



International
Labour
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Safe maternity and the world of work



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	Page
Preface	v
Introduction	1
Maternal mortality: The realities, the reasons	1
The world of work: An entry point for promoting safe maternity	2
Improving maternity protection and health through the workplace	5
The importance of maternity protection at work for maternal and newborn health and for gender equality	5
Maternity protection at work	5
Making maternity protection a reality	6
Workplace education and services	8
Addressing the needs of HIV-positive women during pregnancy	9
Improving maternity protection and health through the workplace: Moving forward	10
Implementing, extending and improving social health protection	11
Achieving universal coverage in social health protection: The ILO strategy towards universal access to health care	12
Maternity benefits schemes	14
Implementing, extending and improving social health protection: Moving forward	15
Promoting decent work for health workers	15
Better working conditions for health workers	15
HIV/AIDS takes a toll on health workers	16
Migration	16
Social dialogue: Building consensus for sustainable solutions	17
Partnerships	17
Conclusions: Mobilizing support, working together	19
Documents and references	21
Annex : Ratifications of international labour standards with particular relevance to maternity and to health workers	25



Preface

In the year 2000, leaders from around the world committed their nations to the UN Millennium Declaration and a set of critical goals intended to reduce poverty, improve health, and promote peace, human rights, gender equality and environmental sustainability. These Millennium Development Goals (MDGs) hold out great promise for upholding human rights and improving the lives of women, men and children around the world. They have become the development targets through which the United Nations and other international agencies have since coordinated their developmental activities.

The International Labour Organization (ILO), as one of the specialized agencies of the United Nations, works with its partners and in joint efforts with other multilateral organizations and civil society in support of the Millennium Declaration. The ILO's goal of Decent Work for All goes hand-in-hand with the Millennium Declaration. Delivering Decent Work for All means ensuring that all women and men who need or want to work can find employment which is productive and is carried out in conditions of freedom, dignity and security. Indeed, the Decent Work Agenda, in a context of fair globalization, is essential to the achievement of these shared aims.

Many countries have reported solid progress toward achieving at least some of the MDGs by the year 2015. But some goals and targets, including those related to maternal health, are proving difficult for most countries to attain. The ILO reiterates its commitment to work in partnership in efforts to realize the MDGs, and sets out, in this paper, contributions through the world of work that stand to strengthen and reinforce efforts to meet women's rights to safe maternity.

That the world of work matters for maternal health is clear. Work is central to the lives of nearly every member of society, with decent work and economic security undeniably linked to the health and well-being of workers and their families. The ILO's main aims — promoting rights at work, encouraging decent employment opportunities, enhancing social protection and strengthening social dialogue between government, employers and workers — contribute to the economic conditions and equitable growth that provide the broader context for the economic and physical well-being of all. The priority that the ILO places on gender equality in all of its work and goals strengthens the foundation for women's access not just to decent work, but to health, to education, to political and legal empowerment.

While decent work and women's economic empowerment are conditions for improving women's status and health, this paper sets out several priority areas within the ILO mandate that stand to contribute substantially to broader efforts aimed at improving maternal health. First, scaling up efforts to improve maternity protection and health through the workplace is a great need everywhere, to ensure that work does not threaten the health of pregnant and nursing women or their newborns and that maternity and women's reproductive roles do not jeopardize their economic security. Second, social health protection is vital to ensure that health care is within the reach of all and that financial barriers do not deter women from securing the care they need. Third, ensuring decent work for health workers is a must for addressing the global crisis facing the health workforce.

Achieving the international and national commitments expressed in the MDGs to improve the lives and health of women and reduce their risks of pregnancy-related death requires renewed commitments, innovative solutions, and stronger partnerships and action. It is our hope that this publication will encourage further discussion for strengthening cooperation and coordination at global, regional and national levels, drawing on the diversity of experiences and expertise of different

actors in different sectors in the service of achieving shared goals. The ILO is committed to playing a decisive role in this effort.

We would like to take this opportunity to thank all those that contributed to this truly collaborative effort. We thank the author of this report, Naomi Cassirer, and the many ILO colleagues who provided valuable contributions to the paper; Laura Addati, Sameera Al-Tuwaijri, Conor Boyle, Dimitrina Dimitrova, Ros Harvey, Sophia Kisting, Ursula Kulke, Christopher Land-Kazlauskas, Susan Leather, Katherine Magaziner, Philippe Marcadent, Susan Maybud, Henrik Moller, Ina Pietschmann, Emmanuel Reynaud, Xenia Scheil-Adlung, Dorothea Schmidt, Manuela Tomei, and Christiane Wiskow. Aviva Ron provided substantial inputs for the paper. Kristine Falciola and Claire Piper provided the editorial and administrative support required to bring this paper to completion.

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Every maternal death is premature and tragic, and often brings lasting negative consequences for the family and society. Each year, around 8 million women have pregnancy-related complications and over half a million women die before, during and after childbirth. Nearly 3 million babies are stillborn, and almost 4 million infants die within the first week of life. Despite global consensus to accelerate efforts to achieve Millennium Development Goal 5 (MDG 5) — *Improve maternal health, and meet international targets of reducing the maternal mortality ratio by three-fourths between 1990 and 2015* — progress has been slow, and in some countries, the situation has worsened.¹

Efforts to accelerate progress on MDG 5 have focused on increasing women's access to skilled attendance during childbirth and to emergency obstetric care, and on improving health systems. These responses are indeed essential to safe maternity, but slow progress toward MDG 5 indicates that greater efforts and renewed commitments are required to reach those women currently falling beyond the scope of existing actions. Action and partnership across sectors and between a variety of stakeholders is needed to address the broader economic and social conditions which affect women's lives and undermine their right to safe maternity.

The International Labour Organization (ILO) is founded on the principle of social justice and promotes decent work as a means to poverty reduction and sustainable development. In this paper, the ILO highlights the linkages between decent work and maternal health, demonstrating that action in the world of work by the ILO and its constituents can contribute to improving maternal health and supporting safer pregnancies, healthier mothers and healthier newborns. This paper provides a brief background of the global concerns regarding maternal health and mortality, followed by a review of the relevance of the world of work — the frameworks, institutions, actors and means — to safe maternity. The rest of the paper details three priority areas within the ILO's mandate for improving maternal health: improving maternity protection and health through the workplace; implementing, extending and im-

proving social health protection; and promoting decent work for health workers.

Maternal mortality: The realities, the reasons

The potential – and the hope – for reducing maternal mortality lie in the tremendous variation in the Maternal Mortality Ratio (MMR) across countries and populations.² Variation in the MMR between developed and developing countries is greater than any other health indicator, including child mortality.³ In the developed world, the average maternal mortality ratio is 20, compared to 830 in Africa, 330 in Asia and 190 in Latin America and the Caribbean. Roughly 85 per cent of all maternity-related deaths occur in Sub-Saharan Africa (with an MMR of 920) and in South-central Asia (MMR of 520).⁴ The variation may also be expressed as the life-time risk to a woman of dying from pregnancy-related causes: one in six in Sierra Leone and Afghanistan, one in 16 in sub-Saharan Africa, and one in 30,000 in Sweden.⁵ Variation within countries can be considerable as well, with the risks of dying from maternal causes significantly higher for the poorest segments of the population relative to the richest.⁶

The major medical causes of maternal mortality globally are obstructed labour, hemorrhage, infections, unsafe abortions and hypertensive disorders.⁷ Unsafe abortions account for a considerable number of maternal deaths,⁸ while in sub-Saharan countries, AIDS is an important factor, increasing women's risk of dying from pregnancy complications and from greater susceptibility to opportunistic infections.⁹

² The MMR is the number of women who die from any cause related to pregnancy or childbirth, or within 42 days of a termination, per 100,000 live births.

³ Ronsmans and Graham, 2006.

⁴ WHO, 2005; www.unfpa.org

⁵ Ronsmans and Graham, 2006.

⁶ *ibid.*

⁷ Khan et al., 2006; Ronsmans and Graham, 2006.

⁸ Worldwide, 19 million women experience unsafe abortions each year; 68,000 of them — all in developing countries — die from complications. See www.who.int/reproductive-health/unsafe_abortion/map.html.

⁹ Van Dillen et al., 2006; McIntyre, 2005.

¹ WHO, 2005

The risk factors are compounded in countries where pregnancies come too often, too close together, and by mothers who are too young or too old. Cultural factors and gender inequality continue to come into play; for example, in decisions on whether, where and when pregnant women can receive care. Causes and responses for many of these factors extend beyond the health sector, and are related to the social and economic empowerment and education of women and the removal of financial and cultural barriers to seeking health care.

In addressing these largely preventable deaths, it is important to note that lower maternal mortality can be achieved at any level of development and does not require ideal political or economic conditions.¹⁰ Findings from around the world demonstrate that it is possible to dramatically reduce maternal mortality, even within low-resource settings, at relatively low cost.¹¹ Indeed, those countries with very low MMR are not all among the richest, while those with very high MMR are not all among the poorest countries. Effective interventions are known, and these need to be defined and led at the national level, coordinated in partnership across different sectors and levels of institutions, each building on their respective strengths and mandates to address the multiple dimensions of women's lives and health.

The world of work: An entry point for promoting safe maternity

The ILO works to promote decent work as part of a larger agenda of freedom, equity, security and human dignity. Decent work is central to poverty reduction and is inextricably linked to gender equality and women's empowerment as fundamentals of just and equitable societies and requirements for realizing women's rights to safe maternity. The high priority that the ILO places on gender equality issues in the world of work contributes to the legal and institutional contexts that matter for all aspects of women's status and lives, including their maternal health.

The ILO is the global body responsible for drawing up and overseeing international labour standards. Working with its 181 member States, the ILO seeks to ensure that labour standards are respected in practice as well as principle.

The International Labour Organization at a glance

The International Labour Organization (ILO) is the United Nations agency devoted to advancing opportunities for women and men to obtain decent and productive work in conditions of freedom, equity, security and human dignity. Its main aims are to promote rights at work, encourage decent employment opportunities, enhance social protection and strengthen dialogue in handling work-related issues.

The ILO is the only "tripartite" United Nations agency in that it brings together representatives of governments, employers and workers to jointly shape policies and programmes.

The ILO is the global body responsible for drawing up and overseeing international labour standards. Working with its 181 member States, the ILO seeks to ensure that labour standards are respected in practice as well as principle.

Indeed, the world of work offers important avenues for addressing maternal health. The world of work brings **international labour standards** that address all facets of work, establishing frameworks for national legislation and policies, and for practical action at the workplace — whether public or private, formal or informal. Several hold particular relevance to maternal health.

Maternity protection. Protecting maternity has been a core issue for the member States of the ILO since its establishment. Over the course of its history, member States have adopted three Conventions on maternity protection (No 3, 1919; No. 103, 1952; No.183, 2000), which have progressively expanded the scope and entitlements of maternity protection at work. The core concerns have been to ensure that women's work does not threaten the health of the woman or child during and after pregnancy, and that women's reproductive roles do not compromise their economic and employment security.¹²

Social security. The Social Security (Minimum Standards) Convention, 1952 (No. 102), sets minimum requirements for the provision of health care during pregnancy and confinement, and cash maternity benefits replacing lost income. It also sets minimum standards for access to preventive and curative health services in general.

¹² See www.ilo.org/standards to see the full texts of the Conventions on maternity protection and www.ilo.org/travail/infosheets/index.htm for an information sheet reviewing the history of ILO Conventions on maternity protection and the provisions of the current Convention, 2000 (No. 183) and its corresponding Recommendation, No. 191.

¹⁰ Ronsmans and Graham, 2006; Pathmanathan et al., 2003.

¹¹ *ibid.*

Other relevant Conventions include the Nursing Personnel Convention, 1977 (No. 149), addressing working conditions and rights of nursing personnel, and the Medical Care and Sickness Benefits Convention, 1969 (No. 130) setting standards for access to preventive and curative medical care. Hazardous work is a threat to the reproductive health of workers, male and female, and a number of occupational safety and health labour standards help establish the context for safe work, providing guidance on policies of action, protection in specific branches of economic activity, protection against specific risks and specific measures of protection.

A number of **key actors and institutions** in the world of work can come together to shape policies and practices promoting social and economic development, good governance, social inclusion and poverty reduction. Labour ministries, employers' organizations and trade unions are essential for the effective formulation and implementation of policies and practices at the national, local, sectoral or enterprise level. Social dialogue brings together these partners, with their distinctive roles, interests, and concerns, to consult, negotiate and act on priority issues. Social dialogue promotes consensus building and democratic involvement among the major actors in the world of work, and in doing so, holds the potential for resolving important problems in a way that responds to the specific local needs and circumstances and holds out improved opportunities for success.

At the level of the **workplace**, the potential is great for leveraging policies, education, services and practical actions to improve maternal health. Work is a central feature of the lives of men and women everywhere, and workplaces are communities where people gather, share information and learn. Workplace communities overlap with families, neighborhoods and other communities, providing opportunities for wider impact of programmes and education. The shared experience of work and the rich potential to reach men and women through workplaces — whether in factories, fields, streets, offices or homes — offer opportunities to make an enormous difference in individuals' lives.

It is in this context that the world of work is a promising entry point for scaling up interventions aimed at improving maternal health. Addressing the effects of poverty, gender inequality and discrimination on safe maternity can directly complement efforts in the health sector to realize women's rights to safe pregnancy and childbirth and to improve women's well-being. Economic empowerment and



decent work contribute to women's health before, during and after childbearing years, for a number of reasons.

- Paid work generates income. Enhancing women's access to and control over **income** increases their autonomy and control over decisions related to their health.
- In many countries around the world, national **rights to health and social security** are often linked to paid employment. Social security is key for the health and security of the population; it provides workers and their families with access to health care (including antenatal, confinement and post-natal care), with protection against loss of income (including leaves due to maternity), and with the right to paid maternity leave for pregnant women workers.
- Many workers lack access to social security, and for these workers, paid work can indirectly increase their access to health, although much less efficiently, by enhancing their capacity to pay for health-care services or for private or micro-health insurance.
- Many working women are also entitled to **rights to maternity protection** and other labour rights, including safe working conditions, paid maternity leave, medical benefits during pregnancy and leave, and employment security. Effective application of these rights is still uneven, due to gaps in coverage and implementation of the laws, policies and regulations that ensure rights.
- Finally, paid work can be beneficial for addressing women's concerns, (including concerns about maternity protections, health care, etc.) through their rights and access to **representation and social dialogue**. It is through genuine,

democratic and independent representatives of workers and employers that many women are able to voice their concerns on issues that matter to them, and through social dialogue between workers, employers, and governments that these concerns can be parlayed into actions and measures that improve women's lives.

Discouraging realities on all of these fronts remain for women around the world. Countless women lack access to decent work that enables them to rise above poverty or work in safe conditions; many fall outside of traditional legal protections and social protection systems that safeguard against vulnerability and provide access to health care; many have yet to realize freedom from discrimination and dismissal on the basis of pregnancy or maternity; and many lack the voice and representation to better their lives. Realizing women's rights to safe maternity requires achievements in their rights to decent work and economic empowerment, as well as their

rights to educational opportunities and to political and legal equality.

The lack of access to decent work is a threat to the maternal health of women everywhere. Compounding this threat further is the global crisis facing the health-sector workforce. Severe shortages and geographic imbalances in the distribution of health-care workers profoundly hinder progress in achieving international commitments to reduce maternal mortality. Decent work for health workers must be part of the global response to make safe pregnancy a reality. It is in the intersection between these challenges in realizing decent work for all, and the challenges in realizing women's rights to safe maternity that the ILO and its constituents stand to contribute most effectively to global and national efforts toward MDG 5. Specifically, given its respective mandate and strengths, the ILO identifies three areas as priorities for action to improve maternal health through the world of work.

Priorities for action to improve maternal health through the world of work

- **Improving maternity protection and health through the workplace**

Promote maternity protection for all women workers during pregnancy, childbirth and breastfeeding

Step up education and services through the workplace, for formal and informal economy workers, including HIV prevention, counseling and services

- **Implementing, extending and improving social health protection**

Promote effective access to quality health care and provide financial protection against health-related costs

Cover all women with adequate maternal benefits including leave benefits, pre-natal, childbirth and post-natal care, as well as hospital care when necessary

- **Promoting decent work for health workers**

Decent terms and conditions of employment for health workers in public and private health sectors

Improving maternity protection and health through the workplace

Promote maternity protection for all women workers during pregnancy, childbirth and breastfeeding

Step up education and services through the workplace for formal and informal economy workers, including HIV prevention, counselling and services

That paid work is a central feature of the lives of most individuals is as true for women of reproductive age as it is for all men and women. Worldwide, nearly 60 per cent of women of childbearing age were in the labour force in 2006.¹³ The importance of paid work in the lives of so many makes the quality of working conditions paramount to the reproductive health of women (as well as men). There is broad consensus that protections at work during maternity are important for safeguarding the health and economic security of women and their children. This consensus is reflected in international labour standards which set out the basic requirements of maternity protection at work. Maternity protection includes the right to a period of leave immediately before and after childbirth, cash and medical benefits, health protection at work, entitlements to breastfeeding breaks, and employment protection and non-discrimination.

The importance of maternity protection at work for maternal and newborn health and for gender equality

Working during pregnancy is not in and of itself a risk and, in general, most would agree that women who remain employed throughout their pregnancy and are granted paid maternity leave and return to work after adequate leave are less likely to suffer negative outcomes of pregnancy. But women around the world continue to face considerable maternity-related threats to their health and economic security. Women continue to face dismissal and discrimination in hiring on the basis of maternity.¹⁴ Workplace environments can pose hazards (e.g. exposure to pesticides, solvents and other chemicals); requirements of physically demanding work (e.g. heavy lifting); and irregular or long working hours: all can have potentially negative effects for the health of pregnant women and their foetuses, including greater risks of preeclampsia and hypertension, complications during pregnancy, miscarriage and stillbirth, fetal growth retardation, premature birth and other problems.¹⁵

Maternity protection at work

Discrimination and the effects of potential hazards facing working women during pregnancy can be mitigated by social and legal measures. The Maternity Protection Convention, 2000 (No. 183), is the most recent maternity protection Convention adopted by the member States, and is accompanied by the Maternity Protection Recommendation, 2000 (No. 191). The Conventions on maternity protection are international treaties, subject to ratification by ILO member States, while Recommendations are non-binding instruments that set out guidelines orienting national policy and action (see Annex for ratifications of ILO maternity protection Conventions).

¹⁴ See, for example, Hein, 2005.

¹⁵ Dabrowski et al., 2003; Brender et al., 2002; Mozurkewich et al., 2000; Tuntiseranee et al., 1998; Paul, 2004.

Maternity protection at work

The Maternity Protection Convention, 2000 (No. 183), covers:

- 14 weeks of maternity leave, including six weeks of compulsory post-natal leave
- Cash benefits during leave of at least two-thirds of previous or insured earnings
- Access to medical care, including pre-natal, childbirth and post-natal care, as well as hospitalization when necessary
- Health protection: the right of pregnant or nursing women not to perform work prejudicial to their health or that of their child
- Breastfeeding: minimum of one daily break, with pay
- Employment protection and non-discrimination

¹³ Based on data for women aged 15 to 49. These data are taken from the following databases: ILO labour force data, EAPPEP version 5, at <http://laborsta.ilo.org/>; population data from the United Nations, 2007 World Population Prospects (2006 revision), at <http://esa.un.org/unpp/>.

The basic requirements of maternity protection at work set out by the Maternity Protection Convention, 2000 (No. 183) contribute to the well-being of women throughout maternity.

Maternity leave. The mother's right to a period of rest when a child is born, together with adequate means of supporting herself and her family and a guarantee of being able to resume work after the leave, is the core element of maternity protection. The purpose of maternity leave is to safeguard the health of a woman and that of her child during the perinatal period, in view of the particular physiological demands associated with pregnancy and childbirth.

Employment protection. A guarantee for pregnant women and new mothers that they will not lose their job as a result of being pregnant, absent on maternity leave or because they have just had a child is essential for preventing maternity from becoming a source of discrimination against women in employment. Pregnancy and maternity leave should have no adverse effects on women's employment or on their entitlements under the employment contract, in particular, those linked to seniority (such as paid annual leave) or to length of service (such as retirement benefits).

Cash and medical benefits. The need for cash benefits during maternity leave and medical care throughout maternity have been recognized in all ILO maternity protection Conventions and in Conventions regarding social security and medical care. Cash benefits are intended to replace a portion of the income lost due to the interruption of the woman's economic activities, giving practical effect to the provision for leave. Without income replacement, the woman's absence during leave and the increased expenditures due to pregnancy and childbirth can pose financial hardships for many families. In the face of poverty or financial duress, women may feel compelled to return to work too quickly after childbirth, before it is medically advisable to do so. Convention No. 183 also requires appropriate health services for women throughout maternity, calling for medical benefits, including pre-natal, childbirth and post-natal care, as well as hospitalization when necessary (Article 6).

Health protection. Pregnancy, childbirth and the post-natal period are three phases in a woman's reproductive life in which special health risks exist and special workplace protections may be needed. Medical supervision and, if necessary, the adaptation of a woman's activities in line with her condition may greatly reduce the specific risks to her health, enhance the probability of a successful outcome to the

pregnancy and set the stage for the healthy development of the child.

Convention No. 183 sets out the right to health protection by calling for measures to ensure that the pregnant or nursing woman is not obliged to perform work prejudicial to her health or that of her child, or where an assessment has established a significant risk to the health of the mother or her child (Article 3). Recommendation No. 191 provides for adaptations in the pregnant or breastfeeding woman's working conditions in order to reduce particular workplace risks related to the safety and health of the woman and her child, and notes that the woman should retain the right to return to her job or an equivalent one paid at the same rate when it is safe for her to do so.

Breastfeeding. The right to breastfeed a child after returning to work has major benefits for the health of the mother and her child. The World Health Organization recommends exclusive breastfeeding of babies until the age of 6 months for mothers who are not HIV positive, and continued breastfeeding with supplemental foods for up to two years. As maternity leave periods typically expire before the child's sixth month, provisions to enable women to continue to breastfeed upon return to work are important to meet international recommendations on breastfeeding and health and are in the best health interests of mother and child. Convention No. 183 entitles women to one or more daily breaks, or a reduction of hours of work, for breastfeeding. Breaks or working hour reductions are to be counted as working time and remunerated accordingly.

Making maternity protection a reality

Over time, the principles of ILO maternity protection Conventions have been universally embraced, with the result that at least some of these basic elements of maternity protection have been adopted into the legislation of virtually every nation in the world, regardless of whether they have ratified Conventions on maternity protection or not. Currently, 62 countries have ratified at least one of the three maternity protection Conventions (see Annex). Together with other components of social protection, member States recognize the importance of maternity protection for the well-being of individuals, of families and of communities; their role in human dignity, equity and social justice. Nevertheless, there remains considerable scope for improving legal protections for maternity and for effective application of those rights in practice.

The ILO, together with its partners, works toward improving the adoption and application of the principles of maternity protection. Promoting ratification of the maternity protection Convention is an important first step. The provisions of international labour standards, whether ratified by a country or not, play a very important role in the elaboration of national laws, policies and judicial decisions, and in collective bargaining agreements. The ILO seeks to expand information and knowledge on how countries translate the principles of the standards into national law, by collecting information on the principal legal provisions for maternity protection at work adopted by member States around the world.¹⁶ An international repository for information on the state of legal protection, this database provides an important foundation for identifying national provisions intended to give effect to maternity protection at work and for enabling comparisons of national provisions to those set out in other countries and in international standards.

Nearly half (48 per cent) provided maternity leave of at least 14 weeks, while 36 per cent reached the standard of providing at least two-thirds of earnings during leave. Countries have also shifted away from financing mechanisms that place direct costs of maternity on employers — a potential burden to employers and source of discrimination against women — to greater reliance on compulsory social insurance or public funds, or a mixed system dividing responsibility between employers and social security systems. Some type of measure to protect against discrimination on the basis of maternity was found in most countries, and provisions to ensure the right to continue breastfeeding upon return to work were found in 92 countries. Examples of protection against workplace risks can be found around the world.

To assist governments, employers and trade unions in understanding the importance and the requirements of maternity protection, the ILO provides training and technical assistance on international labour standards and on specific matters relating to the implementation of the principles of maternity protection. For example, the ILO has worked closely with government, and employers' and workers' organizations in Jordan to assess the feasibility of implementing a maternity cash benefits scheme and to provide guidance regarding the establishment of a fair and affordable maternity protection scheme in Jordan. The ILO has training tools to assist employers and workers in assessing the occupational safety and health risks to pregnancy and maternal health within their workplaces. *Healthy beginnings: Guidance on safe maternity at work* (2005) reviews the specific occupational risks in different sectors¹⁸ and provides tools for identifying and responding to these risks, highlighting the possibilities for preventive action. ILO also brings experience in education and income-generating activities in the informal economy and of working with vulnerable groups in non-formal working situations. Through the **WISE programme**, tools have been developed to improve work conditions in small and medium enterprises, while the **WIND programme** covers tools to improve working conditions among subsistence and agricultural workers and workers in the informal economy. These training tools address multiple aspects of working conditions, including maternity protection. The ILO is also developing training modules aimed at enhancing the capacity

Maternity protection: A trade union priority

The International Trade Union Confederation (ITUC) renewed its commitments and efforts in 2007 to make maternity protection a reality in more countries, noting that a large proportion of women still face unequal treatment in employment owing to their reproductive function, and that women in the informal economy and atypical jobs are among the most vulnerable. ITUC has included in its campaign for maternity protection calls for a strong standard of maternity protection for all women workers; new efforts to ratify and implement ILO Convention No. 183 and Recommendation No. 191; and new commitments by trade unions to prioritize maternity protection through the application of ILO Convention No. 183 and Recommendation No. 191 in collective agreements and labour legislation. ITUC has also appealed to trade unions to “organize collective activities in their countries to raise awareness among political leaders, employers and society as a whole about the vital importance of maternity protection and paid maternity leave”.

Source: ITUC: Statement for maternity protection, 8 March 2007, at http://www.ituc-cis.org/IMG/pdf/Statement_8_march_EN.pdf.

An ILO report, based on the maternity protection database, reviewed national legislative provisions in comparison to the requirements of Maternity Protection Convention, 2000 (No. 183).¹⁷ All of the 166 member States studied have in place some legislative provisions for maternity protection.

¹⁶ The Conditions of Work and Employment database on maternity protection is available at www.ilo.org/travail/database.

¹⁷ Öun and Trujillo, 2005.

¹⁸ These are agriculture, call and contact centres, chemical and pharmaceutical industries, cleaning, waste disposal and laundries, manufacturing, construction and mining, health, social and residential care, hotels and tourism, and retail and distribution trade.

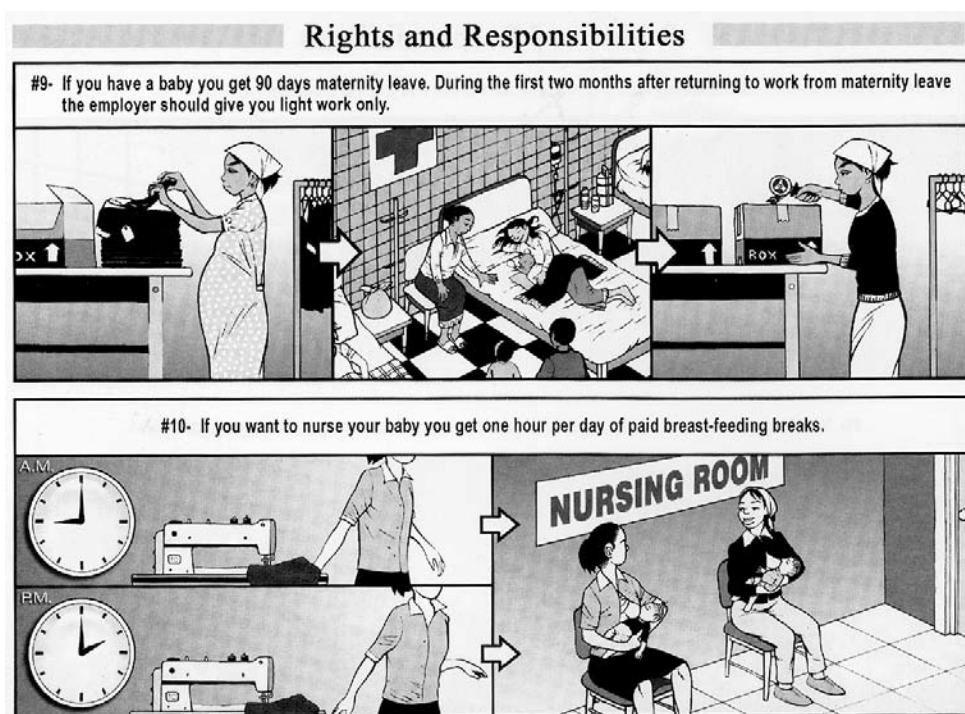
of employers' organizations to assist enterprises in developing and implementing workplace initiatives for improving maternity protection at work.

Workplace education and services

Workplaces serve as important entry points for education on a wide variety of issues, including health concerns. Governments, employers, and workers can come together in common action to increase awareness of maternal health issues, develop workplace policies and programmes to improve maternal health, and undertake educational programmes to build demand for health services. Many workplaces already have programmes and structures in place — human resource and training programmes, occupational safety and health services, workplace committees — that can provide entry points for action. Providing advisory services and training to government officials, employers and workers in the formal and informal economies can strengthen capacities to develop effective programmes, tailored to particular needs in different settings: formal or informal economy; large, medium or small enterprises; urban or rural.

Existing programmes to improve maternal health through the workplace suggest the promise of such approaches. The ILO *Better Factories Cambodia* project helps Cambodia's garment sector improve working conditions in factories. The vast majority of garment workers in Cambodia are women, many of them young and of reproductive age, single, from rural areas, and with low levels of education.¹⁹ Issues taken up by the project have included maternity leave and breastfeeding rights, in recognition of the lack of awareness of these rights among workers and managers. The project reported occasional instances of dismissal of pregnant workers and a large unmet demand of workers to breastfeed until their children were at least 6 months old.²⁰ The project has worked

with managers and workers to raise awareness of the provisions for maternity protection, including leave periods, benefits and breastfeeding breaks, through factory-based training, informational materials (see Figure below), and an episode on maternity pro-



Source: ILO, Better Factories Cambodia, undated.

tection at work in a nationally televised soap opera series aimed at communicating workers' rights and responsibilities through dramatizations in a Cambodian factory setting.

A project by the Reproductive and Child Health Alliance (RACHA) in Cambodia sought to improve maternal health and use of antenatal care services through safe motherhood education in Cambodian garment factories.²¹ Women participated in trainings that provided information on maternal health, including information on the benefits of antenatal care; planning for childbirth; precautions during and after pregnancy and danger signs; post-natal care, including hygiene and breastfeeding; and guidance on nutritional supplementation, including iron fortified fish sauce and iodized salt. Such workplace programmes have multiple benefits: for individuals, they improve health and enhance capabilities to make informed health decisions; for employers, they result in a healthier workforce with fewer health-related work absences and attrition; for nations, they contribute to national health objectives.

¹⁹ ILO, 2006a; RACHA, 2007.

²⁰ ILO, 2006a; ILO, 2005a.

²¹ RACHA, 2007.

Addressing the needs of HIV-positive women during pregnancy

Given that many women access health services only during pregnancy, maternal health services represent a pragmatic entry point for providing HIV intervention tailored to the needs of pregnant and postpartum women. Yet few efforts currently address the HIV prevention concerns of pregnant and postpartum women, especially those who are HIV-negative or whose status is unknown. This need is particularly important in light of the equally pressing need to prevent vertical transmission and to provide treatment, care and support for HIV mothers and their families.

The HIV/AIDS epidemic has exacerbated the health risks to pregnant women and newborn children. Today, HIV/AIDS is a leading cause of maternal deaths in areas of high HIV prevalence.²² HIV-positive women are also at risk of passing the infection on to their babies through mother-to-child-transmission (MTCT). Treatment and appropriate feeding options can halve a mother's risk of passing HIV on to her baby,²³ while improved access to diagnosis, care, treatment and nutritional supplements for pregnant women can greatly reduce HIV-related risks during pregnancy. However, only a small minority of women has access to information and services regarding appropriate prevention measures or ARV treatment, even when free ARV treatments are provided by governments.²⁴ Gender inequalities between women and men increase women's vulnerability to HIV/STIs and can affect how empowered women are to protect themselves and their offspring from HIV. Effective HIV prevention interventions should address the empowerment of women within a rights-based framework and promote male involvement in protecting the health of their partners and children.

The ILO coordinates at international and national levels the development of workplace frameworks, policies and actions that help respond to the HIV/AIDS epidemic. The ILO works with governments, employers and workers to raise awareness of HIV/AIDS in the world of work, to fight discrimination and stigma, and to combat HIV/AIDS through training and policy guidance on prevention, care and social protection. The activi-

The ILO Code of Practice on HIV/AIDS and the world of work

The ILO Code of Practice on HIV/AIDS is the framework for action on HIV/AIDS related to the workplace. It contains key principles for policy development and practical guidelines for programmes at enterprise, community and national levels. It covers the following main areas:

- Prevention of HIV;
- Management and mitigation of the impact of AIDS on the world of work;
- Care and support of workers infected and affected by HIV/AIDS;
- Elimination of stigma and discrimination on the basis of real or perceived HIV status.

The Code stresses the principle of gender equality, noting that successful prevention and impact mitigation will depend on "more equal gender relations and the empowerment of women". The ILO's legal instruments and the Code are bases for promoting the provision of health-care services to all workers, including pregnant women.

ties of the programme and action by the partners, guided by the ILO Code of *Practice on HIV/AIDS and the World of Work*, have included HIV education during working hours, provision of condoms, and information and services for confidential testing, which are aimed at providing the education and services people to make informed decisions about their own situations, behaviour and health.

Workplace programmes on HIV/AIDS are well placed to address the particular needs of HIV-positive women during pregnancy. HIV-positive women may face considerable stigma and discrimination which deters them from accessing reproductive health services. Employers have an important role to play in eliminating stigma and discrimination within the workplace and the community by building a supportive environment and sensitizing workers – both female and male – to enable women to exercise their sexual and reproductive health rights, regardless of their HIV status. Targeted awareness-raising in the workplace and workplace policies and programmes can help mitigate the impact of the epidemic for all. Existing tools and practices can incorporate a stronger focus on maternal health where needed, by extending information, education and counselling on prevention of HIV and on HIV/AIDS and pregnancy, by facilitating access to voluntary and confidential testing, by scaling up access to treatment to prevent MTCT and by providing information on infant feeding options for HIV positive women.

²² Ronsmans and Graham, 2006; McIntyre, 2005.

²³ See UNAIDS, at http://www.unaids.org/en/Issues/Affected_communities/mothertochild.asp (last accessed in September 2007).

²⁴ *ibid.*

Improving maternity protection and health through the workplace: Moving forward

The importance of paid work to the lives of most adult members of society makes work and workplaces a strategic arena for improving maternal health, by addressing working conditions, rights and responsibilities, and launching education and awareness-raising campaigns. Adopting international standards on maternity protection, improving legislative provisions and ensuring the effective application of those provisions are important starting points. Mobilizing the vast networks of government, employers and workers to undertake dialogue and action to develop and implement workplace policies and actions can reach extended communities of managers and workers with important information and practical guidance for improving maternal health. Targeted interventions — for important economic sectors or occupations, geographic areas or specific enterprises — can address particular issues, needs and risks with specific policies and programmes crafted to complement efforts in health and other sectors to improve maternal health.

10



Implementing, extending and improving social health protection

Promote effective access to quality health care and provide financial protection against health-related costs.²⁵

Cover all women with adequate maternal benefits, including leave benefits, pre-natal, childbirth and post-natal care, as well as hospital care when necessary

Today, more than half of the world's population remains without any form of social protection, despite the recognition of social security as a basic human right in ILO Conventions and UN instruments.²⁶ Just 5 to 10 per cent of the working population in sub-Saharan Africa and South Asia is covered by some form of social protection.²⁷ Social protection matters for workers' well-being and health, providing them and their families with access to health care and with protection against certain losses of income. By bolstering living standards and cushioning workers and families against economic change, social protection contributes to social cohesion, and national growth and development.

The lack of adequate social protection is as much a threat to women's health during pregnancy as it is to the lifelong health of all women, men, and children. Where social insurance coverage and government financing of health services are very low, much of the financial costs of health care defaults to families through out-of-pocket payments: for example, in the Democratic Republic of the Congo, where 81.7 per cent of health-care costs are paid for out-of-pocket; in Burkina Faso, 52.2 per cent; Bangladesh, 58 per cent; or in Cambodia, 69.9 per cent.²⁸ Particularly in low-income countries, out-of-pocket payments contribute to increased poverty. The lack of social protection may lead to catastrophic health expenditure and long-term disruption of income

generation due to sale of assets and borrowing. More than 100 million people worldwide are pushed into poverty every year by the need to pay for health care and, in some countries, these payments are the major reason that families fall into poverty.²⁹

During pregnancy, out-of-pocket fees and indirect costs (such as transportation) required for maternal and obstetric services mean that access to appropriate care remains beyond the reach of many. Maternity care may not only be expensive for poor households, but may also be a low priority in the use of scarce household resources. The decision of which family member warrants out-of-pocket spending, particularly when the costs of care are high and unpredictable, creates another barrier in access to timely maternity care. Without effective access to affordable quality health care and protection against related financial burdens — that is, adequate *social health protection* — women and their families are discouraged from seeking the care they need.³⁰

Financial barriers to seeking maternal care

Fees for maternal care and obstetric services impose financial burdens on households, preventing or delaying the use of such services by women and their families. Without access to social health protection, many families lack protection against catastrophic expenditures which can push households into poverty.

- In Benin, a normal delivery in a hospital uses one-twentieth of average annual family income. If there are complications, such as anaemia, hypertension or haemorrhage during confinement, the costs can consume one-third of that income.
- For Nepal's poorest families, a normal delivery in a hospital costs well over three months' worth of household income, while a home delivery still uses up 36 per cent of monthly income. More than one out of five women who delivered at home cited cost as the main reason for not going to hospital.

²⁵ Financial protection means that no family or household should contribute any more than a reasonable proportion of their income to finance a system of social protection and/or access a specific health service.

²⁶ Several international instruments affirm the right of every individual to social security. These include the Universal Declaration of Human Rights, 1948; the International Covenant on Economic, Social and Cultural Rights, 1966; ILO's Declaration of Philadelphia, 1944, and the Income Security Recommendation, 1944 (No. 67). See, for example, Reynaud, 2006.

²⁷ See <http://www.ilo.org/public/english/protection/seccsoc/downloads/events/factsheet.pdf>.

²⁸ ILO, 2007, Table 1b.

²⁹ WHO, 2006.

³⁰ See ILO, 2007.

- A normal hospital delivery in Bangladesh costs one months' average income, while a Caesarean section would require five months of monthly income for 75 per cent of families.
- For 72.4 per cent of poorer families in Gujarat (India), hospital delivery costs were considered to be catastrophic, and on average were 25.5 per cent of their annual income.

Source: Borghi et al., 2003; Borghi et al., 2006; Afsana, 2004; Ranson, 2002.

Some countries have removed user fees for maternal health in an effort to increase demand for services, but found that this action alone may be insufficient. Even where official user fees are removed, unofficial fees may remain as a barrier to access.³¹ In situations where the loss of revenues and increased demand on the health facilities are inadequately compensated by government or other sources, the resulting shortages in drugs and medical supplies and the increased workload for health workers amounts to funding shortages, declines in the quality of care and, ultimately, reduced demand for free services.³² Moreover, the long-term funding of free services is a key concern.

Universal social health protection is crucial to ensure that all people in need have effective access to at least basic health care: as a human right and as a condition of health and well-being, decent work and poverty reduction. Access to social health protection is central to the ILO's Decent Work Agenda, backed by the consensus of governments, workers' and employers' organizations, who agreed, at the International Labour Conference in 2001, that highest priority should go to policies and initiatives which bring social security to all who have none.³³ In the context of maternal health, the challenges lie in extending social health protection to all and ensuring that benefits packages include maternity benefits and services. While challenging, many countries have made strides on both fronts.³⁴

³¹ Parkhurst et al., 2005.

³² Gilson and McIntyre, 2005; Borghi et al., 2006; Witter and Adjei, 2007.

³³ See ILO, 2001.

³⁴ See ILO, 2007. Tunisia, for example, has increased health and pension coverage from 60 per cent in 1989 to 84 per cent in 1999, while Egypt, Ghana and Kenya are all striving for universal coverage. See <http://www.ilo.org/public/english/protection/seccsoc/downloads/events/factsheet.pdf> for facts on social security.

Achieving universal coverage in social health protection: The ILO strategy towards universal access to health care

Achieving universal social health protection coverage – defined as effective access to affordable quality health care and financial protection in case of sickness – is a central objective of the ILO. Social health protection consists of various financing and organizational options intended to provide adequate benefit packages to allow access to quality health care and protect against related financial burden. In many developing countries, the challenge lies in extending social health protection to the majority of the population that currently lacks any social protection. Workers in small and micro-enterprises and the self-employed, particularly those in the informal economy, often face economic insecurity and poverty and have no access to social protection schemes (because efficient schemes are not available and/or they have a limited capacity to contribute).

Financing social health protection is a major consideration. Social health protection is financed through a variety of mechanisms, from tax-funded national health service delivery systems to mandatory social health insurance financed by employers and workers, mandated or regulated private non-profit health insurance schemes, as well as mutual organization and community-based health insurance schemes. Each financing mechanism normally involves the pooling of risks between covered persons, and many of them explicitly include cross subsidizations between the rich and the poor – a key feature of all social health protection systems as a precondition of the goal of universal access.

In *Social protection: An ILO strategy towards universal access to health care*,³⁵ the basic principles and framework are set out for a rights-based approach to social health protection, with an explicit objective of reaching uncovered parts of the population in line with their needs and capacity to pay. It reviews global patterns of social health protection financing and coverage, and assesses the global deficit in access to health services. The strategy provides guiding principles and tools for extending social health protection through national coverage plans that improve health financing mechanisms, such as national health services, social health insurance, private health insurance and social assistance. Further, coverage plans aim at providing adequate benefit packages, and create

³⁵ This document is available in electronic format in English, French and Spanish at <http://www.ilo.org/public/english/protection/seccsoc/areas/policy/social.htm>.

institutional and administrative efficiency. It also supports the strengthening of national capacities — efficient structures and procedures, technical and administrative capacity — as a vital element in ensuring the viability of national plans.

Virtually all countries have built systems based on various financing mechanisms that combine two or more of these financing options. In ILO experience, the most pragmatic route to universal access to health care is often not to build new schemes, but to build upon and incorporate existing schemes into one pluralistic national system. ILO support to countries has drawn on this approach to rationalize pluralistic schemes with the aims of extending access and coverage to social health protection, while respecting existing coverage and financing arrangements and adjusting to the specific social and economic contexts of each country. In the context of this pluralistic approach to extend social health protection, it is useful to consider two instruments that have experienced a strong development during the last decade: micro-insurance and cash transfer.

In low-income countries, where maternal mortality is the highest, health micro-insurance has shown a good potential to reach groups excluded from statutory social insurance, to mobilize supplementary resources (financial, human resources, etc.) which benefit the social protection sector as a whole, to contribute to the participation of civil society and the empowerment of socio-occupational groups, including women. Despite their contribution, stand-alone, self-financed micro-insurance schemes have major limitations in their ability to be sustainable and to develop efficient mechanisms capable of reaching large segments of excluded populations, particularly the poorest. Their impact should be increased notably by developing functional linkages (like subsidizing premiums paid by low-income members, subsidizing or underwriting micro-insurance schemes or providing them with technical assistance in the area of management) with extended and expanded national social insurance systems, contributing in this way to a better equity and efficiency of the national social protection policies.

Cash transfer schemes have gained importance worldwide since the 1990s, in particular in Latin America and more recently in Asia and Africa. At the same time, these schemes experienced considerable transformation, in particular with regard to their relationship with labour market policies. Traditionally, the main concern about this relationship was the identification and minimization of the ad-

verse effects of cash-transfer programmes on the supply of labour. New approaches in the developing world emphasize stronger, multiple and positive linkages with the labour market. In particular, approaches that combine transfers (particularly cash and food transfers) to overcome immediate and fundamental needs of the extreme poor with active support for access to economic opportunities and basic social services are presenting high potential for reducing extreme poverty and promoting social inclusion. Many cash transfer schemes, conditional or not, include measures to improve access to health of the beneficiaries, in particular to maternal and child health.

ILO work in developing social transfers models has indicated that a basic and modest social benefit package including maternal and child health would be affordable in most African countries if governments would commit a reasonable proportion of their budget to social protection and if the international community would provide some temporary support.³⁶ As temporary measures, these programmes can encourage health-care utilization in the context of longer-term efforts to extend and improve social health protection.

ILO STEP programme

The ILO Strategies and Tools against Social Exclusion and Poverty Programme (STEP) works on innovative strategies and mechanisms aimed at providing coverage to those excluded from existing schemes. STEP is a major instrument to implement the Global Campaign on Social Security and Coverage for All launched by the ILO in 2003. STEP has developed worldwide a broad knowledge base and many field experiences on community-based social protection schemes (in particular, health protection), and is working intensively on non-contributory mechanisms aiming to provide basic social protection to all. STEP also works on linking social transfers with employment policies and with measures ensuring better access to basic social services.

The ILO works in cooperation with other agencies to extend health protection coverage in developing countries. In 2004, the ILO, together with the German Development Cooperation (GTZ) and the World Health Organization (WHO), signed a joint letter of agreement on cooperation in the field of social protection in health, sustainable health financing systems and efficient contracting. The GTZ-ILO-WHO Consortium seeks to increase the quality and scope of sustainable and comprehensive health-care

³⁶ Gassman and Behrendt, 2006.

financing in partner countries, strengthen technical support by joining resources, and create synergies and savings through complementary activities. It has carried out conceptual work on policies and tools, technical cooperation at country level, policy dialogue at regional and international levels, and capacity development through seminars, workshops and international conferences.³⁷

Maternity benefits schemes

In addition to extending social health protection, greater efforts must be directed toward improving existing and fledgling social security systems so as to include maternity cash benefits in the systems. Medical benefits during a pregnancy, delivery and the perinatal period, and income replacement during a period of maternity leave, are essential to maternal health and, as such, have been recognized in all ILO maternity protection Conventions, in the Social Security (Minimum Standards) Convention, 1952 (No. 102), the Income Security Recommendation, 1944 (No. 67), and the Medical Care Recommendation, 1944 (No. 69). Cash benefits are important for replacing income lost due to the interruption of the woman's economic activities, and protecting women and their families against financial hardship associated with maternity. Convention No. 183 calls for cash benefits that enable a woman to maintain herself and her child in proper conditions of health and with a suitable standard of living. The amount should reach at least two-thirds of the woman's previous or insured earnings and should be provided through social insurance, public funds or in a manner determined by national law and practice. The Convention also provides for medical benefits, including pre-natal, childbirth and post-natal care, as well as hospitalization when necessary (Article 6).

Greater effort in these areas is needed if improvements in women's access to maternity benefits are to be achieved. Existing experiences are building a body of good practices, examples of which include ILO technical assistance to Jordan for establishing a maternity cash benefits scheme within the national social security system, the efforts of a social providence fund in Burkina Faso, supported by DANIDA and ILO, to incorporate a maternity benefit for women, and the assistance of GTZ, WHO and ILO for a community-based health insurance scheme in Cambodia that incorporated a Safe Motherhood programme and cash maternity grant into its benefits package.

Maternity benefits: Trade unions working toward maternity leave for informal economy workers

Salissa works as a market gardener in Loumbila, a small village on the outskirts of Ouagadougou in Burkina Faso.

She has recently had a second child. Just ten days after giving birth, she was already back at work, doing ten hours of gardening a day to be able to feed her family.

Maternity leave is a luxury enjoyed by a small minority of salaried women covered by social security in Burkina Faso.

But a drive to unionize informal economy workers is set to support new mothers, with plans to help them benefit from paid maternity leave through a newly established Social Providence Fund for Informal Economy Workers (MUPRESSI), designed with the help of the ILO and DANIDA, to extend social coverage for health care and occupational diseases.

Source: ITUC, 2007. See <http://www.ituc-cis.org>.

Implementing, extending and improving social health protection: Moving forward

Clearly, protecting women and their families against the financial burdens of medical care is essential for improving women's access to and demand for health-care services. Key to this goal is implementing and extending social health protection to reach those currently excluded, and improving basic benefits packages to include maternity benefits. The ILO's longstanding role as the major international forum for debates on social health protection, its framework of international labour standards, and its experience in working with national and local governments and employers' and workers' organizations provide a wealth of knowledge and policy tools for implementing, extending, and improving social health protection. Drawing on the strengths of the tripartite constituency and working in cooperation with other international and national partners, efforts toward universal access to health care through social health protection stand to directly complement efforts in the health sector to improve supply and take-up of health-care services.

³⁷ For more information on the GTZ-ILO-WHO Consortium and its work, see <http://www.socialprotectionhealth.org>.

Promoting decent work for health workers

Foster decent terms and conditions of employment for health workers in public and private health sectors

Health-care personnel are critical to the delivery of health services. Globally, formal estimates place the number of people working full time as health workers at 59.2 million,³⁸ but estimates reach up to 100 million if informal, traditional and community health workers are included.³⁹ Still another 4.3 million are needed to meet the health needs of the world's population, with critical shortages of health-care professionals in 57 countries.⁴⁰ Staff shortages, poor working conditions and lack of training opportunities have all contributed to the deterioration of health services. The globalization of the labour market for health workers has enabled large numbers of workers to move to employment situations with more favourable working conditions, but emigration has further exacerbated the problems in countries facing health personnel shortages. Internal migration also leads to imbalances in health staffing between rural and urban areas.⁴¹ Investing in the health workforce and improving the quality of employment for health workers are vital issues in the effort to improve maternal health.

Better working conditions for health workers

The working conditions confronting health workers are a serious concern in the delivery of health services in many countries. Very low salaries and delays in the payment of wages can be extremely demotivating and may force health workers to collect informal payments, refer patients to the private sector, or move to better labour markets, all of which affect women's access to quality maternal care.⁴² Overtime work due to staff shortages or cost containment measures is also an important problem for health workers, and has increased over time in a number of countries around the world.⁴³ The ab-

sence of opportunities for on-going training, education and career possibilities further compel health personnel to look toward overseas employment as a means for professional development.⁴⁴

Health-care workers speak about their working conditions

"Sometimes we finish working one month and there is no pay. The second month there is no pay, and the third month. So you are always in arrears. Within those three months if you have no other means of income, how can you survive? That is a very, very demotivating factor." **Jane O. Shihemi**, *Kenya Registered Nurse and Midwife, Chief Nursing Officer and Hospital Matron, Nairobi City Council Local Authority*

"The workload is very big. Some weeks we work a lot of overtime. Normally, each shift is six hours, times seven days a week, is 42 hours. But some days it's really ten or 12 or maybe even 14 hours. Very difficult. So the quality of care for the patients goes down." **Ramya Karunanayanaka**, *Registered Nurse, Colombo, Sri Lanka*

Source: Van Eyck, 2006.

Workplace safety is a chief concern for health-sector workers who face alarming levels of violence in the workplace. Almost 25 per cent of all violent incidents at work occur in the health sector and more than 50 per cent of health-care workers have experienced violent incidents at work.⁴⁵ The impact on organizations and individuals can include a decline in the quality of care, greater occupational hazards, attrition and higher costs.⁴⁶ In South Africa, for example, nurses have specifically cited fears about safety at work as a reason for considering emigration.⁴⁷ Long hours, poor pay, and unsafe working environments can result in a number of negative consequences, including patient morbidity and mortality, higher levels of workplace violence, job dissatisfaction leading to

³⁸ WHO, 2006, p. 5.

³⁹ Joint Learning Initiative, 2004.

⁴⁰ *ibid*, p. 12.

⁴¹ Bach, 2003

⁴² WHO, 2006, p. 77.

⁴³ ILO, 1998.

⁴⁴ Bach, 2003.

⁴⁵ ILO/ICN/WHO/PSI, 2002.

⁴⁶ Di Martino, 2002.

⁴⁷ Bach, 2003

the intention to quit, and flight of health workers to better working environments, all of which exacerbate existing imbalances in the distribution of health-care workers and further erode the provision of maternal care among other health services.⁴⁸

Addressing the shortage of health-care workers as a major cause underlying poor supply and quality of maternal care services urgently requires action to improve the working conditions of health personnel as a means to attract and retain workers. Concern about the global shortage in nursing was a major concern over 30 years ago, leading the ILO and WHO to jointly develop standards for adequate nursing personnel policies and working conditions. The *ILO Nursing Personnel Convention, 1977 (No. 149)*, and *Recommendation (No. 157)* remain as relevant today as they were in the 1970s. The Convention calls for:

- Adequate education and training to exercise nursing functions;
- Attractive employment and working conditions, including career prospects, adequate remuneration and social security;
- The adaptation of occupational safety and health regulations for nursing work;
- The participation of nursing personnel in the planning of nursing services;
- The consultation with nursing personnel regarding their employment and working conditions;
- Dispute settlement mechanisms.⁴⁹

To date, 38 countries have ratified the Convention,⁵⁰ but the provisions of the Convention and Recommendation have provided guidance to many more governments, employers and workers' organizations as well as professional associations around the world for addressing needs and promoting solutions to nursing personnel issues. Further promotion of the ratification and implementation of the Convention will contribute to achievements toward all Millennium Development Goals related to health: improving maternal health, reducing child mortality and combating HIV/AIDS, malaria and other diseases.

HIV/AIDS takes a toll on health workers

The HIV/AIDS epidemic has had a major impact on the health workforce. In addition to the staff shortages, long hours and workplace violence, health-care workers in countries with HIV/AIDS epidemics face the additional burdens of a higher workload related to the epidemic, greater risks of infection themselves, greater stress, and lack of adequate training or provisions for dealing with HIV/AIDS.⁵¹ A number of countries already beleaguered by high rates of HIV/AIDS are facing alarming rates of attrition in their health workforces due to HIV/AIDS-related illness and death.⁵²

In 2005, the International Labour Organization and the World Health Organization collaborated to produce *Joint ILO/WHO guidelines on health services and HIV/AIDS*, together with experts in the field of HIV/AIDS and health care and representatives of workers, employers and governments. The guidelines provide wide-ranging and practical approaches to protection, training, screening, treatment, confidentiality, prevention, the minimizing of occupational risk, and the care and support of health-care workers. The guidelines also address the essential role of social dialogue among governments, employers and workers in meeting the challenges posed by the HIV/AIDS epidemic in the sector.

Migration

International migration has become an accepted feature of globalized labour markets in health care, yet its effects on the nations supplying health-service workers are cause for concern. National systems that have invested a great deal in educating and training their health-service staff see the dwindling of their qualified and experienced personnel. In sub-Saharan Africa, health systems already weakened by deaths and disability caused by HIV/AIDS are further depleted by the migration of health workers. The Governing Body of the ILO moved forward the agenda to address these issues in March 2005, leading to the launch of an ILO Action Programme, "The International Migration of Health Service Workers: The Supply Side". The overall aim of the Programme is to develop and disseminate strategies and good practices for the management of health services migration from the supplying nations' perspective. The ILO collaborates with the World Health Organization (WHO) and the International Organization for Migration (IOM) in the implementation of the Action Programme. Six

⁴⁸ ILO, 2005b.

⁴⁹ For more information, see ILO, 2005b.

⁵⁰ See Annex I for a list of ratifications.

⁵¹ WHO and ILO, 2005; Joint Learning Initiative, 2004.

⁵² WHO, 2006.

countries are participating: Costa Rica, Kenya, Romania, Senegal, Sri Lanka, and Trinidad and Tobago. The Programme fosters social dialogue to explore the effects of health-worker migration on these countries, analyse their existing migration policies and practices, and identify best practices to guide in the development of effective policies. The Programme also seeks to strengthen capacities for data collection and analysis to improve the quality of data on the movement of health workers, and it supports specific research in selected countries to assist in social dialogue and policy formulation, with particular attention to recruitment and retention issues.

Social dialogue: Building consensus for sustainable solutions

Concerns about the quality and performance of health-service systems have led to a number of reform efforts, but health-care personnel are often not consulted in the plans that ultimately affect their work. Including health workers in the planning and design of health system reforms can have tremendous benefits, building the commitment and support of health workers, and enabling plans to make the most of their valuable knowledge and experience.⁵³ That reforms are much more likely to achieve their objectives when planned and taken with the full participation of the social partners has raised awareness of the importance of and potential for social dialogue to advance and sustain reform processes. Strengthening social dialogue and tripartism are among the ILO's strategic objectives and are essential for achieving decent work. The ILO works to promote social dialogue, strengthen the institutions of social dialogue and the capacities of the parties to participate effectively in social dialogue.

To ensure better delivery of health services, the ILO works to strengthen the capacities and institutions for social dialogue in the health services. ILO constituents have accentuated the need for concerted action, practical guidance and tools to foster social dialogue,⁵⁴ culminating in the development of *Social dialogue in the health services: A tool for practical guidance*. This tool is aimed at policy-makers and others who plan and organize processes of social dialogue in the health services. It provides instruments to manage and facilitate processes of social dialogue and offers guidance on issues to be considered. It is complemented by the *Handbook for Practitioners*,⁵⁵ which offers practical direction for the facilitators and organizers of the ILO constituents and other stakeholders in health services as a means to assist in either conducting training courses for participants in social dialogue, or in implementing social dialogue processes.

Partnerships

The ILO works together with its partners and in broad global alliances to address health workforce concerns. The ILO is a partner in the Global Health Workforce Alliance, which was launched in May 2006 and is hosted by the WHO. The Alliance is a partnership dedicated to identifying and implementing solutions to the health workforce crisis. It brings together a variety of actors, including national governments, civil society, workers, international agencies, finance institutions, professional associations and academic institutions. As a member of the Health Worker Migration Policy Initiative under the Global Health Workforce Alliance, the ILO brings its technical expertise on labour migration in the health sector to the challenge of finding practical solutions to the problem of the increasing migration of health workers from developing to developed countries.

Efforts to achieve the Millennium Development Goals related to maternal health, newborn health, and HIV/AIDS and other diseases are profoundly hampered by crisis in the health workforce. Overcoming the severe shortages and geographic imbalances in health-care personnel will require global and national responses. The ILO, together with its partners, is committed to improving the quality of

⁵⁴ ILO, 2006c; "Resolution concerning tripartism and social dialogue", adopted by the International Labour Conference at its 90th Session, Geneva, June 2002. The resolution can be consulted at <http://www.ilo.org/public/english/standards/relm/ilc/ilc90/pdf/pr-21res.pdf>.

⁵⁵ ILO, 2005c.

Effects of health sector reforms during the 1990s in Cameroon

- Salary reduction of 50 per cent and loss of allowances
- Recruitment freeze and retrenchment leading to staffing shortages
- Poor working conditions
- Decline in quality of care
- Drops in health care utilization by rural and suburban populations
- Demoralization, exit and emigration of health workers

Source: ILO, 2000a.

⁵³ ILO, 2002a; Ssengooba et al., 2007; Boussen et al., 2002.

Workers for quality public services

The public service unions, under the umbrella of Public Services International, have launched a Quality Public Services Campaign to promote government investment in quality public services through adequate financing, improved accountability, better jobs and accessible, affordable and relevant services.

- To ensure that public services are adequately funded so that well-trained and properly resourced workers can deliver quality services to the population or those who want to use them;
- To develop the ability of public services to meet social objectives, especially poverty eradication and people's empowerment;
- To ensure that public services meet quality objectives, including high standards of ethical behaviour, which enable national and global economies to operate effectively and equitably; and
- To ensure that all public sector workers can use all of their workers' rights and can achieve quality working conditions.

Source: See www.world-psi.org.

18

employment of health workers, addressing the interrelated issues of poor working conditions, workplace violence, lack of training opportunities, HIV/AIDS and migration which underpin the challenges of recruiting and retaining health-care workers. In all efforts to improve health services, consultation and participation of health-service workers through social dialogue and collective bargaining are important means for bringing together the perspectives and expertise of all actors in the interest of effective solutions and policies.



Conclusions: Mobilizing support, working together

At the current rate of progress, the target for MDG 5 of reducing maternal deaths by 75 per cent by 2015 will not be met. As the unifying framework for the activities of the multilateral system of the United Nations, the Millennium Development Goals call on all countries and the world's development partners to share responsibility for meeting these global commitments. In the field of maternal health, as in all of the MDGs, translating goals and targets into results requires policy coherence and better cooperation between UN agencies, national level governments and other development partners.

The ILO works closely with its constituents, other multilateral organizations and other development partners at global, regional and national levels in support of the Millennium Declaration. The ILO Decent Work Agenda strives for economic growth with equity through employment, rights, social protection and dialogue. These are fundamental for the security, health and well-being of all, and an important component of efforts to address the broader social and economic determinants of poor maternal health and maternal mortality. Indeed, women's economic empowerment and access to decent work, together with their educational opportunities, political rights, and their access to quality health care and reproductive health services, are all interwoven dimensions of maternal and overall health.

The ILO highlights several areas in particular within its mandate that have potential to support and contribute to broader efforts toward safe pregnancy. First, there is a need to scale up efforts to improve maternity protection and health through the workplace. Work is central to our lives. We must ensure that work does not threaten the health of pregnant and nursing women or their newborns. Equally important, maternity and women's reproductive roles should not jeopardize their economic security. Shared international frameworks for guaranteeing these rights already exist in the form of maternity protection Conventions. What is needed is greater commitment to bridge the principles with deeds.

Secondly, social health protection is vital to ensure that health care is within reach for all who need it. Isolated initiatives will not be sufficient: the central objective — and challenge — is to build upon and incorporate existing local and national schemes

into a pluralistic national system that provides effective access to quality health care and financial protection against health related costs. Ensuring that maternity benefits are included in the coverage must be part of this work if women are to enjoy effective access to safe maternity. A longstanding priority of the ILO, the governments, workers' and employers' organizations reached a new consensus at the International Labour Conference in 2001 to place highest priority on the development of policies and initiatives to bring social security to all who have none.

Thirdly, initiatives to improve maternal health must find effective international and national responses to the health workforce crisis. The quality of health services rests squarely on the people who deliver them. But today, health-care workers in many countries struggle under the staff shortages, poor working conditions, and absence of career or training opportunities imposed by years of rising health-care costs, structural adjustment policies and cost-containment measures. Promoting decent work for health workers and fostering social dialogue must be at the top of the agenda in all efforts to address the crisis in health services.

The ILO brings to bear universally shared international labour standards, providing guidance for national law, policy and practice in maternity protection, social security, and terms and conditions of employment in the health sector. The ILO commits its experience of policy advice, technical assistance and capacity building in all of these areas to global and national partnerships aimed at reducing maternal mortality. The ILO's greatest strength lies in its tripartite constituency — governments, workers' and employers' organizations — who bring their commitment, their networks and their ingenuity to generate the necessary action, momentum and capacity to organize at all levels of society. Constructive dialogue at the national and international level, across sectors and actors, must be encouraged to take advantage of key opportunities for aligning strategies for policies and initiatives in the world of work with objectives for better maternal health.

It is in this spirit that the ILO engages actively in global partnerships and works to harmonize Decent Work objectives and strengthen coordination to achieve national priorities expressed in national

development plans and in international programming frameworks, including the CCA-UNDAF, Poverty Reduction Strategies, and the One UN pilot initiatives. The United Nations Economic and Social Council (ECOSOC) ministerial declaration of July 2006 endorsed decent work as a central development goal and called upon the United Nations system to support efforts to mainstream the goals of full and productive employment and decent work in all policies, programmes and activities. The ILO is strengthening its capacity and tools to assist UN agencies and its tripartite constituents to mainstream the Decent Work Agenda in their operations. Decent Work Country Programmes have been established as the main vehicle for delivery of ILO support to countries. Decent Work Country programmes have two basic objectives. They promote decent work as a key component of national development strategies. At the same time they organize ILO knowledge, instruments, advocacy and cooperation at the service of tripartite constituents in a results-based framework to advance the Decent Work Agenda within the fields of comparative advantage of the Organization. Tripartism and social dialogue are central to the planning and implementation of a coherent and integrated ILO programme of assistance to constituents in member States. The ILO invites further opportunities promoting cooperation and coordination at global, regional and national levels to harness collective strengths for the achievement of shared goals.

The high numbers of women who die needlessly every year from largely avoidable pregnancy-related causes throws into sharp relief the urgent need for effective action, based on coherent and collaborative approaches at international and national levels. The Millennium Development Goals hold the promise and the obligation for diverse actors and stakeholders to come together to train their unique strengths on the achievement of a common set of goals. That progress on MDG 5 has been far too slow reflects the need for renewed commitments and innovative solutions. The ILO is committed to playing a decisive role, strengthening partnerships and finding new approaches to work toward the more peaceful, just and prosperous world envisioned by all parties to the Millennium Declaration.



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Mining worker feeds her baby after work, Perma gold mine, Benin, July 2001.



Annex: Ratifications of international labour standards with particular relevance to maternity and to health workers

	Maternity Protection Convention, 1919 (No. 3)	Maternity Protection Convention, 1952 (No. 103)	Maternity Protection Convention, 2000 (No. 183)	Social Security (Minimum Standards), 1952, (No. 102)	Nursing Personnel Convention, 1977 (No. 149)
Africa	No. 3	No. 103	No. 183	No. 102	No. 149
Algeria	✓				
Burkina Faso	✓				
Cameroon	✓				
Central African Republic	✓				
Congo					✓
Côte d'Ivoire	✓				
Dem. Republic of Congo				✓	
Egypt					✓
Equatorial Guinea		✓			
Gabon	✓				
Ghana		✓			✓
Guinea	✓				✓
Kenya					✓
Libyan Arab Jamahiriya	✓	✓		✓	
Malawi					✓
Mauritania	✓			✓	
Niger				✓	
Senegal				✓	
Seychelles					✓
Tanzania, United Republic of					✓
Zambia		✓			✓

	Maternity Protection Convention, 1919 (No. 3)	Maternity Protection Convention, 1952 (No. 103)	Maternity Protection Convention, 2000 (No. 183)	Social Security (Minimum Standards), 1952, (No. 102)	Nursing Personnel Convention, 1977 (No. 149)
Americas	No. 3	No. 103	No. 183	No. 102	No. 149
Argentina	✓				
Bahamas		✓			
Barbados				✓	
Belize		D**	✓		
Bolivia		✓		✓	
Brazil	D*	✓			
Chile	D*	✓			
Colombia	✓				
Costa Rica				✓	
Cuba	✓	D**	✓		
Ecuador		✓		✓	✓
Guatemala		✓			✓
Guyana					✓
Jamaica					✓
Mexico				✓	
Nicaragua	✓				
Panama	✓				
Peru				✓	
Uruguay	D*	✓			✓
Venezuela	✓	D		✓	✓

	Maternity Protection Convention, 1919 (No. 3)	Maternity Protection Convention, 1952 (No. 103)	Maternity Protection Convention, 2000 (No. 183)	Social Security (Minimum Standards), 1952, (No. 102)	Nursing Personnel Convention, 1977 (No. 149)
Arab States	No. 3	No. 103	No. 183	No. 102	No. 149
Iraq					✓

	Maternity Protection Convention, 1919 (No. 3)	Maternity Protection Convention, 1952 (No. 103)	Maternity Protection Convention, 2000 (No. 183)	Social Security (Minimum Standards), 1952, (No. 102)	Nursing Personnel Convention, 1977 (No. 149)
Asia and the Pacific	No. 3	No. 103	No. 183	No. 102	No. 149
Bangladesh					✓
Japan				✓	
Mongolia		✓			
Papua New Guinea		✓			
Philippines					✓
Sri Lanka		✓			

	Maternity Protection Convention, 1919 (No. 3)	Maternity Protection Convention, 1952 (No. 103)	Maternity Protection Convention, 2000 (No. 183)	Social Security (Minimum Standards), 1952, (No. 102)	Nursing Personnel Convention, 1977 (No. 149)
Europe	No. 3	No. 103	No. 183	No. 102	No. 149
Albania			✓	✓	
Austria		D**	✓	✓	
Azerbaijan		✓			✓
Belarus		D**	✓		✓
Belgium				✓	✓
Bosnia and Herzegovina	✓	✓		✓	
Bulgaria	✓		✓		
Croatia	✓	✓		✓	
Cyprus			✓	✓	
Czech Republic				✓	
Denmark				✓	✓
Finland					✓
France	✓			✓	✓
Germany	✓			✓	
Greece	✓	✓		✓	✓
Hungary	✓	D**	✓		
Iceland				✓	
Ireland				✓	
Israel				✓	
Italy	✓	D**	✓	✓	✓
Kyrgyzstan		✓			✓
Latvia	✓				✓
Lithuania			✓		✓
Luxembourg	✓	✓		✓	
FYR of Macedonia	✓	✓		✓	
Malta					✓
Moldova		D**	✓		
Montenegro	✓	✓		✓	
Netherlands		✓		✓	
Norway				✓	✓
Poland		✓		✓	✓
Portugal		✓		✓	✓
Romania	✓		✓		
Russian Federation		✓			✓
San Marino		✓			
Serbia	✓	✓		✓	
Slovakia			✓	✓	
Slovenia	✓	✓		✓	✓
Spain	✓	✓		✓	
Sweden				✓	✓
Switzerland				✓	
Tajikistan		✓			✓
Turkey				✓	
United Kindgom				✓	
Ukraine		✓			✓
Uzbekistan		✓			

D = Denunciation, D* = Denounced, C.103 ratified, D** = Denounced, C.183 ratified

