ASIAN-PACIFIC RESOURCE & RESEARCH CENTRE FOR WOMEN (ARROW)
www.arrow.org.my

MDG 5 IN ASIA: PROGRESS, GAPS AND CHALLENGES 2000 – 2010

In September 2000, the Millennium Declaration endorsed by the heads of State and Government across the world, resolved to *reduce maternal mortality by three quarters, of their current rates.*[1] In addition, as part of the 2005 World Summit Outcome heads of State, *committed to achieve universal access to reproductive health by 2015, as set out at the International Conference on Population and Development (ICPD),*[2] *integrating this goal in strategies to attain the internationally agreed development goals, including those contained in the Millennium Declaration, aimed at reducing maternal mortality, improving maternal health, reducing child mortality, promoting gender equality, combating HIV/AIDS and eradicating poverty.*[3]

THE 'RIGHTS' AGENDA WITHIN THE MDGS

It is important to recognize that promoting, respecting and fulfilling rights as well as addressing inequalities is fundamental to achieving the MDGs. The Millennium Declaration, on which the MDGs are based, explicitly states that human rights should be central to development. Additionally member states have also signed onto, adopted, ratified various human rights treaties. Hence it is imperative to recognize that the development framework offered by the MDGs should be one that is contextualized within the human rights framework and this includes, especially with regards to MDG 5, the right to health, the right of sexual and reproductive health and sexual and reproductive rights. 'Rights' are the linchpin of the MDG agenda, although the indicators attributed to the MDGs do not explicitly state the words and analysis of progress on indicators must be predicated on the realisation of these 'rights.'

MDG 5 IN ASIA

Progress in the Asia-Pacific region on the achievement of Millennium Development Goal 5, has been slow according to the UN Asia-Pacific regional report.[4,5] ARROW's close monitoring of the UN indicators and alternative indicators shows also a similar trend of slow progress.

It is also important to note that not many countries in the region have started to track target 5B, on universal access to reproductive health. This may be due to the fact that target 5B and its indicators was introduced only in 2007.

Table 1: Comparison of 1990, 1995, 2000, 2005, and 2008 estimates of maternal mortality ratio (MMR, deaths per 100 000 live births) by country based on the estimates developed by WHO, UNICEF, UNFPA and World Bank;most recent national estimates and lifetime risk of maternal death 2008

Country	*1990*	*1995*	*2000*	*2005*	*2008*	*Annual% change in MMR between 1990 and 2008**	*Progress towards improving maternal health***	*Maternal deaths per 100,000 live births (national estimates)*	*Lifetime risk of maternal death: 1 in … 2008*
Bangladesh	870	640	500	420	340	–5.3	*Making progress*	322 (BMMS 2001)	110
Cambodia	690	640	470	350	290	–4.8	*Making progress*	472 (CDHS 2005)	110
China	110	82	60	44	38	–6.0	*On track*	30 (CDSS 2005)	1500
India	570	470	390	280	230	–4.9	*Making progress*	254 (RGI, SRS 2004/06)	140
Indonesia	620	440	350	270	240	–5.4	*Making Progress*	228 (IDHS 2004-07)	190
Lao PDR	1200	970	790	650	580	–4.0	*Making progress*	405 (Lao Pop Census2005)	49
Malaysia	56	46	39	34	31	–3.2	Countries with MMR <100 in 1990 are not categorized.	30 -2000 (MOH AR 2004)	1200
Nepal	870	700	550	440	380	–4.6	*Making progress*	281 (Nepal DHS 2006)	80
Pakistan	490	410	340	290	260	–3.6	*Making progress*	276 (PDHS 2006-07)	93
Philippines	180	140	120	110	94	–3.6	*Making progress*		320
Thailand	50	52	63	51	48	–0.2	Countries with MMR <100 in 1990 are not categorized.	12.2 (BPS MOPH 2005)	1200
Vietnam	170	120	91	66	56	–6.0	*On track*	165 (MOH 2003)	850

Source: Trends in Maternal Mortality: 1990 to 2008.Estimates developed by WHO, UNICEF, UNFPA and The World Bank. WHO 2010
Note:
**Negative values indicate a decreasing MMR from 1990 to 2008, while positive values indicate an increasing MMR. Given that the uncertainty intervals are wide for some countries, these will have to interpreted with caution.*
***Countries with MMR ≥100 in 1990 are categorized as "on track" if there has been 5.5% decline or more annually, "making progress" if MMR has declined between 2% and 5.5%, making "insufficient progress" if MMR has declined less than 2% annually, and having "no progress" if there has been an annual increase in MMR. Countries with MMR <100 in 1990 are not categorized.*

MDG 5A IN ASIA

1. MDG TARGET: REDUCING MATERNAL MORTALITY BY THREE QUARTERS BY 2015.

Based on the recent 2008 WHO/UNICEF/UNFPA and World Bank estimates, eight of the twelve countries are said to be "making progress", Vietnam and China are "on track" towards achieving the reduction of maternal deaths by three quarters by 2015. Malaysia and Thailand have not been categorized in this grading as these countries had an MMR of less than 100 in 1990.

Despite this progress in the region, maternal mortality estimates continue to be remain high particularly in South Asia - Bangladesh (340), India(230), Nepal (380) and Pakistan (260) - and in South East Asia - Lao PDR (580), Indonesia (240), and Cambodia (290).

Many countries in the region do not have a vital registration system for births and deaths, and hence the MMR estimates suffer from wide confidence intervals. The national numbers for MMR do not capture the large inter-state and regional variations within the countries in the region. For example in India, in the states of Uttar

Pradesh, Bihar, Jharkhand, Orissa, Madhya Pradesh and Rajasthan the MMR is much higher than the national MMR. In China, in the western provinces, the MMR is significantly higher than the national estimates.[6] The national numbers also do not illustrate that there are great variations between the national numbers and the numbers for marginalised groups such as poor women, lesser educated women, women from ethnic minorities and migrant groups.[7]

2. MDG TARGET: PROPORTION OF BIRTHS ATTENDED BY SKILLED HEALTH PERSONNEL

This is a critical intervention towards reducing MMR but it is important to tighten the definition of what constitutes skilled attendance at birth. A skilled attendant, according to WHO, refers to "an accredited health professional-such as a midwife, doctor or nurse - who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns."Traditional Birth attendants (TBA) either trained or untrained are excluded from the category of skilled health workers. There continues to be lack of clarity on what constitutes a skilled birth attendant in many countries.

Table 2: Skilled health attendants at birth

Name of the Country	*% skilled health worker (doctors, nurses, midwives and other cadres of health workers)*	*ICPD/ICPD+5 targets for 2005 met?(by 2005, 80% of births should be assisted by skilled attendants)*
Bangladesh	20. (2006)	no
Cambodia	43.8(2005)	no
China	97.8 (2006)	yes
India	46.6 (2005-06)*	no
Indonesia	66.3**(2002-03)	no
Lao PDR	19.4*** (2005)	no
Malaysia	100 (2006)	yes
Nepal	18.7 (2006)	no
Pakistan	54(2005-06)	no
Philippines	59.8 (2003)	no
Thailand	97.2 ****(2005-06)	yes
Vietnam	87.7*****(2006)	yes

**includes "auxiliary nurse midwife, lady health visitors, other health professional" (1.1%)*
***includes "village midwife" (20.3%)*
**** includes "auxiliary midwife" (8.9%)*
***** includes "auxiliary midwife" (0.3%)*
****** includes "auxiliary midwife" (3.9%)*
Source: Proportion of Birth Attended by Skilled Health Worker 2008 Updates (WHO, 2008)

While countries like China, Malaysia, Thailand and Vietnam have made significant improvements in skilled attendants at birth, other Asian countries in the study have a long way to go to achieve this milestone which significantly contributes to prevention of maternal deaths.

Skilled attendance, is a term which is more comprehensive than skilled health personnel attending all births. Skilled attendance denotes not only the presence of midwives and others with midwifery skills (MOMS) but also the enabling environment they need in order able to perform capably. It implies access to a more comprehensive level of obstetric care in case of complications requiring surgery or blood transfusions.[8] Findings from studies[9] point to the fact that these life saving facilities are sparsely distributed in most of the South Asian countries. In trying to reduce maternal deaths it is important to understand the key causes of maternal deaths in the Asia-Pacific region, and develop interventions based on these causes.

Table 3: Causes of maternal deaths in the Asian region

Asia-Pacific Sub-region	*South Asia (1997-2007)*	*South East Asia (1997-2007)*
Haemorrhage	35%	32%
Hypertension	17%	17%
Abortion	10%	9%
Indirect causes	19%	22%
Other direct causes	11%	10%
Embolism	1%	2%
Sepsis	7%	8%

Source: Countdown to 2015 Decade report (2000–2010) with country profiles Taking stock of maternal, newborn and child survival: WHO UNICEF 2010

Regional estimates show the leading causes of maternal deaths are haemorrhage and hypertension. Unsafe abortion contributes up to at least 9-10% of the maternal deaths[10] and provision of safe abortion services and post-abortion care is instrumental in saving lives. Understanding and tackling the reasons women resort to unsafe abortion is critical to reducing maternal deaths.

It is crucial that the current MDG5 indicators cover interventions that address these major causes of maternal deaths such as provision of both comprehensive emergency obstetric care services and post-partum care coverage.

It is also critical to recognize that violence also contributes to maternal deaths and reproductive morbidities. However maternal deaths due to violence are yet to be captured consistently and comprehensively in MMR estimations.

MDG5 B IN ASIA

Goal 5 B was added in 2007 and promises to deliver universal access to reproductive health by 2015. 5B covers 4 indicators: Contraceptive Prevalence Rates, Unmet need for family planning, antenatal care coverage and adolescent birth rate.

3. MDG TARGET: CONTRACEPTIVE PREVALENCE RATES

Table 4: CPR any method and any modern method.

Country	*Any method*	*Any modern method*
Bangladesh	55.8	47.5
Cambodia	40.0	27.2
China	90.2	90.0
India	56.3	48.5
Indonesia	60.3	56.7
Lao PDR	38.4	35.0
Malaysia	54.5	29.8
Nepal	48.0	44.2
Pakistan	29.6	21.7
Philippines	48.9	33.4
Thailand	71.5	70.1
Vietnam	78.5	56.7

Source: Country Demographic & Health Survey(s). Bangladesh DHS: 1993-4, 1999-2000, 2007; India DHS: 1992-93, 1998-99, 2005-6; Nepal: 1996, 2001, 2006; Pakistan: 1990-91, 2006-7. Cambodia DHS: 2005, 2000, 1998; Indonesia DHS: 2007, 2002, 1997; Philippines DHS: 1993, 1998, 2003; Vietnam: 1997, 2002, 2005; Lao PDR Reproductive Health Survey 2005. World Contraceptive Use 2007: China; Malaysia; Philippines; Thailand.

Based on the demographic health surveys and the World Contraceptive Prevalence Report the highest CPRs is noted in China (90.2%), Vietnam (78.5%) and Thailand (71.5%). The lowest CPRs are noted in Lao PDR (38.4%) and Pakistan (29.6%). The other seven countries have CPR that range between 40% - 61%.

However a closer look at the methods of contraception reveal that the promise of a choice of methods, and the provision of services around informed choice still remain a distant dream.

Access to modern methods of contraception continue to be a challenge in a high CPR country like Vietnam, a middle-level CPR country like Malaysia and the Philippines as well as a low CPR country like Lao PDR. It is critical to understand the reasons behind the CPR which may vary from lack of choice, religious constraints and cost and availability of contraceptives. In China, permanent methods of contraception are highly used with IUD users forming almost half of all contraceptive users (49.7%); and female sterilization comprises 34.5% of all methods. In comparison, male sterilization only forms 7.42% of all methods. In India, female sterilization accounts for a whopping two-thirds - 66.25% of all methods! In comparison, male sterilization forms a mere 1.77% of all methods.[11]

In countries that strongly implement population stabilisation policies such as China and India, permanent methods and long-term methods such as sterilisation and IUDs are favoured. Targets for permanent methods are mainly women. In other countries such as Bangladesh, in the 2007 BDHS, pill users formed more than 50% of all contraceptive users and Indonesia, in the 2007 IDHS, injectable users form more than 50% of all contraceptive users. A preponderence of one method often demonstrates provider bias/ service provision bias.

It is also important to note that the Demographic Health Surveys in all countries in this region, with the exception of the Philippines and Cambodia, only survey married women and as such, the CPR numbers are only pertinent to married women.

4. MDG TARGET: UNMET NEED FOR FAMILY PLANNING

Table 5: Unmet need for contraception 1995/ 2000/ 2005

Country	*Unmet Need*		
	1995	*2000*	*2005*
Bangladesh	19.4	15.3	17.4
Cambodia		32.6	25.1
China			
India	19.5	15.8	12.8
Indonesia	9.2		8.6
Lao PDR			27.3
Malaysia			
Nepal	31.4	27.8	24.6
Pakistan	28.0		24.9
Philippines	20.0		17.3
Thailand			
Vietnam			4.8

Source: Country Demographic & Health Survey(s).
Bangladesh DHS: 1993-4, 1999-2000, 2007; India DHS: 1992-93, 1998-99, 2005-6; Nepal: 1996, 2001, 2006; Pakistan: 1990-91, 2006-7. Cambodia DHS: 2005, 2000, 1998; Indonesia DHS: 2007, 2002, 1997; Philippines DHS: 1993, 1998, 2003; Vietnam: 1997, 2002, 2005

The accepted definition of "[u]nmet need for contraception is the percentage of fertile, married women of reproductive age who do not want to become pregnant and are not using contraception."[12] The concept of unmet need is an important one because it assesses the 'need' for contraception based on whether and when a woman wants a child or another one rather than focusing on government limits on family size. The limitation, currently, is that the DHS calculates unmet need based on a sample of married, heterosexual women and not single, unmarried women and this does not

accurately capture the extent of unmet need in a country. Another limitation is that it assumes all users as having their need 'met.' But many women may be using a contraceptive method not of their choice due to provider bias or government policy as earlier discussed and this constitutes an 'unmet need' too. It is also important to keep in mind that contraception is primarily focused on pregnancy prevention. There is also an urgent unmet need for disease/infection prevention which is not being considered. The table above shows that unmet need has been declining in all countries, where data are available. Unmet need is highest in Lao PDR, followed by Cambodia, Pakistan and Nepal.

Unmet need is lowest in Vietnam. Differentials of wealth, area of residence, age and education are all important correlations to unmet need. Unmet need is lowest among wealthy women in Bangladesh[13] and in India: "Unmet need for both spacing and limiting decreases with an increase in wealth quintiles."[14] Unmet need is higher in women living in rural as compared urban areas in Pakistan, [15] India[16] and Lao PDR.[17] Even in Vietnam which has a high CPR, unmet need is higher for women living in the more remote areas in of the country: unmet need is "highest among women in the Central Highlands (12.3%). It is lowest among women in the Red River Delta (3%) and the Mekong River Delta (4%)."[18] Unmet need is also highest among the youngest age group of women (15-19 years) in Vietnam. [19]

The most common reasons given by married women with an unmet need are concerns about the side effects, health consequences and inconvenience of methods were the most prominent reasons. The prevalence of these concerns is particularly high in South and Southeast Asia.[20] It is also important to look at and address reasons for non-use of contraception which include spousal opposition and religious opposition to use of contraception by women. Contraception is the first step in women gaining control over their own fertility, and being able to decide the number, spacing and timing of their pregnancies.

5. MDG TARGET: ANTENATAL CARE COVERAGE

Of the 12 countries, Cambodia(69%), China(90%), India (74%), Indonesia (92%), Malaysia (79%),Philippines (88%), Thailand (98%) and Vietnam (91%) of at least one antenatal visit, while Lao PDR (27%) has the lowest antenatal care coverage of the countries in South-East Asia, and Pakistan (36%) has the lowest in South Asia. It is worth noting that the Philippines (70 %) and Indonesia (80%), have a high coverage of antenatal care of at least four visits. Yet the Philippines' MMR is estimated at 230 per 100,000 live births and Indonesia's is 420 per 100,000 live births.[21]

6. MDG TARGET: ADOLESCENT BIRTH RATE

Adolescent fertility, characterised by births to women under age 20, account for 11% of all births worldwide. They account for 23% of the overall burden of disease (disability- adjusted life years) due to pregnancy and childbirth. Early childbearing entails an increased risk of maternal deaths or physical impairment. Almost 10% of the girls become pregnant, by age 16 in South and South-east Asia.[22]

There are two clear strains of thinking about adolescents in the 12 countries surveyed. In South Asia, where the age of marriage is rather low, adolescents are very often married and their rights to services are recognized within this framework. In South-east Asia, where the age of marriage is comparatively higher, adolescent sexual activity is often perceived as being outside the framework of marriage. As SRH services have been so often subsumed within the framework of reproduction, access to these services including sex and sexuality education and information becomes problematic for adolescents.

RECOMMENDATIONS

1. UNDERSTAND THAT SEXUAL AND REPRODUCTIVE RIGHTS AND WOMEN'S RIGHTS UNDERPIN SEXUAL AND REPRODUCTIVE HEALTH OUTCOMES

These rights are continuously being encroached upon by religious and political conservatives and market-based approaches to health service provision, and there needs to be continued work and investment to ensure that these rights are respected, promoted and fulfilled.

2. STRENGTHEN HEALTH SYSTEMS TO ADDRESS MDG 5

It is important for respective countries in the region to identify gaps and prioritize plans and formulate effective strategies to achieve the MDG5 targets and indicators. This includes ensuring a functional health system that provides comprehensive sexual and reproductive health services at the primary, secondary and tertiary level of health care. This should be sufficiently resourced through increased public expenditure in health.

3. ADDRESS DATA GAPS

Countries should make every effort to implement vital registration systems for births and deaths. This should be complemented with verbal autopsies and confidential enquiries into maternal deaths. This is critical to accurately calculate the number of maternal deaths and to prevent under-age marriage. Significant data gaps also exist in the current MDG 5 reporting at the national level in the Asia-Pacific region. For MDG 5, access to sexual and reproductive health care and services including maternal health care and services, are more difficult for women who suffer from a variety of political, spatial and social exclusions – those who are poor, young, less educated, migrants (particularly illegal ones), displaced populations (due to conflict and disasters), asylum-seekers, refugees, from ethnic and religious minorities and indigenous populations, from lower castes, do not follow gender and sexual norms, in sex work, have disabilities, live in remote and/or rural and those who live in conflict and disaster areas. Like other MDG indicators, data is not disaggregated for these groups.

4. RECOGNISE THE BROAD SPECTRUM OF SERVICES WHICH CONSTITUTE SEXUAL AND REPRODUCTIVE HEALTH

It is important to understand that MDG5B while promising

universal access to reproductive health has an almost exclusive focus on family planning. It is critical to recognize the broad spectrum of services that constitute sexual and reproductive health according to the ICPD Programme of Action paragraph 7.2 and to ensure access of these services to all groups especially those disadvantaged by social exclusion. The provision of these services should be the responsibility of the state to ensure access to all.

5. ADD NECESSARY INDICATORS TO ADEQUATELY ADDRESS THE LOFTY GOALS OF MDG5A & 5B

It is also imperative to acknowledge that the current targets/ indicators for MDG5 are inadequate to assess the commitment of the Heads of State and Governments to *achieve universal access to reproductive health by 2015, as set out at the International Conference on Population and Development*. The Asian-Pacific Resource and Research Centre for Women (ARROW) with her partners in the Asia-Pacific regional have initiated an MDG 5 focused campaign that proposes additional, alternate indicators that would measure MDG 5 more comprehensively as shown in table 6.

6. COMPREHENSIVE REVIEW AND REPORTING MECHANISM NEED TO BE PUT IN PLACE

A proper MDG review process is one which involves complete country progress reports involving all stakeholders concerned and backed up with NGO shadow reports, and reviewed by an expert committee which is empowered to make recommendations to governments and hold governments accountable (similar to the CEDAW reporting mechanism).

7. USE CURRENT PROCESSES AVAILABLE MORE CONCRETELY AND CONSISTENTLY TO UPHOLD THE RIGHTS AGENDA OF MDG 5 AND TO HOLD GOVERNMENTS ACCOUNTABLE

The Human Rights Council has made concerted efforts to ensure that maternal mortality and morbidity is treated as a human rights issue and this needs to be supported and effectively used by NGOs and donors. NGOs and donors also have to look at how women's sexual and reproductive health and rights (SRHR) is comprehensively reported in the health chapter of the CEDAW reporting processes especially in the shadow reports compiled by women's NGOs.

Table 6: Current official MDG targets and indicators and proposed additional/alternate indicators

MDG 5: Improve Maternal Health	*Official Indicators*	*Proposed additional/alternate Indicators*
Target 5a: Reduce by three quarters the maternal mortality ratio	Maternal Mortality Ratio	• Lifetime risk of maternal death • Maternal deaths due to unsafe abortions; looking at the reasons why women have to resort to unsafe abortion. • Maternal deaths due to violence against women
	Proportion of births attended by skilled health personnel	• Availability of EmOC services (recommended level- one comprehensive EmOC facility+ four Basic EmOC facilities for every 500,000 people.)[23] • Access and availability of post-partum care within 48 hours of delivery
Target 5b: Achieve by 2015, universal access to reproductive health	Antenatal care coverage (at least one visit and at least four visits)	
	Unmet Need for family planning	• Wanted Fertility Rates Vs Total Fertility Rates • Reasons for non use of contraception
	Contraceptive Prevalence Rate	• Range of contraceptive methods available • Provision of informed choice
	Adolescent Birth Rate	• Legal age of marriage and compare it to the Median age of marriage • Access to comprehensive sex and sexuality education • Accessibility and availability of youth-friendly sexual and reproductive health services

8. REAFFIRM THE ROLE OF NGOS AND SOCIAL MOVEMENTS AS EQUAL PARTNERS IN DEVELOPMENT

The role of NGOs and progressive social movements in enacting social change needs to be reaffirmed and reinstated within international processes. NGOs and progressive social movements have to be recognized as equal partners in development at the local, national, regional and global arenas especially in MDG5. NGOs have to be actively involved in policy-making, programme planning, implementation, monitoring and evaluation at the national, regional and international levels. NGOs, especially from the Global South, should be active participants in all UN processes where governments and donors are reviewing and reporting progress on development targets to help hold governments accountable to their commitments.

9. ALLOCATE SUFFICIENT RESOURCES AND BUDGETS TO MEET THE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS NEEDS OF ALL

There needs to be renewed financial commitment by both donors and national governments to sexual and reproductive health, including maternal health. 2009 UNFPA update on the resource requirements to achieve the costed components of the ICPD PoA SRH and FP, HIV/AIDs, basic research and policy analysis starts from US48.9 billion in 2009 to 69.81 billion to 2015 totalling upto 457.68 billion for the 7 years.[24]

ENDNOTES

1. United Nations (UN) General Assembly. (2000). *United Nations Millennium Declaration*, para. 19. Retrieved September 14, 2010, from United Nations Web site: http://www.un.org/millennium/declaration/ares552e.pdf

2. "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and wellbeing by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases." (ICPD Paragraph 7.2)

3. United Nations (UN) General Assembly. (2005). *2005 World Summit Outcome*, para. 57(g) (p. 16). UN Retrieved September 15, 2010, from United Nations Web site: http://unpan1.un.org/intradoc/groups/public/documents/un/unpan021752.pdf

4. The Economic and Social Commision for Asia and the Pacific (ESCAP); Asian Development Bank (ADB); United Nations Development Programme (UNDP). (2010). *Achieving The Millennium Development Goals in an Era of Global Uncertainty: Asia Pacific Regional Report 2009 – 2010*. Retrieved September 15, 2010, from the Millennium Development Goals in Asia and the Pacific Web site: http://www.mdgasiapacific.org/files/shared_folder/documents/Regional_MDG_Report_2009-10.pdf

5. "Achieving the Millennium Development Goals in an Era of Global Uncertainty: Asia-Pacific Regional Report 2009-2010" by UNESCAP,ADB and UNDP . This report basically looks at two indicators a) Antenatal coverage at least once and b) Births by skilled professionals and these basic indicators show slow progress in the region.

6. Thanenthiran, S; Racherla S.J. (2009). *Reclaiming & Redefining Rights ICPD+15: Status of Sexual and Reproductive Health and Rights in Asia*. Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW).

7. Thanenthiran, S; Racherla S.J. (2009). *Reclaiming & Redefining Rights – ICPD+15: Status of Sexual and Reproductive Health and Rights in Asia*. Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW).

8. *Skilled Attendance at Birth.* Retrieved September 15, 2010 from United Nations Population Fund (UNFPA) Web site: http://149.120.32.2/mothers/skilled_att.htm

9. Paxton A; Bailey, P; Lubis, S.M; Fry, D. (2006). Global patterns in availability of emergency obstetric care. In *International Journal of Gynecology and Obstetrics, Vol. 93, Issue 3* (pp. 300-7). Maryland, USA: Elsevier Inc.

10. World Health Organisation (WHO); United Nations Children's Fund (UNICEF). (2010). *Countdown to 2015 Decade report (2000–2010) with country profiles: Taking stock of maternal, newborn and child survival.* Retrieved September 15, 2010, from Countdown to 2015: Maternal, Newborn and Child Survival Web site: http://www.countdown2015mnch.org/documents/2010report/CountdownReportAndProfiles.pdf

11. MDG3: India. *Women are Watching their Governments: MDG5 Watch*. Retrieved September 15, 2010, from http://mdg5watch.org/index.php?option=com_content&view=article&id=94&Itemid=156#_edn39 Or International Institute for Population Sciences (IIPS) and Macro International. (2007). *National Family Health Survey (NFHS-3),2005–06: India*. Deonar, Mumbai, India: IIPS

12. *% of Married Women Ages 15-49, Unmet Need for Contraception Statistics, Countries Compared*. (2005). Retrieved August 6, 2009, from Nationmaster.com Web site: http://www.nationmaster.com/graph/hea_unm_nee_for_con_of_mar_wom_age_1549-married-women-ages-15-49

13. National Institute of Population Research and Training (NIPORT); Mitra & Associates; ORC, Makro. (2009). Fertility Preferences. In *Bangladesh Demographic and Health Survey.* Dhaka, Bangladesh and Calverton, Maryland ,USA: NIPORT, Mitra and Associates, and ORC Macro

14. International Institute for Population Sciences (IIPS) and Macro International. (2007). Summary of Findings. In *National Family Health Survey (NFHS-3), 2005–06: India: Volume* (pp.xxix). Deonar, Mumbai, India: IIPS

15. National Institute of Population Studies; Macro International Inc. (2007). Fertility Preferences. In *Pakistan Demographic and Health Survey 2006-07* (p. 81). Islamabad, Pakistan: National Institute of Population Studies; Macro International Inc.

16. National Institute of Population Studies; Macro International Inc. (2007). Fertility Preferences. In *Pakistan Demographic and Health Survey 2006-07* (p. 81). Islamabad, Pakistan: National Institute of Population Studies; Macro International Inc.

17. Committee for Planning and Investment (CPI); National Statistics Centre (NSI); United Nations Population Fund (UNFPA). (2007*). Lao Reproductive Health Survey 2005*. Vientiane Capital, Lao PDR: CPI, NSI, UNFPA

18. Committee for Population, Family and Children Vietnam]; ORC Macro.(2003). Fertility Preference. In *Vietnam Demographic and Health Survey 2002* (p. 71). Vietnam: Committee for Population, Family and Children Vietnam]; ORC Macro.

19. Committee for Population, Family and Children Vietnam]; ORC Macro.(2003). Fertility Preference. In *Vietnam Demographic and Health Survey 2002* (p. 71). Vietnam: Committee for Population, Family and Children Vietnam]; ORC Macro.

20. Sedgh G; Hussain R; Bankole A; Singh S. (2007). *Women with an Unmet Need for Contraception in Developing Countries and Their Reasons for Not Using a Method. Occasional Report No. 37.* Retrieved October 1, 2009, from Guttmacher Institute Web site: http://www.guttmacher.org/pubs/2007/07/09/or37.pdf

21. United Nations Children's Fund (UNICEF). (2008). *Progress for Children, A Report Card on Maternal Mortality.* Retrieved September 15, 2010, from UNICEF Web site: http://www.unicef.org/childsurvival/files/Progress_for_Children-No._7_Lo-Res_082008.pdf

22. World Health Organization (WHO). (2009). *Adolescent Pregnancy*. Retrieved September 25, 2009, from WHO Web site: http://www.who.int/making_pregnancy_safer/topics/adolescent_pregnancy/en/print.html

23. The Six UN Process Indicators and Recommended Levels (1997)- Issued by UNICEF, WHO and UNFPA in 1997

24. United Nations. 2009. Report of the Secretary-General on the Flow of Financial Resources for Assisting in the Implementation of the Program of Action of the International Conference on Population and Development. E/CN.9/2009/5. NewYork: United Nations.