority of the causes of infant mortality rate are those related to the perinatal period, which by logic are correlated with maternal health. Therefore, efforts are directed towards more investigation, assessment and management of the underlying factors that would help reduce infant mortality in Palestine.

6.6. Turkey

Dr. Bekir KESKİNKILIÇ, Deputy Director General of Public Health of Ministry of Health of Turkey, firstly outlined general overview of maternal and child health services in Turkey.

In the first part of his presentation, Dr. KESKİNKILIÇ gave information about the services provided by the Ministry of Health about maternal health and pregnancy. Accordingly, in Turkey and there are thirteen different programs and/or projects for pregnants or mothers who have recently delivered birth.

In the beginning, Dr. KESKİNKILIÇ emphasized these programs include regular monitoring of mother candidates from the beginning of pregnancy by health personnel. Counseling services are provided to mother candidates through physicians. In this context, mothers are informed by

physicians about risky pregnancies. During pregnancy, all kinds of medical support is provided to mothers, especially for the fight against sexually transmitted diseases and nutrition support.

He stated that monitoring of pregnancy and maternal health services in Turkey are fulfilled by appointed health personnel. This follow-up process is supported by soft wares in health care facilities.

He added that the services for maternal health are provided free-of-charge in maternal health facilities during and after the pregnancy.

Dr. KESKİNKILIÇ expressed that the Ministry of Health also carries out important activities in child health and prevention of child deaths. The tests performed for the child after birth are supported by baby follow-up, child follow-up and adolescent follow-up programs. In addition, nutritional support and vaccination programs are provided free of charge by health personnel.

He mentioned in Turkey, since 2003, maternal and child health programs have led to a significant reduction in mortality. Maternal deaths, which were 70 per hundred thousand in 1998, decreased to 13,6 in 2018. The infant mortality rate decreased from 31,5 per thousand in 2002 to 9,2 in 2018.

In the last part of the presentation, two types of services provided by the Ministry of Family, Labor and Social Services were explained to the participants. Accordingly, the Conditional Cash Transfer for Health Program aims to make financial contributions to families suffering financial difficulties after pregnancy and childbirth. Multiple Birth Assistance Program aims to support the needy families with multiple births in terms of their nutritional and self-care needs.

7. Perspective of International Institutions and NGOs

7.1. World Health Organization

Dr. Tufan NAYIR, Consultant at WHO Country Office of Turkey, presented the WHO Strategic Framework to End Preventable Maternal Mortality and Morbidity.

Dr. NAYIR commenced his presentation by stating that ending preventable maternal mortality remains an unfinished agenda and one of the world's most critical challenges. Maternal health, wellbeing and survival remain a central goal and investment priority in the post-2015 framework for sustainable development.

Dr. NAYIR emphasized the investing in both women's and children's health leads to high economic returns, including greater national productivity and higher GDP for countries. The global economic impact of maternal and newborn mortality is estimated at US$15 billion in lost productivity every year.

He reminded that SDG's Goal 3 is "Ensure healthy lives and promote well-being for all at all ages" and Target 3.1 is "By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births".

Dr. NAYIR pointed out that a new report on maternal mortality, released today by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division in September this year, estimates a worldwide number of 295 000 maternal deaths in 2017. This figure represents a 38% reduction since the year 2000 an average reduction of just under 3% per year.

He expressed that despite the ambition to end preventable maternal deaths by 2030, the world will fall short of this target by more than 1 million lives with the current pace of progress.

Dr. NAYIR mentioned that maternal deaths are just the "tip of the iceberg", in order to capture the full impact of various conditions, a multiplier was used to estimate the size of the unseen burden of disability.

He continued with maternal morbidity risks underlining that the risks are cyclical since women can become pregnant more than once. In addition, sequelae of a maternal condition can occur in the next pregnancy. For example, women who deliver by cesarean, for example, are at increased risk of placenta previa in subsequent pregnancies. Moreover, the effects of maternal morbidity can last a long time, beyond the customary 6 weeks postpartum, and there may be consequences later in life, during the post reproductive or postmenopausal periods. For instance, women who have hypertension during pregnancy are more likely to suffer cardiovascular diseases at older ages.

Dr. NAYIR expressed that it is important for all countries to increase efforts to reach vulnerable populations with high-quality primary and emergency sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) services. Understanding barriers to access (such as financial, legal, gender- or age-related, cultural, geographic, or fear of disrespectful care) and factors, including values and preferences, valid equity indicators are needed so that disaggregated data on barriers can be routinely collected to help design, implement and monitor interventions to eliminate them.

He gave examples of evidence-based interventions in preconception care including addressing nutritional conditions; genetic conditions; and too early, unwanted and rapid successive pregnancies. He added that the WHO Regional Office for Europe has prepared a report highlighting the latest evidence on maternal nutrition and the prevention of obesity and non-communicable disease.

He stated that recent evidence indicates that when midwives are educated to international standards, and midwifery includes the provision of family planning, it could avert more than 80% of all maternal deaths, stillbirths and neonatal deaths. Beyond preventing maternal and newborn deaths, quality midwifery care improves over 50 other health-related outcomes.

Dr. NAYIR continued his presentation with maternal death stressing that most countries with high maternal mortality have weak civil registration systems. Consequently, many maternal deaths and the reasons behind these deaths remain unrecorded and unreported, particularly when women die at home. Preventing maternal deaths can be effective only if accurate information is available to support targeted responses. Maternal death surveillance and response approach makes each maternal death a notifiable event, and ensures that communities and facilities report and respond

to each death in their efforts to end preventable maternal deaths. WHO's "Beyond the Numbers" methodology which includes Confidential Enquires conducted at national level provides guidance on the different methods for review of maternal deaths and morbidity.

Lastly, he emphasized the key areas where action is required to enhance financing, strengthen policy and improve service delivery:

- Support for country-led health plans, supported by increased, predictable and sustainable investment.
- Integrated delivery of health services and life-saving interventions, so women and their children can access prevention, treatment, care when and where they need it.
- Stronger health systems, focus on primary health care, sufficient skilled health workers.
- Improved monitoring and evaluation to ensure the accountability

7.2. UNICEF

Dr. Mehmet Ali TORUNOĞLU, Health Specialist, shared the experience of UNICEF in the field of maternal and child mortality.

Dr. TORUNOĞLU began his presentation mentioning that according to The United Nations Maternal Mortality Estimation Inter-Agency Group's (UN MMEIG) Trend in Maternal Mortality 2000-2017 Report, global level MMR is 211/100 000 LBs (live births) in 2017, it is reflecting 295 thousand maternal deaths. WHO highlighted; every day in 2017, approximately 810 women died from preventable causes related to pregnancy and childbirth. Between 2000 and 2017, the maternal mortality ratio dropped by about 38% worldwide, 94% of all maternal deaths occur in low and lower-middle-income countries. He added that young adolescents (ages 10-14) face a higher risk of complications and death as a result of pregnancy than other women. Skilled care before, during and after childbirth can save the lives of women and newborns.

Dr. TORUNOĞLU emphasized that despite the ambition to end preventable maternal deaths by 2030, the world will fall short of this target by more than 1 million lives with the current pace of progress. In the context of efforts to achieve UHC, improving maternal health is critical to fulfilling the aspiration to reach SDG-3.

Dr. TORUNOĞLU continued his presentation by stating that 2018 Declaration of Astana repositioned primary health care as the most (cost) effective and inclusive means of delivering health services to achieve the SDGs. Primary health care is thereby considered the cornerstone for achieving universal health coverage (UHC), which only exists when all people receive quality health services they need without suffering financial hardship.

He continued by emphasizing that it is needed to expand horizons beyond a sole focus on mortality, to look at the broader aspects including health systems, UHC, quality of care, morbidity levels and socioeconomic determinants of women's empowerment and education and ensure that appropriate action is taken to support family planning, healthy pregnancy and safe childbirth.

Dr. TORUNOĞLU continued his presentation by stressed that according to The United Nations Inter-Agency Group for Child Mortality Estimation (UN-IGME) group Level and Trend Child Mortality 2019 Report; tremendous progress in child survival has been made over the past two decades. The total number of deaths among children and young adolescents under 15 years of age dropped by 56 per cent from 14.2 (14.0, 14.5.5) million in 1990 to 6.2 (6.0, 6.7) million in 2018. Still, one child or young adolescent died every five seconds in 2018, globally, 85 per cent of deaths among children and young adolescents in 2018 occurred in the first five years of life.

Dr TORUNOĞLU emphasized that if current trends continue without acceleration, some 52 (49, 58) million children under 5 years of age will die from 2019 to 2030.

He pointed out that globally, pneumonia, diarrhoea and malaria remain the leading causes of death for children under age 5. Injuries play a more prominent role in the deaths of older children and young adolescents.

He finally emphasized the expanding inexpensive and cost-effective prevention and quality treatment for these causes will improve child survival. Greater attention to saving newborn lives can accelerate reductions in the under-five deaths burden. To accelerate progress, greater investment is needed in building stronger health systems and services and improving coverage, quality and equity of care in the antenatal period; care at birth and in the first week of life; and care for small and sick newborns, which gives a triple return on investment by saving maternal and newborn lives and preventing stillbirths and disability.

7.3. Doctors Worldwide

Dr. Safa ŞİMŞEK, Head of Programs and Operations at Yeryüzü Doktorları Derneği (Doctors Worldwide, YYD), presented the experiences of YYD as an international humanitarian organization focused on healthcare and health access. He stated that the Organization began the operations as an international humanitarian organization in 2000. YYD has carried out hundreds of projects in nearly 50 countries to date, ranging from Afghanistan to Syria, Somalia to Gaza, and Uganda to Yemen with support of over 100 thousand donors and volunteers exceeding 20 thousands.

In his presentation Dr. ŞİMŞEK, mentioned about the maternal and infant health clinics. He pointed out that the YYD improves and empowers the existing clinics or establishes health centers in the areas, where delivery possibilities are limited, and problems related to birth are more. The YYD provides medical services to vulnerable communities with doctors, nurses, midwives and community health workers. The YYD ensures trainings on baby-care and reproductive health to pregnant, newly born and/or nursing mothers. He enumerated the clinics and health centers established in Syria, Somalia, Democratic Republic of Congo and Niger.

Dr. ŞİMŞEK also gave some examples of their training projects on maternal and child care. Regarding the Advanced Pediatric Life Support (APLS) Trainings in Azerbaijan, he explained that the APLS is a systematic, hands-on course program developed for critical patient classification in life-threatening emergency and trauma cases, basic and advanced life support, and other

emergency treatment approaches. Within the framework of the APLS Training of the YYD 224 beneficiaries (health professionals) have been trained.

He continued with Newborn Hearing Screening Trainings in Zanzibar, Tanzania. As a result of the trainings carried out by the volunteers, local crew formed by 19 nurses and 3 audiologists were trained in January and June 2015, in Zanzibar, Tanzania.

Dr. ŞİMŞEK mentioned that the YYD opens and supports nutritional health centers for pregnants, mothers and their children in the areas where hunger problems are experienced. According to 2016 UNICEF report , pediatric health problems stem from lack of nutrition as %60. For this reason the YYD supports 4 Nutrition Centers in AlMimdara, Al-Bassten, Al-Mualla, Al-Shab in Yemen. Therapeutic foods are provided for children who are under 5, mothers and pregnants.

He also touched upon the activities of the YYD in Chad. He expressed that malnutrition in Chad is a serious concern, as 43% of children under the age of 5 are stunted. In 2018 the YYD launched a nutrition center in Chad which provides training for mothers and pregnants, therapeutic foods and sub-compliments meals for children under 5 years, in accordance with UNICEF nutrition standards. In 2019, 4.770 child has received free examinations and 1.763 child are registered in the YYD Severe Acute malnutrition program (SAM). As starting last two months 111 child are registered in the YYD Moderate Acute Malnutrition program (MAM).

Dr. ŞİMŞEK concluded his presentation stating that prevention is always more important than cure. Therefore, he stressed the importance of training, promotion and awareness for the maternal and child care. He added that the commitment of stakeholders such as local leaders, scholars, local NGOs is a vital component of successful implementation of projects and programs contributing to maternal and child health.

8. Closing Remarks

The Meeting ended with closing remarks of Mrs. Juldeh CEESAY, Chairperson of the Meeting and Mr. Deniz GÖLE, Director at the COMCEC Coordination Office (CCO).

Mrs. CEESAY thanked all the member country representatives as well as participants from WHO, UNICEF and Doctors Worldwide for their active participation and valuable contributions.

Mr. GÖLE also thanked all delegates for their attendance and valuable contributions. He expressed that the main outcome of the meeting is the policy recommendations for the member countries. He stated that these recommendations will be submitted to the 35th Session of the COMCEC as an output of the 14th Meeting of the Poverty Alleviation Working Group.

Furthermore, Mr. GÖLE informed the participants that the 15th Meeting of the COMCEC Poverty Alleviation Working Group will be held with the theme of "Eradicating Urban Poverty in the Islamic Countries". He stated that as per the usual practice a research report will be prepared on the theme of the Meeting and shared with the focal points in advance of the meeting.

ANNEXES

Annex 1: Agenda of the Meeting

AGENDA OF THE 14TH MEETING OF THE COMCEC POVERTY ALLEVIATION WORKING GROUP

November 6th, 2019, Ankara, Turkey

"Child and Maternal Mortality in Islamic Countries"

Opening Remarks

1. COMCEC Poverty Outlook
2. Overview of Child and Maternal Mortality in the World and the OIC
3. Lessons Learnt from the Selected Case Studies and the Policy Options
4. Policy Options on Reducing Child and Maternal Mortality Rate in the OIC Member Countries
5. Utilizing the COMCEC Project Funding
6. Member State Presentations
7. Perspectives of International Institutions and NGOs

Closing Remarks

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Annex 2: Programme of the Meeting

PROGRAMME OF THE 14TH MEETING OF THE COMCEC POVERTY ALLEVIATION WORKING GROUP

(November 6th, 2019, CP Ankara Hotel, Ankara, Turkey)

"Child and Maternal Mortality in Islamic Countries"

08.30-09.00 **Registration**

09.00-09.05 **Recitation from Holy Qur'an**

09.05-09.15 **Opening Remarks**

09.15-09.35 Outlook of Poverty in the OIC Member Countries

Presentation: Dr. Güneş AŞIK
COMCEC Coordination Office

09.35-09.45 Discussion

09.45-10.25 Overview of Child and Maternal Mortality in the World and the OIC

Presentation: Dr. Saifuddin AHMED
Johns Hopkins University

10.25-10.55 Discussion

10.55-11.10 **Coffee Break**

11.10-11.50 Lessons Learnt from the Selected Case Studies and the Policy Options

Presentation: Dr. Saifuddin AHMED
Johns Hopkins University

11.50-12.20 Discussion

12.20-14.00 **Lunch**

Policy Options on Reducing Child and Maternal Mortality Rate in OIC

There will be a moderation session under this agenda item. Participants are expected to deliberate on the policy options/advices for reducing child and maternal mortality in the Islamic Countries. At the beginning of the session,

the CCO will make a short presentation on the responses of the Member Countries to the policy questions as well as the Room Document.

14.00-14.10 Responses of the Member Countries to the Policy Questions on the Policy Framework for Reducing Child and Maternal Mortality in the OIC Member Countries

Presentation: Mr. Selçuk KOÇ, Director
COMCEC Coordination Office

14.10-15.30 Discussion

Utilizing the COMCEC Project Funding

15.30-15.45 Presentation: *Mr. Deniz GÖLE, Director*
COMCEC Coordination Office

15.45-16.00 Discussion

16.00-16.15 **Coffee Break**

16.15-17.00 **Member Country Presentations**

Sharing Experiences and Good Practices in Reducing Child and Maternal Mortality

Discussion

Perspectives of International Institutions and NGOs

17.00-17.15 Presentation: "WHO Strategic Framework to End Preventable Maternal Mortality and Morbidity"

Dr. Tufan NAYIR, Consultant
WHO Country Office in Turkey

17.15-17.30 Presentation: "Trends in Maternal and Child Mortality in the World and UNICEF's Approach"

Dr. Mehmet Ali TORUNOĞLU, Health Specialist
UNICEF Ankara Office

17.30-17.45 Presentation: "Experience of Doctors Worldwide in Child and Maternal Health in the OIC Region"

Dr. Safa ŞİMŞEK, Head of Programs and Operations
Doctors Worldwide, Turkey

17.45-18.00 Discussion

18.00-18.10 **Closing Remarks and Family Photo**

Annex 3: The Policy Recommendations

POLICY RECOMMENDATIONS HIGHLIGHTED BY THE 14TH MEETING OF THE COMCEC POVERTY ALLEVIATION WORKING GROUP

A policy debate session was held during the 14th Meeting of the Poverty Alleviation Working Group (PAWG). The Working Group came up with some concrete policy recommendations for reducing maternal and child mortality in the OIC and approximating policies among the member countries in this important issue. The policy advices presented below have been identified in light of the main findings of the research report titled "Child and Maternal Mortality in Islamic Countries" and the responses of the Member Countries to the policy questionnaire which was sent by the COMCEC Coordination Office.

Policy Advice 1: Developing a strategy/policy to improve access to maternal, neonatal and child health (MNCH) care, and to provide equitable distribution of health providers

Rationale:

Although proven and cost-effective interventions are available to prevent maternal, newborn and child deaths, the utilization and coverage of MNCH care interventions are low in many settings. Supply related health system factors – such as access to and availability of services, quality of care, emergency transportation – and demand related factors – such as income, education, social norm factors – affect the utilization of obstetrical and child health care services.

High inequity in MNCH care exists among the poorest segments of the population. Reaching the poorest population remains a challenge in many countries. Improving access to high-quality MNCH services, assuring high-quality services in public facilities, and improving the availability of skilled providers to poor segments of the population are very critical for substantially reducing maternal and child mortality at the national level. Life threatening maternal complications need emergency transportation and in many settings, especially in rural areas, ambulance services are not available. Often the nearest facilities may not have trained service providers, especially in rural and remote areas. Improving physical accessibility and financial affordability through health insurance programs and vouchers are likely to help women and families to overcome the economic barriers. Improving the availability of trained health workers and affordable, high quality, easily accessible services in poor settings and rural areas are critical for reducing inequity. Policy will be needed to improve workforce capacity and to develop incentive strategies for equitable distribution of health providers.

Sociocultural beliefs and practices also affect women from seeking care. Identifying local sociocultural barriers and developing culturally sensitive intervention programs would help in raising awareness and improving acceptability of MNCH services.

With the recent UN declaration of universal health coverage, there is growing recognition that universal health care access to MNCH services will be critical for countries to accelerate the progress towards achieving the SDG-3.1 (to reduce the global maternal mortality ratio to less than 70 per 100 000 live births by 2030) and SDG-3.2 (all countries to reduce neonatal

mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births by 2030) goals.

Policy Advice 2: Improving health system functioning and quality of MNCH care through training and practice of recommended standard of care protocols, and regular monitoring of standards

Rationale:

Improving delivery rates with skilled birth attendants (SBA) at health facilities is one of the key strategies for reducing maternal and perinatal mortality. However, many OIC member countries with high SBA have very high maternal mortality ratios and child mortality rates. There are concerns that quality of care in health facilities is poor. A recent estimate suggests that half of all maternal deaths and 1 million neonatal deaths could be prevented by ensuring high quality of health care delivery system.

Stakeholders suggest to improve the quality of care through good governance and ensuring accountability. Standard protocols are available for the management of normal delivery and for the treatment and referral of women for maternal complications. However, the practice of such protocols and monitoring of practice are often poor in low and middle-income countries. Results-based financing programs were instituted in some settings for improving quality of health services. Studies also suggest that often the competency level of health providers is low and needs improvement through refresher training. Doctors are often not available at health facilities or engage in moonlighting, which also affect the quality of care at health facilities.

Essential drugs or medical equipment are often not available or functional in many public health facilities. Assuring financing and timely planning for procurement and distribution of supplies will help to avoid stock-out challenges.

Providing safe, effective, women-centered, timely, efficient and equitable MNCH care will be critical for improving its acceptance and utilization.

Policy Advice 3: Improving continuum of maternal, neonatal and child health care for assuring uninterrupted services before and during pregnancy, delivery and postpartum period through among others developing specific conditional cash transfer programs

Rationale:

Although antenatal care (ANC) is high in many OIC member countries, often more than 90% for at least one visit, the continuum of maternity and postpartum child care is low. In spite of receiving ANC from a health facility, many women do not deliver at a health facility or under a skilled birth attendant and receive medical care during postnatal period, when mortality risks are highest. The World Health Organization now recommends conducting ANC visits 8 times and initiating early in the first trimester. In many countries, however, the visits of at least four antenatal care (ANC4+), which was recommended earlier, are even substantially low (often less than 50% of one ANC visit rate); reaching 8 visits will need more efforts, resources and programmatic interventions.

Similarly, the immunization coverage for the selected vaccination or the first dose is high in many countries, but the coverage of "all recommended doses for the basic vaccinations" is low. These are missed opportunities: each contact with a health provider provides the opportunities of counseling women for delivering at a health facility, seeking immediate postpartum care for them and their newborns, and completing age-specific full doses of vaccination. Community based outreach programs are also needed for maintaining continuum of care. Rapid expansion of mobile phone technology opens new opportunities for contacting women and families for reminding and assuring continuum of care. It is imperative to identify the barriers of continuum of care and provide remedial solutions. Identifying the scopes and challenges of integrated programs for the continuum of maternal, neonatal and child health care also needed to develop appropriate MNCH policy and action plans. In this respect, specific conditional cash transfer programs can be developed targeting pregnant women to ensure their continuum of maternity and postpartum child care.

Policy Advice 4: Developing/Improving integrated health information management systems for monitoring MNCH care level and reporting births and deaths, including maternal deaths, nationally and locally

Rationale:

Monitoring key health data is crucial to identify challenges and priorities in providing quality health services. Strengthening health information systems facilitates planning and allocation of resources as well as contributes to accountable and transparent public health management. Fully functional health information systems would enable government officials give sound and timely decisions based on reliable data towards enhancing access to health services.

Many OIC Member Countries face challenges regarding health information management such as reporting quality and timeliness, duplication and fragmentation of data collection as well as lack of rigorous validation within different programmes. Some member countries do not have sufficient registration of births and deaths as well as reporting complete and accurate causes of death is lacking. This adversely affects the estimations of maternal and child mortality indicators. The most recent mortality estimates for the developing countries are based on model based estimates, which are available at a national level. These estimates are not helpful for tracking sub-national situations. Knowing causes of deaths is critically important for developing and planning appropriate public health interventions. It is possible to provide such information from a good, functional HMIS system.

Therefore, allocating required resources to develop and maintain infrastructure to enhance a well-designed health information management system is highly important. Moreover, in order to ensure uniformity in aggregating data, collaborating with different stakeholders such as statistical departments, relevant ministries and organizations is crucial to achieve a strong multi-sectoral coordination mechanism. Coverage of information will be needed from both health facilities and communities.

Policy Advice 5: Developing sustainable educational programs on women and child health care delivered to community with a view to eliminating the inequities linked to low education levels

Rationale:

As a long term investment and strategy, improving female education is critical for reducing maternal and child mortality. A large inequity in maternal and child health care was observed by education level, wealth quintile, and urban-rural areas. Education is also a key factor for inequity in socioeconomic status and urban-rural residence. The elimination of inequity due to education may increase maternal and child health care considerably. In many of the OIC member countries that have high maternal and child mortality and low utilization of MNCH care, female education level is low.

Education is also likely to improve women's empowerment and decision making for health care for themselves and their children. Lack of permission is cited in the literature as one of the main causes of not delivering at a health facility. Improving women's empowerment is likely to reduce such barriers. Therefore, activities towards raising awareness among mothers and pregnant women can be encouraged by the high level country strategy documents and regulations.

Instruments to Realize the Policy Advices:

COMCEC Poverty Alleviation Working Group: In its subsequent meetings, the Working Group may elaborate on the above-mentioned policy areas in a more detailed manner.

COMCEC Project Funding: Under the COMCEC Project Funding, the COMCEC Coordination Office issues calls for project proposals each year. With the COMCEC Project Funding, the member countries participating in the Working Groups can submit multilateral cooperation projects to be financed through grants by the COMCEC Coordination Office. For realizing above-mentioned policy recommendations, the member countries can utilize the COMCEC Project Funding facility. These projects may include organization of seminars, training programs, study visits, exchange of experts, workshops and preparation of analytical studies, needs assessments and training materials/documents, etc.

Annex 4: List of Participants

LIST OF PARTICIPANTS

14th MEETING OF THE COMCEC POVERTY ALLEVIATION WORKING GROUP 6 November 2019 Ankara

A. MEMBER COUNTRIES OF THE OIC

ISLAMIC REPUBLIC OF AFGHANISTAN

- Mr. M.USMAN HEJARAN

Advisor to the Minister, Ministry of Economy

- Mr. MUQADAR HASHIMI

Director of Economic Policy, Ministry of Economy

PEOPLE'S DEMOCRATIC REPUBLIC OF ALGERIA

- Ms. SALIMA OUBOUSSAD

Deputy Director, Ministry of National Solidarity Family and Status of Women

REPUBLIC OF AZERBAIJAN

- Mr. SHAHIN KHASIYEV

Head of Department Health Statistics and Informatics, Azerbaijan Republic Ministry of Health

- Ms. JAMILA BAGHIROVA

Head of Department, State Committee for Family Women and Children Affairs

REPUBLIC OF BENIN

- Dr. KODJO RODRIGUE KOHOUN

Health District Manager, Ministry Of Health

- Mr. MENSAH HYACINTHE MONTCHO

Head of Research Department, Ministry of Planning And Development

ARAB REPUBLIC OF EGYPT

- Mr. AMR SELIM

Deputy Head of Mission, Embassy of Egypt in Ankara

REPUBLIC OF GAMBIA

- Mrs. JULDEH CEESAY

Deputy Permanent Secretary, Ministry of Finance and Economic Affairs

REPUBLIC OF INDONESIA

- Mr. ADHY KARYONO

Head of Planning Bureau, Ministry of Social Affairs

- Ms. ENI GUSTINA

Secretary, Ministry of Health

- Ms. YANTI DAMAYANTI

Deputy Director, Ministry of Social Affairs

- Ms. MAYANG SARI

Deputy Director, Ministry of Health

REPUBLIC OF IRAQ

- Ms. DHIFAF HIKMET NAJI

Chief Observer, Ministry of Labour and Social Affairs

KINGDOM OF MOROCCO

- Ms. LOUBNA EL MAAROUFI

Head Of the Coordination and Inter Sectorial Cooperation Department, Ministry Of Health

- Ms. FATIHA BARKATOU

Executive at the Division of Maternal and Child Health, Ministry Of Health

REPUBLIC OF NIGER

- Mr. SOULEY IRO

Director, Ministry of Planning and Development

- Ms. AMINA ALFOUZAZI

Expert, Ministry of Health

SULTANATE OF OMAN

- Ms. MAYA AL HAJRI

Financial Analyst, Supreme Council for Planning –The General Secretariat

- Dr. JUMANA AL ABDUWANI

Head of Child Health Section, Ministry of Health

ISLAMIC REPUBLIC OF PAKISTAN

- Mr. UMER SIDDIQUE

Counsellor, Embassy of Pakistan in Ankara

THE STATE OF PALESTINE

- Mr. KHALED ABUKHATTAB

Director, Ministry of Social Development

- Ms. HADIL ALI-MASRI

Consultant Doctor, Ministry of Health

STATE OF QATAR

- Ms. KHLOUD ALMARAGHI

Expert, Ministry of Administrative Development, Labor and Social Affairs

- Ms. MUNEERA AL EMADI

Expert, Ministry of Administrative Development, Labor and Social Affairs

REPUBLIC OF TUNISIA

- Mr. MOHAMED CHAOUCH

Deputy Director, Ministry of Health

REPUBLIC OF TURKEY

- Mr. BEKİR KESKİNKILIÇ

Deputy General Director, Ministry of Health

- Mr. NEVZAT KUNDURACI

Head of Department, Ministry of Family Labour and Social Services

- Mr. YUSUF IRMAK

Head of Department, Ministry of Health

- Mr. AHMET SAİD ALTIN

EU Expert, Ministry of Health

- Ms. ZEYNEP DEMİRTAŞ

Project Assistant, Ministry of Family Labour and Social Services

- Mr. RIDVAN CIVAN

Expert, Ministry of Health

- Mr. OZAN İLTER

Expert, Ministry of Family Labour and Social Services

- Mr. YUNUS EMRE TOPÇU

Project Assistant, Ministry of Family Labour and Social Services

- Mr. UMUT KAYA

Assistant Expert, Ministry of Family Labour and Social Services

- Ms. YAĞMUR ÖZBUÇAK

Program Assistant, Ministry of Family Labour and Social Services

B. THE OIC SUBSIDIARY ORGANS

STATISTICAL, ECONOMIC, SOCIAL RESEARCH AND TRAINING CENTER FOR ISLAMIC COUNTRIES (SESRIC)

- Mr. SEYİD TAHİR MAHMUD
  Researcher, SESRIC

- Mr. KAAN NAMLI
  Social Researcher, SESRIC

- Ms. ESMA DEMİRTAŞ
  Training Expert, SESRIC

C. INVITED INSTITUTIONS

WHO Country Office in Turkey

- Mr. TUFAN NAYİR
  Consultant, WHO

UNICEF Ankara Office

- Dr. MEHMET ALİ TORUNOĞLU
  Health Specialist, UNICEF

DOCTORS WORLDWIDE

- Mr. SAFA ŞİMŞEK
  Coordinator, Doctors Worldwide

- Mr. AHMET ÇEVİK
  Coordinator, Doctors Worldwide

- Mr. FATİH CEYHAN
  Project Assistant, Doctors Worldwide

- Mr. OĞUZHAN BİLİCİ
  Coordinator, Doctors Worldwide

D. CONSULTANT

- Mr. SAIFUDDIN AHMED
  Consultant, Johns Hopkins University

E. COMCEC COORDINATION OFFICE

- Mr. DENİZ GÖLE

Director

- Mr. SELÇUK KOÇ

Director

- Mr. MEHMET ASLAN

Director

- Mr. ERHAN SIRT

Director

- Dr. GÜNEŞ AŞIK

Consultant, COMCEC

- Mr. MEHMET AKİF ALANBAY

Expert