ARROWs For Change

Women's and Gender Perspectives in Health Policies and Programmes

Vol 7 No 1 2001
ISSN 1394-4444

Maternal Mortality— Why Women Need Not Die

Graphic Source: Asian and Pacific Development Centre (APDC). 1990. *Asian and Pacific Women's Resource and Action Series—Health*. Kuala Lumpur: APDC. p. 63.

To this day, women continue to die from the age-old and most common complications of pregnancy and childbirth — haemorrhage, infections, unsafe abortion, obstructed labour, and the hypertensive disorders of pregnancy. In 1995, the latest estimated number of maternal deaths globally was 515,000. Of these deaths, 53 per cent (272,000) occurred in Africa, 42 per cent (217,000) in Asia, four per cent (22,000) in Latin America and the Caribbean, and less than one per cent (2,900) in the world's more developed regions[1].

In terms of maternal mortality ratio (MMR)[2], it is an estimated 400/100,000 live births (lb) worldwide. The MMR in some Asian-Pacific countries range from 850/100,000 lb to 6/100,000 lb. For instance, it is 830 in Nepal, 650 in Lao PDR, 600 in Bangladesh, 590 in Cambodia, 470 in Indonesia and 440 in India. By comparison, the MMR is 95/100,000 lb in Vietnam, 60 in China and Sri Lanka, 44 in Thailand, 35 in DPR Korea, 20 in Fiji and the Republic of Korea, 15 in New Zealand, 12 in Japan, nine in Singapore and six in Australia.

These deaths are tragic because they are all so unnecessary, especially in view of what we have already learned from the experiences of many countries. Sweden and Norway in the mid-17th century, the US in the early 1900s, Sri Lanka and the State of Kerala in the late 1800s, and Malaysia in the late 1940s– all decided to institute measures to prevent maternal deaths. Historical accounts of these countries depict the different contexts in which maternal deaths occurred. Despite these differences, the causes and the ways to prevent these deaths have remained essentially the same throughout the centuries. From these countries' experiences, we have learned three fundamental requirements to prevent maternal deaths: a) that emergency obstetric care is life-saving because it cures pregnancy and childbirth complications; b) that a functioning health referral system must exist to allow the unimpeded flow of services to any pregnant woman who needs them at any place and at any time; and c) that skilled and competent birth attendants as well as efficient and creative hospital managers and administrators are indispensable to the efficient functioning of the entire health system. These three basics form the most effective response to prevent maternal deaths. This is only possible if governments, as well as the donors and international agencies that support them, make protecting pregnant women a priority. And this possibility is not remote if governments and donors are persuaded to acknowledge and treat this basic necessity as a human right. The implications are enormous. Human rights, after all, embody needs, presuppose responsibilities and delineate accountabilities. A woman's right to quality obstetric care, for instance, presupposes a government's responsibility to provide it. A woman's right to a skilled birth attendant during her pregnancy and delivery presupposes a government's responsibility to ensure that she has a midwife or a doctor by her side during those critical periods. And a woman's right to access accurate information and education on the danger signs of pregnancy[3] presupposes a government's responsibility to make sure that not only does she have the correct information but that she is able to act on it. Governments are thus duty-bound to provide a health system which ensures that pregnant women can access quality health care, especially life-saving emergency obstetric care. If governments are remiss in this duty, they are, and should be, held accountable and liable for every woman who dies because the health services she needed were not available or accessible.

International agencies and donors are just as accountable. In many instances, they determine or greatly influence governments to take on programmes that while easily measured in terms of results, seem to exert a marginal impact on preventing maternal deaths. These programmes are of course not totally useless for they do have a place in the larger scheme of things; they just do not prevent maternal deaths and disabilities. Distribution

of iron tablets to pregnant women, for instance, may raise women's haemoglobin to normal levels. But they cannot prevent massive haemorrhage due to a ruptured or flaccid uterus. Giving away birth kits to traditional birth attendants may likewise facilitate the birthing process but they do not guarantee that women will be less prone to infection or that they will be relieved from their prolonged obstructed labour. Similarly, donors have supported the training of skilled birth attendants but usually the support stops there. While training does add to the skills of a birth attendant, it does not solve a couple of vexing issues which donors and governments have to wrestle with: the rational deployment of skilled birth attendants and the need to keep them in difficult and remote places where they are needed most. Donors can no longer afford, therefore, to promote projects which may yield easy-to-count results, e.g. number of iron tablets distributed and number of skilled birth attendants trained, which, from their perspective, may pass as a success. What is needed now is a convergence of efforts among donors and governments to establish or revitalize health care systems that women can rely on for the much-needed quality services during their pregnancy, delivery, and postpartum period. Other measures such as transport and communication systems; financial schemes; information and education campaigns on pregnancy, childbirth, and its complications; the need to involve husbands or partners, families, and organise communities in birth-preparedness; and the unceasing efforts to raise women's overall status are all definitely worth pursuing. They bring women closer to gaining access to health care. But, to save women's lives, all these measures require a pivot around which they can hinge on — functioning health referral systems that deliver quality health care, particularly emergency obstetric services. Without this pivot, these measures are bound to get disjointed and efforts to reduce maternal deaths and disabilities may be rendered meaningless. Financing schemes to defray costs of delivery or transport arrangements may have been prepared. But if the skilled birth attendants are unavailable or if the health services are non-existent, such arrangements may prove futile. Consequently, the hoped-for and combined synergistic effects of all other measures and activities are not funnelled into a focus sharp and powerful enough to dissect and resolve the problem.

Thus, to ensure that women go through pregnancy and delivery safely, this pivot of health systems and services need to be in place. And the most compelling argument for this can be found in human rights principles. Truly, they are, and have always been, the cornerstone upon which everything else rests.

Endnotes:

[1] AbouZhar, Carla; Wardlaw, Tessa. 2001. *Maternal Mortality in 1995: Estimates Developed by WHO, UNICEF, UNFPA*. Geneva: WHO. p. 2.

[2] MMR measures the risk of maternal death among pregnant or recently pregnant women. The use of 100,000 live births as a denominator is somewhat imprecise. Some women, especially those who experience unsafe abortions, risk dying a maternal death without ever having a live birth. A more precise MMR would be the number of maternal deaths per 100,000 pregnancies. However, data on the number of pregnancies, even in countries with good vital statistics systems, are difficult to obtain.

[3] Danger signs requiring emergency obstetric care include bleeding; severe headaches and vomiting; high fever; prolonged labour and alterations of consciousness and convulsions.

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***ARROWs* For Change,** published three times a year, is primarily for Asian-Pacific decision-makers in health, population, family planning, and women's organisations. It provides: ♦ women's and gender perspectives on women's health, particularly reproductive health ♦ a spotlight on innovative policy development and field programmes ♦ monitoring of country activities post-ICPD, Cairo and post-FWCW, Beijing ♦ a gender analysis of health data and concepts ♦ resources for action.

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Preventing Maternal Deaths in India

India is one of the countries in Asia with the most maternal deaths. According to the two national family health surveys done in the 1990s, the estimated maternal mortality ratio of 540 deaths per 100,000 live births has remained virtually unchanged.[1, 2] Though various studies give the causes of maternal deaths, they do not explain why some women with serious complications die while others do not. For programme planners, knowing the answer to this is as important as knowing the numbers.

The Population Council conducted this study in the states of Andhra Pradesh, Madhya Pradesh and Orissa from January 2000 to June 2001 together with local NGOs, the Foundation for Research in Health Systems (Ahmedabad); Academy of Nursing Studies (Andhra Pradesh); Mahila Chelna Manch (Madhya Pradesh); and the National Institute of Applied Human Research and Development (Orissa). The study aimed to: (1) assess people's awareness of danger signs in pregnancy, delivery and postpartum periods; (2) understand why medical help was not sought for emergencies; (3) identify barriers and facilitating factors in seeking maternal health care; (4) understand the decision-making involved in seeking health care during the three periods; and (5) assess the social and economic factors that contribute to maternal mortality. A case-control study design was used whereby investigators randomly selected two blocks from two poorly performing districts in each state. From each block, they listed 12-13 maternal death cases, 25 cases with and 25 cases without complications in the previous year. They used a framework similar to the 3-Delays approach (delay in recognising, delay in seeking treatment and delay in getting the treatment for complications) to explore the differences between women who develop complications and those who do not, and between those who die and those who do not, that affected their chances of getting timely medical care.[3] Through in-depth interviews, data were collected from 250 households on 170 women who had died, 300 survivors of serious delivery complications and 300 women who had normal deliveries. Focus group discussions were held to understand community perceptions of maternal health care services. The study sought to understand the conditions people believed were necessary to prevent maternal deaths; identify areas in which changed practices could improve maternal health; design interventions for women with obstetrical emergencies; and improve prenatal, delivery and postpartum care and treatment of complications. The study revealed that the postpartum period is the riskiest period, with 62 per cent of all the deaths occurring then. Of those who had died, 72 per cent had been poor, 82 per cent had been illiterate while 88 per cent had been jobless. The families of the deceased reported massive bleeding and high fever as the main complications. Seventy-three per cent of the deaths happened at home. In 37-40 percent of all cases, the husband made the decision to seek care. Mothers-in-law and mothers made the decision for half of the women who died, 33 percent of those with complications, and 22 percent of those with no complications. While 95 per cent of survivors of complications had sought treatment, 73 per cent of the deceased had not done so because they had not realised the need. Poor roads and transportation posed a great barrier to seeking health care. For more than half of the maternal death cases, it took one to two hours to reach the health facility while 30 percent took more than two hours. Results showed that most maternal deaths might not have happened if: the women had received proper and timely advice towards the end of their pregnancy and during the immediate postnatal period; they had received better care at home; their families had known of the danger signs in pregnancy and childbirth; and adequately equipped and managed referral centres had existed.

Thus, the government needs to make women, husbands and families more aware of the danger signs; educate people on giving immediate and proper help in obstetric emergencies; conduct safe motherhood campaigns for village leaders, women's groups, families and adolescents; train traditional birth attendants and field-level health care providers on pregnancy care, safe delivery practices and care after delivery; improve quality of emergency obstetric care; and increase women's decision-making power in the family and community by educating them. Although these suggestions are not new, they were not followed before or needed strengthening. They are directed at the government because it delivers most of the health care in India.

■ **References:**

[1] **International Institute for Population Sciences (IIPS).** 2000. *National Family Health Survey (NFHS-2), 1998-99.* Mumbai, India.

[2] **IIPS**. 1994. *National Family Health Survey, 1992-93.* India Introductory Report, Mumbai, India.

[3] **Thaddeus, S. and Maine, D**. 1994. "Too far to walk: maternal mortality in context". *Social Science and Medicine*. Vol. 38, No. 8. pp. 1091-1110.

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Combating Maternal Mortality: The Malaysian Experience

Malaysia's maternal mortality rate was reduced from 570 per 100,000 live births in 1957 to 30 in 1999[1]. Maternal and child health care is now easily accessible and more than 95 per cent of deliveries are safe deliveries[2]. This is a result of Malaysia's conscious effort to reduce avoidable or preventable maternal deaths.

Malaysia's experience in combating maternal mortality spans three and a half decades of initiating, field-testing, implementing, modifying and reviewing strategies. Its success is due largely to the high priority given by the Ministry of Health, the country's main provider of public health service, which is complemented by the support of the private, non-governmental sector and other specific agencies. Malaysia adopted a multi-strategy approach that focused on: (1) improving quality of care by making basic health services more accessible and available; (2) upgrading the quality of essential obstetric care in district hospitals; (3) streamlining and improving the efficiency of referral and feedback systems; (4) increasing the capacity and skills of professionals and paramedical staff in managing pregnancy and delivery complications; (5) reviewing the system of investigation periodically; and (6) reporting maternal deaths.

Since Malaysia gained independence from the British in 1957, fragments of a few maternal and child health centres in the larger towns gave way to a phased development of a comprehensive and systematic health infrastructure, with priority given to rural health services in the 1960s and 1970s. From the mid 1970s, major efforts included upgrading the rural health programme and infrastructure, and integrating major activities such as family planning, nutrition and immunisation into the Maternal and Child Health programme. The 1980s was dedicated to improving quality of care; expanding the scope and content of services; improving access to underserved and underprivileged groups in remote areas; and initiating strategies to reduce specific causes of infant and maternal mortality. Maternal health care and safe motherhood strategies to combat maternal mortality as well as an integrated health management information system were also begun.

In 1990, the quality assurance programme was initiated. It functioned as a diagnostic and evaluation tool using selected indicators such as eclampsia incidence rate, puerperal sepsis incidence rate and maternal death to measure the quality of maternal health care. Districts or facilities that fell below the standards set by the indicators had to identify the weaknesses and take remedial actions to improve the conditions. Consequently, the rate of puerperal sepsis came down from 3.2 per 10,000 pregnant women in 1996 to 2.4 in 1998 and the rate of eclampsia decreased from 5.0 per 10,000 in 1996 to 4.4 in 1998. With most of the efforts to reduce maternal and infant mortality already institutionalised, the 1990s was more of a time for consolidation, review and evaluation, and of moving onto a broader spectrum of health care. Thus, initiatives continued in the areas of reproductive health, adolescent health, HIV/ AIDS, mental health and care of the aging.

Two major approaches in maternal health care were used nationwide — the Risk Approach and the District Team Problem Solving Approach. Both were initially developed with the support of the WHO. The Risk Approach, implemented nationwide in 1986, aimed to provide health care for all, but particularly for those identified as being at higher risk of suffering from pregnancy or delivery complications. The approach sought to identify all pregnant women, particularly those at higher risk, and provide them with the necessary level of care, referral and support. In this process, the pregnant women, after a health screen and examination, were categorised according to the Colour Coding System. Implemented in 1989, it denoted the level of health care needed, the category of health staff responsible and the place of delivery. Red signified immediate hospital referral; yellow indicated that the patient should receive antenatal monitoring by a doctor; green meant that the antenatal case may be seen by a senior nurse; and white indicated low risk, making home delivery possible. Women in all the categories besides white were advised to have a hospital delivery since they would have risk factors as noted in the standard checklist. More importantly, active case management of code red women allowed for anticipatory care for the highest detectable risk.

A case coded:

Green might be changed to yellow or red

Yellow might be changed to red but not green

Red might be changed to yellow if the patient's condition improved and she could be discharged from the hospital.

The District Team Problem Solving Approach was developed by the WHO and field-tested in Malaysia by the Public Health Institute, Ministry of Health. Training was conducted in 1989. In this

approach, team leaders received insight into the causes and contributory factors of maternal deaths in their respective districts. They also had the chance to suggest solutions, which were then developed and implemented by the district. These were reviewed in a peer exchange of experiences and suggestions by the other districts, which met every six months, followed by an annual review. The peer exchange provided a valuable forum for presenting district interventions, informing on the actual situation in the field and how problems and needs of women and families were addressed. These energised and motivated the teams to carry on with their efforts.

Post-natal home visit by public health nurse and community nurse

In 1994, the Home-based Maternal Health Card was introduced, with the aim of improving communication of information among providers. With this tool, the maternal record card was kept and carried by the mother rather than filed at the health outlet she frequented, as was the practice previously. In this way, the doctor and staff at any health facility she visited had access to vital information about her and thus, were able to provide better continuity of care. The card was designed to be useful not only for health professionals, but also for mothers with varying health needs, levels of literacy and access to treatment facilities.

Quality of maternal health care was also upgraded through retraining of personnel in obstetric emergency skills, upgrading of district hospitals, decentralisation and district strengthening. Client demand for institutional deliveries resulted in the establishment of "Low Risk Delivery Centres" in urban areas and Alternative Birthing Centres in rural areas for women in the code white category. These centres decreased the proportion of deliveries of low-risk pregnancies in hospitals and released more hospital beds, staff and other scarce resources for high-risk mothers who required specialised care.

One of the major initiatives in the whole process of improving maternal care was to involve women, husbands and families in the knowledge of the impending dangers of the problems or risk factors identified and to prepare them to take the necessary and early action to avoid complications. This varied from getting help to take care of the family while the mother was in the hospital, to giving financial aid, providing transport, sensitising the mother-in-law or husband or enlisting the help of the traditional birth attendant to support and escort the mother to the hospital. The Ministry of Health's health education, information and motivation programmes also concentrated on: enabling women to recognise early signs of pregnancy complications; maintenance of good health during pregnancy; indications for hospital delivery; and importance of birth spacing. These programmes were the driving force behind the changes in the perceptions, attitude of and practices by women to make responsible and informed choices for their health care. Education and involvement of men, family members and traditional health workers such as traditional birth attendants in the care of women during pregnancy, in childbirth and after delivery provided further support for maternal health.

The sheer hard work, dedication, commitment and perseverance of all the health workers in the Ministry of Health are the main ingredients of the country's success in reducing maternal mortality. The ministry's implementation of innovative strategies and giving of priority to understanding and responding to the needs of women, families and the community are indicators of the government's commitment to reducing maternal mortality.

The Ministry of Health continues to strive for greater accessibility, expanded coverage and improved quality of services. Malaysia's low maternal mortality rate tells a success story in the region but in the face of reforms and other challenges to the health sector, maternal health is one area that deserves continued investment in terms of efforts, resources and use of innovative strategies.

Graphic Source: Aun Ting Lim; Sharifah Tahir; Dr. A. Vasanthimala. 1998. *Combating Maternal Mortality: Lessons from Pasir Mas, Malaysia*. Kuala Lumpur: ICOMP. p. 28.

■ **Endnotes:**

[1] **The Star**. 2001, August 31. "Healthcare in Malaysia". *The Star* [Newspaper] . Selangor: Star Publications (M) Berhad. p. 39.

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AJM

IMMPACT

■ Earlier this year, a meeting hosted by the Bill & Melinda Gates Foundation and the Rockefeller Foundation was held in New York to breathe new life into global efforts to reduce maternal mortality in the developing world. Participants from 12 major international or bilateral agencies and foundations discussed an innovative five to seven year programme of research called Initiative for Maternal Mortality Programme Assessment (IMMPACT), prepared by the Dugald Baird Centre for Research on Women's Health at the University of Aberdeen. IMMPACT's goal is to help reduce maternal mortality and severe morbidity in developing countries by providing rigorous evidence of the most effective and efficient intervention packages. Improving the evidence base for decision-makers will enable the enhancement of methods and capacity for robust evaluation of health programmes. The key partners— the Bill & Melinda Gates Foundation, UNFPA and WHO— had awarded the first $1.2 million for the initial nine months (June 2001-February 2002). To ensure success, IMMPACT will build a partnership among centres of excellence and key organisations across developing and developed countries. Participants will include researchers, policy makers, service managers and providers, professional associations, international and bilateral agencies, NGOs, women's groups and safe motherhood advocates.

Source: Dugald Baird Centre for Research on Women's Health. 2001. *IMMPACT Information Sheet 1, July 2001*. United Kingdom: University of Aberdeen. Available at <www.abdn.ac.uk/dugaldbairdcentre/immpact>.

India

■ About 130,000 women (22 per cent of the world total) die each year in India alone. Sixty-five per cent of births take place at home. Prenatal care and safe motherhood are inadequately addressed, leading to maternal mortality. Thus, in 1999, the White Ribbon Alliance for Safe Motherhood/ India (WRAI) was launched to: (1) raise awareness of the need to ensure safe pregnancy and childbirth; (2) build alliances through wide-ranging, intersectoral partnerships, recognising that a large and united effort is critical to effect change; and (3) act as a catalyst for action to address maternal deaths and sustain current Safe Motherhood efforts. There are 43 alliance members throughout India, including local and international NGOs, researchers and donors. The alliance believes that a broad-based coalition can make safe motherhood a priority issue for governments, NGOs, donors and international organisations. Strategies used include identifying and sharing existing materials and best practices; mobilising involvement of politicians and policy makers; implementing innovative projects and campaigns through partners and networks; and disseminating information through the mass media.

Source: WRAI. 2001. *Safe Motherhood At Home—Realities, Perspectives and Challenges*. New Delhi: WRAI. 60p. <www.whiteribbonalliance-india.org>.

Nepal

■ Over 90 per cent of women in Nepal give birth at home without skilled medical help and equipment. A birth-preparedness package (BPP) called *Jeevan Surachsa* in Nepali (meaning "Life Security") is being developed to increase access to and demand for maternal and neonatal health services. It is being made for the Family Health Division of the Ministry of Health by a collaboration of government health agencies and donors coordinated by the Centre for Development and Population Activities (CEDPA), an American international NGO. The strategy of having a broad stakeholder involvement is used to generate ownership and adoption of the tool for nationwide use. The BPP is designed for pregnant women and their families, who have very limited access to health services of any kind. Comprising 15 pictures and accompanying messages, the BPP informs them on care during pregnancy, childbirth and the postpartum period, helping them to overcome delays in deciding to seek care and in reaching care. It will be in two different formats: a counselling flipchart for use by community workers, and a small playing card size set on a key chain for pregnant women. The BPP is expected to be used by over 46,000 government-trained volunteer female community mobilisers and heath care providers. Pilot testing of the BPP will be completed in February 2002.

Source: Ms. Christa Skerry, Country Director, CEDPA Nepal Country Office, Gairidhara, GPO 8975, EPC 5316, Kathmandu, Nepal.Tel:(9771) 427739; (9777) 417071; Fax: (9771) 421696. E-mail: <christa@cedpa.wlink.com.np>.

■ The Center for Research on Environment Health and Population Activities (CREHPA) and Nari Bikash Sangh, a Biratnagar NGO, held the "Regional Level Seminar on the Role of NGOs and Local Governance in Preventing Unsafe Abortions in Nepal" in Biratnagar from 25 to 26 July 2001. It touched on the impact of restrictive abortion laws on women's health, the level of unsafe abortion practices and government and NGO measures to reduce the problem. Papers were presented on the legal, medical and health aspects of unsafe abortions and the role of the mass media, NGOs and local governance. Participants comprised 95 district public health officers, senior police officers, lawyers, gynaecologists, women activists, politicians, UNFPA representatives and representatives from 21 partner NGOs under CREHPA's Public Education and Advocacy Against

Unsafe Abortion programme in the eastern region. One of the seminar's main objectives was to identify the expected roles of the Ministry of Health's district health offices, district level government and NGOs in combating unsafe abortion. The seminar was a milestone for CREHPA and Nari Bikash Sangh because, for the first time in Nepal, participants from such varied backgrounds gathered on a common platform to listen and contribute significantly in identifying their roles in preventing unsafe abortion.

Source: Ms. Renuka Gurung, Research Associate, CREHPA, P.O. Box 9626, Kathmandu, Nepal; Tel: (9771) 530344; Fax: (9771) 530341; E-mail: <crehpa@crehpa.wlink.com.np>.

Pakistan

■ HEAL Trust, an NGO, was contracted by the World Population Foundation (WPF)-Pakistan to develop a package of pictorial stories on reproductive health in three local languages— Urdu, Pashtoo and Sindhi—to be used by its nine partner NGOs to educate rural communities. The package was developed from July 2000 to January 2001. Topics included safe motherhood, infertility, HIV/AIDS, child spacing, safe abortion and child survival. Photographs from the rural community were used, except for the booklet on HIV/AIDS, which used manual illustrations instead. Due to the sensitivity of the topics, it was a big challenge for HEAL to shoot the photographs in a rural area but it became possible after counselling and advocating to the target group on the importance of reproductive health. In fact, the villagers acted well as models. HEAL also facilitated a workshop by the WPF to teach its partner NGOs on how to use the package. The partner NGOs now used the package in the community, and it has been successful since the messages were very simple and led the discussion effectively. Consequently, the women's participation in the village meetings increased. Noticing the package's impact, the Save The Children organisation is printing 1,500 copies for use in its project areas and the Government Population Welfare Department will be using the package for its rural health workers.

Source: Farkhanda Tabassum, Executive Director, HEAL Trust, 53-K, Gulberg 3, Lahore- Pakistan, Tel: (92042) 586 7630; Fax: (92042) 586 7630; E-mail: <heal@one.net.pk>; <healtrust_pk@yahoo.com>.

Philippines

■ Likhaan, a local NGO, held a forum on "Sexuality, the Church and the State" to celebrate the International Day of Action for Women's Health on 28 May. More than 500 people, mostly grassroots women, attended. The speakers were Dr. Margie Go-Sinco-Holmes, a well-known psychologist and sexologist, and Dr. Sylvia Estrada-Claudio, a feminist psychologist. The rationale for the theme was the evident meddling of the church in government policies such as in reproductive health. The speakers stressed that neither the church nor the government had the right to control reproductive rights. There were two exhibits. The Creative Collective Center Inc.'s exhibit, "Who Owns Women's Bodies" showed art pieces depicting sexuality while Likhaan's exhibit, aimed at increasing knowledge of one's body, showed anatomic models of female and male genitalia; breasts, including ones with lumps one had to be aware of; contraceptives; and instruments used for examination such as speculums. Participants could touch and feel the exhibits in order to be comfortable and be aware of their own bodies as well as the instruments used. Condoms were also distributed, along with a demonstration on their use. A wide array of books and videotapes on sexuality were also exhibited.

Source: Caridad Pineda, Education and Training Coordinator, Likhaan, 92 Times St., West Triangle Homes, Quezon City, 1104 Philippines. Tel: (632) 926 6230; Fax: (632) 411 3151; E-mail: <likhaan@pacific.net.ph>.

Sri Lanka

■ Though about a third of Sri Lankans live below the national poverty line, the maternal mortality ratio, at 60 per 100,000 live births, is among the lowest in the developing world. The number of maternal deaths had fallen from 520 in 1990 to 250 in 1998. Now, over 96 per cent of deliveries are attended to by a skilled birth attendant and over 90 per cent take place in a health facility with a referral system. All first and high-risk pregnancies are referred to health facilities with obstetricians. Community midwives provide antenatal care for about 75 per cent of the women. Sri Lanka's success in reducing maternal deaths is due to the government's commitment to improving education and health care. Maternal and child health services are provided as part of integrated reproductive health services at the community level. Over 60 per cent of married women use contraception, allowing them to space births and limit family size. Other factors are the education (adult female literacy rate is 88 per cent and girls can have free education up to university) and relatively high status of women. However, efforts need to be continued to reach the minority of women who still lack good maternal health care. Of the five per cent of women who give birth at home, not all have access to a skilled birth attendant. Maternal death ratios are also far higher in the north due to the ongoing civil conflict and poor living conditions.

Source: WHO. 2001. "Sri Lanka reduces maternal deaths." *Health, A Key to Prosperity: Success Stories in Developing Countries.* Geneva: WHO.<www.who.int/inf-new/mate.htm>.

From the Information & Documentation Centre

Abdullah Cholil; Meiwita B. Iskandar; Sciortino, Rosalia. 1998. *The Life Saver: The Mother Friendly Movement in Indonesia*. Jakarta: The State Ministry for the Role of Women, Republic of Indonesia; Ford Foundation. 104p.

This publication on the Mother Friendly Movement or *Gerakan Sayang Ibu* (GSI) begins by giving some background information on Indonesia, women's position in society and maternal mortality. The second chapter introduces GSI, and explains the policies and programmes. The third chapter shows how barriers are removed by improving cross-sectoral coordination, creating community-based reporting systems, dismantling social barriers, promoting men's role, and educating adolescents on reproductive health. The next chapter describes measures taken to increase quality of care such as training midwives, formulating standard procedures, and ensuring sufficient blood supply. The last chapter highlights efforts to strengthen the referral system by bringing the health services closer to the community, improving transportation and communication and eliminating economic barriers. GSI has shown impressive preliminary results in the eight pilot districts, as maternal mortality has become a common concern, whereby pregnant women, families and communities learned about causes of maternal death, signs of high-risk pregnancies, men's crucial role in preventing maternal deaths and the importance of monitoring maternal and child health. More communities are expected to become part of GSI. Its programmes can also be replicated and adapted to other socio-cultural contexts.
Source: The State Ministry for the Role of Women, Republic of Indonesia, Jalan Merdeka Barat No.15, Jakarta Pusat 10110, Indonesia.

Berer, Marge; Ravindran, T.K. Sundari (eds.).1999. "Safe Motherhood Initiatives: Critical Issues". Reproductive Health Matters (RHM). London: RHM. 244p.

This thematic issue on safe motherhood has four broad segments. The first segment focuses on measuring and understanding maternal morbidity and mortality, and the effects of safe motherhood programmes. The next segment is on the national policies and programmes of Bangladesh, Indonesia, Bolivia, Uganda, South Africa and Kenya. The third segment presents case studies on the causes of maternal deaths and morbidity, looking at various aspects such as hospital procedures, poverty, nutrition during pregnancy, the influence of traditions and other factors which contribute to maternal deaths in certain country settings such as India, Mexico, Vietnam, Ghana and Tanzania. The last segment focuses on preventing maternal deaths through effective policies and programmes. Altogether, the 25 articles raise issues, answer important questions on maternal morbidity, and place safe motherhood in the context of broader health issues such as the use of services, the effects of health sector reform, the place of safe motherhood in the broader reproductive and sexual health agenda as well as the revision of policies and programmes based on experience in order to improve services. It also provides suggestions on financing safe motherhood at the national level.
Source: Blackwell Science Ltd, P.O. Box 88, Oxford OX2 ONE, UK. Tel: (441865) 206180/206038; Fax: (441865) 20619; E-mail: <journals.cs@blacksci.co.uk>; Website: <www.blackwell-science.com/rhm>.

Cook, Rebecca J; Dickens, Bernard M; Wilson, Andrew F; Scarrow, Susan E. 2001. *Advancing Safe Motherhood Through Human Rights*. Geneva: WHO. 169p.

Daily, an estimated 1,400 women die due to pregnancy-related causes. This report aims to facilitate initiatives by government and NGO bodies and international organisations to foster compliance with human rights in order to protect, respect and fulfil women's rights to safe motherhood. It explains how the dimensions of unsafe motherhood can be measured and comprehended and how the causes can be identified by referring to medical, health and socio-legal factors. It introduces human rights laws by identifying their sources and governmental obligations to implement them and explains a range of specific human rights applicable to advancing safe motherhood— (1) rights to life, survival and security; (2) rights relating to maternity and health; (3) rights to non-discrimination and due respect for differences; and (4) rights to information and education relevant to women's health protection during pregnancy and childbirth. Performance standards to monitor compliance with reproductive health rights and the availability and use of obstetric services are also

highlighted. The report ends by considering several strategies to encourage professional, institutional and governmental implementation of the various human rights in national and international laws relevant to reduction of unsafe motherhood, and to enable women to go through pregnancy and childbirth safely.
Source: Department of Reproductive Health and Research, WHO, 1211, Geneva 27, Switzerland. E-mail: <rhmpublications@who.int.>.

Freedman, Lynn P. 2001. "Using human rights in maternal mortality programs: from analysis to strategy." [Unpublished]

Though most fatal obstetric complications cannot be predicted or prevented, they can be treated with a few well-known technologies, which make up a package called emergency obstetric care (EmOC). However, technical solutions alone cannot save lives because various social, economic, political and educational forces have combined to prevent the widespread implementation of EmOC and the conditions that would make universal access to it possible. The author suggests that two things be done as a starting point for change: (1) Create and maintain a grand vision of the work that needs to be done, while still valuing and prioritising the concrete, grounded steps of health programming; and (2) Strengthen understanding of the ways in which large-scale economic and social forces influence maternal mortality, yet not allow the complexity of the analysis to decrease the clarity and directness of the strategy. Human rights can guide in striking this balance. The author maintains that in the big picture, maternal mortality is a serious deprivation of human dignity. The patterns of maternal mortality are shaped by the intersection of gender discrimination with imbalances of power by race, ethnicity, class and age; and within households, across societies and between countries. Ultimately, the fulfilment of human rights related to pregnancy and childbirth will require change in all spheres— households, communities, health facilities and national and international policies.
Source: Dr. Lynn Freedman, Associate Professor, Department of Population and Family Health, The Heilbrunn Centre. E-mail: <lpf1@columbia.edu>.

Inter-Agency Group for Safe Motherhood. 1997. *The Safe Motherhood Action Agenda: Priorities for the Next Decade*. Report on the Safe Motherhood Technical Consultation. Colombo, Sri Lanka, 18-23 Oct. 1997. New York: Family Care International. 78p.

In 1987, the global Safe Motherhood Initiative (SMI) was launched in Nairobi, Kenya to highlight and mobilise action to address maternal death and disability in developing countries. The goal set by the SMI and adopted at several UN conferences, was to halve maternal mortality levels by the year 2000. The WHO, IPPF, UNFPA, UNICEF, Population Council and the World Bank funded the SMI, which achieved much in its first decade. For example, safe motherhood became a central component of reproductive health; countries began to improve maternal health services; and much was learnt about strategies that effectively reduced maternal mortality. The Safe Motherhood Technical Consultation's agenda was structured around ten key safe motherhood action messages. The first three aimed at changing the political environment around women's health and empowerment issues: (1) *Advance safe motherhood through human rights*; (2) *Empower women, ensure choices*; and (3) *Safe motherhood as a vital social and economic investment*. The other seven action messages related directly to programme design and implementation: (4) *Delay marriage and first birth*; (5) *Every pregnancy faces risks*; (6) *Ensure skilled attendance at delivery*; (7) *Improve access to quality maternal health services*; (8) *Prevent unwanted pregnancy and address unsafe abortion*; (9) *Measure progress*; and (10) *Power of partnership, with safe motherhood as priority for governments, policy makers, health providers, and civil society at large*. Each action message is followed by an overview of facts and findings of case studies to show how the message had been implemented nationally.
Source: Family Care International, Secretariat, Inter-Agency Group for Safe Motherhood, 588 Broadway Suite 303, New York, NY 10012, USA. Tel: (212) 941 5300; Fax: (212) 941 5563; E-mail: <smi10@familycareintl.org>; Website: <www.safemotherhood.org>.

Sprechmann, Sofia; et al. 1996. *Estimating the Magnitude of Maternal Mortality in Cambodia: An Application of the Sisterhood Method*. Cambodia: National Maternal and Child Health Center. 15p.

Accurate information on the magnitude and causes of maternal deaths is necessary in order to support the Cambodian Ministry of Health's efforts to make maternal and child health a priority. Thus, this study's main objective is to provide a reliable maternal mortality estimate. It used the sisterhood method, an indirect demographic technique developed by the London Institute of Hygiene and Tropical Medicine, which is suited for countries with deficient death registrations and health service statistics. After pretesting to determine the validity of the method in Cambodia and testing in three sites to gauge whether a sufficient majority of Cambodians knew the cause of their sisters' death, 6,000 households were interviewed in 1995. The results showed that

the lifetime risk of maternal death was 0.024, meaning one out of every 42 women who had reached the age of 15 and married died a maternal death. At a maternal mortality ratio of 473/100,000 live births, it is still one of the highest compared to those of neighbouring countries, although it is lower than previous estimates. This study was a first attempt to provide a population-based estimate of maternal mortality for Cambodia, which is critical in focusing the attention of policy makers and donors on reproductive health problems. But, the authors argue that the biomedical, social and programmatic causes of the maternal deaths reported in this study need further investigation in order to help focus on preventing specific causes.
Source: National Maternal and Child Health Centre, Ministry of Health, Phnom Penh, Cambodia.

Yamin, Alicia Ely; Maine, Deborah P. 1999. "Maternal mortality as a human rights issue: measuring compliance with international treaty obligations". *Human Rights Quarterly*. No. 21, Issue 3, August. pp. 563-607.

Despite the availability of preventive technology for decades, the WHO and UNICEF estimated that close to 600,000 maternal deaths occur yearly, 99 per cent of them in developing countries. There is no single cause of death and disability for men that comes close to the magnitude of maternal mortality and morbidity. UNICEF and the Centre for Population and Family Health, Columbia University School of Public Health developed indicators to monitor the availability and use of medical services by women who have life-threatening obstetric problems. These indicators provide performance standards for key aspects of women's right to health. The authors have two goals: (1) to give a public health overview of the scope and determinants of maternal morbidity and mortality, and the issues involved in their detection, treatment, and measurement; and (2) to explain how to use the UN guidelines for monitoring national programmes as human rights tools to monitor states' adherence to the right to health stated in various international treaties. The article describes the scope of maternal mortality and the public health approaches to address it, and gives the reasons for and the implications of using the UN guidelines. The legal context for creating a state obligation to reduce maternal mortality as a guarantee of the right to health is given, followed by a proposal of effective ways to use the UN guidelines in setting enforceable standards to ensure that states act on reducing maternal mortality on a non-discriminatory basis.
Source: The John Hopkins University Press, 2715 North Charles St., Baltimore, Maryland 21218-4363; Tel: (410) 516 6900; Fax: (410) 516 6998.

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Maine, Deborah; et al. 1997. *The Design and Evaluation of Maternal Mortality Programs*. New York: Centre for Population and Family Health, Columbia University. 171p.

Meiwita B. Iskandar; et al. 1996. *Unravelling the Mysteries of Maternal Death in West Java*. Depok: Centre for Health Research, Research Institute University of Indonesia. 135p.

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ARROW. 2000. *Women's Health Needs and Rights in Southeast Asia.* A Beijing Monitoring Report. Kuala Lumpur: ARROW. 39p.
■ *Price: US$10.00 plus US$3.00 postal charges.*

Rashidah Abdullah. 2000. *A Framework of Indicators for Action on Women's Health Needs and Rights after Beijing.* Kuala Lumpur: ARROW. 30p.
■ *Price: US$10.00 plus US$3.00 postal charges.*

ARROW. 2000. *In Dialogue for Women's Health Rights: Report of the Southeast Asian Regional GO-NGO Policy Dialogue on Monitoring and Implementation of the Beijing Platform for Action, 1–4 June 1998, Kuala Lumpur, Malaysia.* Kuala Lumpur: ARROW. 65p.
■ *Price: US$10.00 plus US$3.00 postal charges.*

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■ *Price: US$15.00 plus US$5.00 postal charges.*

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■ *Price: US$10.00 plus US$3.00 postal charges.*

ARROW. 1996. *Women-centred and Gender-sensitive Experiences: Changing Our Perspectives, Policies and Programmes on Women's Health in Asia and the Pacific. Health Resource Kit.* Kuala Lumpur: ARROW. v.p.
■ *Differential pricing. For more information, please contact ARROW.*

ARROW. 1994. *Towards Women-Centred Reproductive Health: Information Package No. 1.* Kuala Lumpur: ARROW. v.p.
■ *Price: US$10.00 plus US$3.00 postal charges.*

Note: Payments accepted in bank draft.

Direct Maternal Deaths

Deaths resulting from obstetric complications of the pregnant state (pregnancy, labour and the puerperium), from interventions, omissions, or incorrect treatment, or from a chain of events resulting from the above.

Source: WHO. 1999. *Reduction of Maternal Mortality.* A Joint WHO/UNFPA/UNICEF/World Bank Statement. Geneva: WHO. p. 40.

Essential Obstetric Care

This incorporates the provision of properly trained and skilled birth attendants able to recognise abnormality in labour, able to deal with unpredictable complications as they arise and able to arrange transfer to a facility which can cope with obstetric emergencies.

Source: O'Loughlin, John. 1997. "Safe motherhood: impossible dream or achievable reality?". *The Medical Journal of Australia.* <www.mja.com.au>.

Indirect Maternal Deaths

Deaths resulting from previous existing disease or disease that developed during pregnancy and that was not due to direct obstetric causes but was aggravated by the physiological effects of pregnancy.

Source: WHO. 1999. *Reduction of Maternal Mortality.* A Joint WHO/UNFPA/UNICEF/World Bank Statement. Geneva: WHO. p. 40.

Lifetime Risk of Maternal Death

This measurement reflects the probability of maternal death faced by an average woman over her entire reproductive lifespan. Like the maternal mortality rate, it reflects a woman's risk of dying from maternal death as well as her risk of getting pregnant. It also considers the accumulation of risk with each pregnancy.

Source: Inter-Agency Group for Safe Motherhood. 1997. *The Safe Motherhood Action Agenda: Priorities for the next decade*. Report on the Safe Motherhood Technical Consultation. Colombo, Sri Lanka, 18-23 October 1997. New York: Family Care International. p. 62.

Maternal Mortality

The death of a woman while pregnant or within 42 days of termination of pregnancy, regardless of the pregnancy's duration and site, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

Source: WHO. 1992. *International Statistical Classification Of Diseases And Related Health Problem (ICD-10): Tenth Revision*. Geneva: WHO.

Maternal Mortality Rate

This measures both the obstetric risk and the frequency with which women are exposed to this risk. It is calculated as the number of maternal deaths in a given period per 100,000 women of reproductive age (15-49 years).*

Source: WHO. 1999. *Reduction of Maternal Mortality. A Joint WHO/UNFPA/UNICEF/World Bank Statement*. Geneva: WHO. p.10.

Maternal Mortality Ratio

This represents the risk associated with each pregnancy, i.e. the obstetric risk. It is the number of maternal deaths in a given year per 100,000 live births in the same period.*

Source: WHO. 1999. *Reduction of Maternal Mortality. A Joint WHO/UNFPA/UNICEF/ World Bank Statement*. Geneva: WHO. p. 9.

* **Note**: The terms **ratio** and **rate** are often used interchangeably; thus for the sake of clarity, it is necessary to specify the denominator used.

Safe Motherhood

A woman's ability to have a safe and healthy pregnancy and delivery.

Source: Safe Motherhood. 2001. *What is Safe Motherhood*.<www.safemotherhood.org>.

Skilled Birth Attendants

People with midwifery skills (for example doctors, midwives and nurses) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose or refer obstetric complications.

Source: WHO. 1999. *Reduction of Maternal Mortality. A Joint WHO/UNFPA/UNICEF/World Bank Statement.* Geneva: WHO. p. 31.

Traditional Birth Attendants

These are community members who deliver infants according to local customs and beliefs. They may have some training to help them avoid harmful practices, make clean deliveries, recognise danger signs and refer women to health facilities if they have any complications. However, without emergency back-up support (including referral to a district hospital), training traditional birth attendants does not decrease a woman's risk of dying in childbirth.

Source: Tinker, A.; Koblinsky, M. 1993. *Making Motherhood Safe*. Washington D.C.: World Bank, cited in Safe Motherhood. 2001. *Skilled Care During Childbirth.* <www.safemotherhood.org>.

Maternal Mortality Data: Questions of Reliability

Reduction of maternal mortality by 50 per cent by the year 2000 was the goal stated in the 1995 Beijing Platform for Action. To assess progress in attaining this goal, indicators such as maternal mortality ratio, maternal mortality rate and lifetime risk were used to provide estimates. However, lack of current and reliable data made monitoring progress difficult. This was one of the findings in the monitoring of Beijing PFA in Southeast Asian countries project coordinated by ARROW.

One reason for this problem is that large sample sizes are needed to produce estimates, leading to wide margins of error and high costs. Secondly, maternal deaths are often not reported. If they were, the cause might be misidentified or the woman's pregnancy might be unknown. Hospitals also might not report the death to avoid blame for improper treatment or mismanagement. Thirdly, maternal deaths are often misclassified, as health workers might not know the cause or whether the woman had been pregnant or had recently delivered. Even if it were known, it might not be recorded to avoid embarrassing the woman's family in case she had been unmarried or had a secret abortion.

Producing maternal mortality estimates requires finding out the number, time and cause of death and pregnancy or recent pregnancy status among women of reproductive age in a specific time period and area. The following methods are used:

Vital Registration Method: Involves comprehensive and accurate registration of deaths together with medical certification of death. Data are collected regularly, cover the whole country and provide time trends. But the system is incomplete in most Asian-Pacific countries except for China, Malaysia and Sri Lanka and suffers from under-reporting and misclassification.

Household surveys using direct estimation: They need very large sample sizes to provide reliable and representative results.

Sisterhood Method: Obtains data by interviewing women about the survival of their adult sisters— how many had reached adulthood, how many had died and whether they had been pregnant at the time. It requires much smaller sample sizes because data are collected on all sisters of the respondent and is cost-effective. But, the data are not current because they apply to 10-12 years before the survey and have wide margins of error.

WHO/ UNICEF Models: Are based on estimates from countries with relatively good maternal mortality data. Maternal mortality ratios are based on the general fertility rate and the coverage of skilled attendants at delivery. It has wide margins of error and should be used only to gauge the general extent of the problem.

No single method provides accurate and reliable data. They are all open to wide margins of error due to large sample sizes. One oft-quoted example is the household survey conducted in Addis Ababa, Ethiopia where 32,300 households were interviewed to identify 45 deaths. Nevertheless, the estimates are needed to calculate the general extent of the problem and to allocate adequate national and international resources. Measuring maternal mortality is difficult not because of a lack of tools but because of the need for a lot of human resources, money and other resources. However, understanding the possible causes with the aim of preventing them is more important than merely estimating the number of deaths through outcome indicators. Thus, the WHO, UNICEF and UNFPA had developed guidelines for process indicators that examined access to and correct use of essential obstetric services and the quality of care by measuring the percentage of births attended to by skilled birth attendants; the percentage of pregnant women receiving antenatal care; the percentage of births in health centres; and the ratio of deliveries booked in health centres. These are important in finding ways to reduce maternal deaths. Although process indicators may be initially deterred by poor record-keeping of delivery complications, they are very useful in trying to understand why women continue to die of delivery complications; in identifying and taking necessary actions; and in monitoring progress. Ultimately, the lack of current, comprehensive and reliable data remains a barrier in monitoring the implementation of the Beijing goal to reduce maternal mortality.

Therefore, governments need to more quickly address the data issues and requirements at country and decentralised levels so that the data are made reliable, accurate and accessible. From there, appropriate and adequate steps can be devised and taken to ensure that women have more accessible, affordable and available health care services of high quality before, during and after pregnancy.

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