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Mothers & Child Survival

Lessons learned in adding maternal health
interventions to PVO Child Survival projects

Cecile De Sweemer-Ba, MD, DrPH

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to PVO Child Survival projects**

By

Cecile De Sweemer-Ba, MD, DrPH

With contributions from

**Rani Bang, MD, MPH; Loren Galvao, MD, MPH;
Donald Kaminsky, MD, MPH; Han Xiao Ming, MD, MPH;
Elizabeth Preble, MPH; Michele Strachan, MD;
Luis Tam, MD, DrPH and Rajani Ved, MBBS, MPH.**

In June 1992, the PVO Child Survival Support Program of The Johns Hopkins University School of Hygiene and Public Health convened a PVO Maternal Health Lessons Learned Conference in Shiprock, New Mexico. The purpose of this conference was to provide country national project managers of Child Survival projects an opportunity to talk about the potential for improving women's health within the context of a focused Child Survival program. Participants shared their experience in implementing maternal health strategies, lessons learned, and issues for further research. The conference resulted in some broad guidelines and recommendations that new Child Survival projects can use to build maternal health programming. Videos and a conference report were produced for participants. This document incorporates the discussion and recommendations from the conference and can provide a useful guide for PVO project managers.

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The views presented in this report are those of the author, who has tried to be faithful to the expression of conference participants. They do not necessarily represent those of USAID, the funding agency.

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women needs no justification other than its being a basic human right, in Child Survival projects the rationale for maternal health usually begins from the need to assure a mother's health in order to protect her current and future children.

In the summer of 1992, country national project managers from 14 Child Survival projects in 11 countries gathered in Shiprock, New Mexico, to talk about the potential for improving a mother's health within the context of a focused Child Survival program. These projects had allocated 20% or more of their resources to maternal health. They shared their experience in implementing maternal health strategies, lessons learned, and discussed other questions that remain unresolved so far, but were felt to need further research.

The Shiprock Conference

More than 60 people from 20 countries participated in the conference. (For a complete list of participants, see Annex 5.) Fourteen Child Survival projects supported by *Adventist Development & Relief Agency*, *CARE*, *Project HOPE*, *Minnesota International Health Volunteers*, *PLAN International*, *Program for Appropriate Technology in Health*, *Project Concern International*, *Save the Children*, and *World Vision* were represented from Bangladesh, Bolivia, Ecuador, India, Indonesia, Kenya, Malawi, Nepal, Nigeria, Papua New Guinea, Sudan and Zimbabwe. Health professionals with experience in maternal health programs in Brazil, China, Ethiopia, Haiti, Honduras, India, Mexico, and Sudan attended, adding their expertise to that of the UNICEF Safe Motherhood Office. Representatives of the U.S. Indian Health Service and the Navajo Nation Division of Health elaborated on the lessons they had learned working with an economically disadvantaged Native American population in the United States. The conference was organized by The Johns Hopkins University School of Hygiene and Public Health PVO Child Survival Support Program.

Conference Objectives

Overall, the conference sought to validate the importance of women's health; participants met to:

- (1) Discuss links between culture, childbearing practices, health of women, and survival of mothers and children.
- (2) Share strategies and experiences in raising women's self-esteem and status.
- (3) Share qualitative methods for talking with mothers and fathers about childbearing, prevention of unwanted births, and

reproductive health.

- (4) Develop a common understanding of the definitions of maternal deaths, mortality rates and ratios, and underlying causes of maternal death. (See Annex 2)
- (5) Discuss program priorities for antenatal, delivery, and postnatal care, and the key elements required for integration and sustainability of these activities.
- (6) Identify approaches to improve health care access and quality of services for women and for hard-to-reach adolescents.
- (7) Identify essential strategies to strengthen collaboration and referral care for women felt to be at risk for the more serious complications of pregnancy, labor, delivery, and postpartum.
- (8) Reinforce the value of training and supervision for traditional birth attendants.
- (9) Encourage participants to develop activities at the community level for prevention of sexually transmitted diseases (STDs) and reproductive tract infections (RTIs), and identify starting points for HIV/AIDS education.
- (10) Explore how PVOs can help adolescent females prepare for parent roles.

The first three objectives try to come to grips with the cultural and societal context of maternal health and maternal health services. The next six objectives center around access, relevance, and effectiveness of maternal health services for women and adolescent females. Finally, the last objective centers on helping adolescents prepare for motherhood, contributing to a better future for their children.

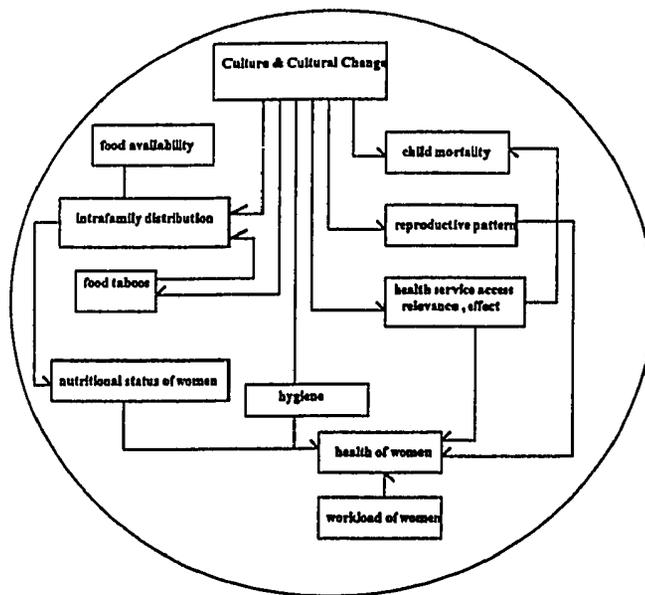
These objectives are expressions of an underlying conceptual framework, presented in Figure 1. This model states that the health of women is influenced and enmeshed with the nutrition system, the health system, and the reproductive system. At almost all levels health is shaped by role, access to resources, decision power or lack thereof, as well as self-perception. The model underlies the recommendations presented in this report.

Avoiding Past Mistakes

The reader will not find explicit technical details or treatment protocols in this report. Clearly, no externally designed program for maternal care will work in all settings. The report highlights issues of major importance in the care of mothers. This compendium is an attempt to assist program managers to delineate strategies and plan

interventions for maternal health. It raises awareness about problems encountered, and strategies found useful by PVO projects in many different countries. Recommendations, based on these lessons learned, are presented at the end of each section. New Child Survival projects can avoid "re-inventing the wheel" and, instead, build maternal health programming to greater levels by following these recommendations. Additional readings are listed in Annex 2.

SOCIO-ECONOMIC CONTEXT



1. WOMEN'S HEALTH, CULTURE, AND EMPOWERMENT

1.1 Culture and Women's Health

Each person is culturally defined by his/her gender, age, reproductive role, and by his/her membership in two or more kinship lineages. It is culture that tells us how others perceive us and that regulates self-image and expectations about fate and role. Culture mediates interpretation of reality, perceived freedom of action, and perceived power (or lack of power) over life and health. It prescribes the "virtues" to pursue and the "sins" to fear.

The woman as mother is venerated as the mainspring in the

biological and cultural reproduction of society. The central mystery of conception, pregnancy, and birthing are protected, codified, and feared by all cultures, ancient and modern.

Conversely, in many cultures, women's role as mother defines women's social status. An example of this is the stigma some cultures attach to infertility or even to sexual activity not aiming at reproduction.

In most traditional cultures, taboos and customs regulating sex, pregnancy, and birthing, first and foremost aim not only at maximizing fertility, but also at assuring that the child will be conceived, carried, and brought into the world surrounded by signs and symbols that call up the core forces of the specific culture and the blessings of its God(s).

The modern teaching of sexual health and the provision of antenatal, intrapartum, and postpartum care will be acceptable in the measure that they fit or can be adapted to the culture.

1.2 Lessons Learned

PVO projects are acutely aware of the power of local culture. They have a need to adapt to it. Projects are challenged to develop scientifically valid, culturally suitable, and financially affordable maternal health services that the community can fully utilize. But PVOs often encounter similar problems in adapting to the local culture. External evaluations have found the following common problems:

- (1) PVOs design antenatal care without sufficient attention to the characteristics and causes of local problems, which makes it less scientifically valid and less likely that users benefit.
- (2) Intrapartum care in health centers or hospitals tends to be an alienating expression of the power of technology and technologists over life; therefore, in many traditional societies modern intrapartum care is little appreciated, particularly by rural women.
- (3) Modern postnatal care and sexual health are the two areas that have been the least systematized in most services—if not neglected outright—by both providers and community.

Not surprisingly, these are the areas where customs and taboos are most forceful. The pursuit of child survival and maternal health demands that the communities have access to scientifically valid information and services, but these goals can only be reached if this can be done in a culturally sensitive way.

1.3 Major Approaches to the Question of Cultural Fit

Providers need to investigate carefully the question of cultural fit by addressing four major issues:

- (1) The place of women (the female child, adolescent girl, woman of reproductive age, and the post-menopausal woman) in the cultural, social, economic, and spiritual life of the society.
- (2) The major maternal health problems and high-risk groups specific to the particular community.
- (3) The key cultural, social, and economic factors that favor or harm women's health.
- (4) The cultural barriers that may be responsible for low coverage or effectiveness despite a seemingly adequate service delivery system, taking into account that both the community and the providers could be "at fault."

Providers need to consider subquestions and strategies related to these issues in determining the cultural position, receptivity, and needs of women in a given community.

- (1) *What is the place of women in the cultural, social, economic, and spiritual life of the community?* How are women defined primarily?—as reproducer, educator, worker, man's helpmate or family servant, trader, other? What are the feminine moral values? To whom is the woman accountable? Who makes fertility-related decisions? To whom does the child "belong"? Are there female hierarchies within families and between families? What is the mythical vision of conception, pregnancy, birth? Who should officiate? Who can bless or curse? What is the traditional health-seeking behavior relating to conception, pregnancy, birth, and postpartum? What are the most feared complications? Who are the preventive/curative traditional "specialists"?
- (2) *What are the major maternal health problems and high-risk groups specific to the particular community?* What maternal health problems are seen in the maternity units in hospitals? What are the common complications of pregnancy and delivery, common gynecological problems, common skin diseases? Check available sources of data on maternal (mal)nutrition, weight, height, anemia, night blindness, and goiter. Where cemeteries or vital registration records exist: which women died at which age over the last five years? Where a good vital statistics registration system exists: try to study causes of maternal deaths to find out how they could be prevented.

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- (3) *What are the key cultural, social and economic factors that favor or harm women's health?* What are the main features of the reproductive patterns of the community? Use key-informants, focus-groups and other qualitative methods to collect information on subjects like: average age at menarche, its rituals and meaning; age at marriage, type of "normal" marriage; completed ideal family size, age at completion; traditional spacing and family planning; customs related to pregnancy, birthing, postpartum; reproduction before age 20, after age 35; menopause: social, cultural meaning; infertility, widowhood, remarriage, levitical law; desertion, single parenthood, migration of one spouse.
- (4) *What are the barriers to use of health services by women?* Low coverage or low compliance with maternal health services illustrates that the providers of services and/or community create cultural barriers to the use of services. What is the coverage and compliance with regard to antenatal, intrapartum and postpartum care, family planning and prevention of sexually transmitted diseases? Are some services better utilized than others? Bring some community people together and design some consciousness-raising participatory action research in which the community's preferred approaches to maternal health services will be identified, tried, and evaluated.

PVOs should be constantly alert for signs that the community does not feel comfortable with particular aspects of service delivery. The need to design and carry out culturally appropriate maternal health care interventions demands that PVOs invest the time in action-research relying heavily on qualitative methods for getting information on beliefs, attitudes, and preferences.

1.4 Building Women's Self-Esteem

In most of the projects the status of women, their self-esteem, and their ability to bear the costs of health care are major, almost generic determinants of their health and access to health care. Status and self-esteem are interrelated; women can acquire better self-esteem and better status through a variety of interventions.

A basic condition for improving self-esteem is to be able to contribute to one's family or community and to receive positive feedback. This may also be expressed as having a relationship to a person (in the case of a woman this is usually her man or children) and a membership in society (usually through kin and in-laws, but can be through women's support groups.) The woman makes contributions

through her different roles as procreator, educator, producer, wife/lover, and/or public figure. In each of these roles, culture has placed expectations and constraints. Can women be helped to perform one or more roles successfully through acquiring new skills in literacy, health, nutrition, production, marketing, etc.? Can they be helped to reflect together on the constraints and expectations and question their logic and justice? Can they be trained in assertiveness; in organizing?

Literacy and acquisition of new skills create their own dynamics in favor of enhanced self-esteem and better participation in health activities. Moreover, positive role models are important. Potentially the TBA or other village-based health workers can be such models. Access to the money economy through women's saving societies and banks, to NGO programs permitting investment in trade, or to workshops that market their women's skills can help give women an esteemed place in their family and in society at large.

The lessons learned so far must spur PVOs on to explore more deeply how to assure that the services offered are more culturally appropriate.

2. COMMUNITY PARTICIPATION & SUSTAINABILITY

To be productive, management plans or any health problem must address coverage, efficiency, effectiveness, and equity as well as sustainability. In part, this can be achieved by collaborating with people other than project staff in promoting and implementing maternal care services. Project sustainability depends on maintaining community participation, transfer of skills and knowledge, financial viability, and collaboration and networking with the Ministry of Health and other organizations. As more of these criteria are met, the chances of sustainability are better. In contrast, communities of refugees, displaced persons, seasonal migrants, or nomads have more difficulties in developing community participation and, therefore, sustainability. The following are important issues related to involving others in maternal care programs.

2.1 Involvement of Community Members

Involvement of community members other than pregnant women in maternal health promotion should be a natural first step in a maternal care program. In cultures quite different from one another, pregnant women are surrounded by similar support networks, key protectors and decision makers: husbands, mothers-in-law, maternal uncles, and

sisters-in-law.

PVO projects should try to understand the roles key figures play and involve them in discussions on maternal health. Some Child Survival projects such as Project Concern International/Papua New Guinea, train men as promoters of maternal health—in particular, the husbands of the village birth attendants. Other projects include family education classes for adolescents of both genders or for whole families. In Bolivia, husbands fulfill the role of birth attendant, so one project is training husbands in safe delivery.

Some projects find that married women are too busy to attend health education activities and so have switched to a child-to-child or adolescent-to-adolescent approach. They recognize that the adolescents of today will become mothers and fathers tomorrow. This approach can promote sustained behavioral change, as well as better physical preparation of the girls by improved nutrition prior to puberty.

Emergency transportation of women in labor is another problem that can only be solved with the help of community members working together with the MOH referral center for the community. Both parties must be willing to commit time and effort. One project involves street youngsters in emergency transport networks; in another, a truckers' union; in another, village men.

Recommendations for Involving Community Members

- (1) Discover what resources for a mother's care already exist in the community.
- (2) Give the community the opportunity to define the maternal health problems and design solutions in order to strengthen the existing resources.
- (3) Optimize the involvement of children, adolescents, husbands, and other concerned family members. Maternal health should become the active concern of all.
- (4) To reach children and adolescents about maternal health, go beyond those in schools or families, and reach out to those that work and/or live in the streets and markets.

Deal with the child or adolescent in the context of his or her family. In the case of "street children" work with the child in the context of his or her "substitute family" or peers who live with the child in the streets.

Children and adolescents need care as well as education if they are to be prepared for life. Take the time to deal first with health needs

and education needs that adolescents voice, before touching sensitive issues like sexuality, sexually transmitted diseases, and drugs. Start by individual counseling and rehabilitation, where indicated. Respect the youngsters, their time, and their choices of activities.

2.2 Involvement of Community Volunteers

Projects that involve volunteers do so to stimulate community participation and increase coverage. But volunteers can also help in equity of coverage and sustainability. Volunteers are vital in the health education of groups largely inaccessible to modern mass media and to clinic personnel.

The effective incorporation of volunteers in project program implementation requires careful consideration. Issues arise in selection criteria; workload; supervision; incentives; support from community, NGOs, and MOH; and reliability and continuation of activities. The advantages of using volunteers are many. Volunteers know the community, the culture, and people's perception of problems. They can stimulate community participation. They can increase effective demand of services. They are "free."

The constraints are also well recognized. Volunteers are difficult to supervise; they may not feel accountable. Their knowledge base may be too small to give them satisfaction. If the workload is too much, or unrewarding, they lose motivation and leave the project.

2.2.1 Consult with the community about whether to have unipurpose or multipurpose volunteers. Unipurpose volunteers are specialized in one task or health intervention. A multipurpose worker is responsible for many tasks. Specialized volunteers have a chance to serve beyond their family or clan; multipurpose volunteers usually serve just their clan or hamlet. Keep in mind that unipurpose volunteers are easier to train and supervise, but will need to be more numerous since they will be expected to cover a larger population of project beneficiaries.

2.2.2 Whatever the decision, whether specialized or multipurpose worker, it is necessary to define volunteer tasks so that each is limited in time, useful, and leads to recognition in the community.

2.2.3 The community and the PVO, together, must set the criteria for selection for: literacy (if the task demands it); age and gender (depending on task); residency in the village; hours of availability; respect by those she/he would serve.

2.2.4 The initial training of volunteers is very important. Structure training to improve knowledge, skills, and attitudes. Determine the place and length of training according to training objectives, availability and convenience of the volunteers, and cost. Include training at the referral center so that the volunteers can provide a link between the community and the referral center. Determine content by tasks to be carried out and expressed needs of the volunteers and the community. Use methods that are objective, practical, participatory, and fun. Focus on competency.

Trainers must be good, popular communicators, capable of handling local vernacular and skilled in the health techniques. Where possible, training should be conducted by the people who will be the supervisors. Evaluate learning based on performance in the first three months and in the first year.

2.2.5 Incentives to volunteers can be periodic or performance based. They can be in cash, in kind as social recognition (e.g., certificates, awards, etc.), or as continued access to new information or new experience. The source of such incentives may be the community, the NGO, or the MOH.

2.2.6 Volunteers can be supervised by the trainers, the community, the NGO, or by government officials. Define responsibilities for supervision and make assignments clear to all. Supervision should be carried out on a regular schedule (at least once every month where possible) and, in addition, as necessary. Use supportive methods of supervision. Acknowledge accomplishments and improvements, and collaborate on problem solving. Make sure that necessary supplies are available. Use information obtained by direct observation, checklists, focus groups, and problem-solving sessions to monitor volunteers and lead to retraining.

2.3 Enhancing Sustainability

The involvement of other community members and volunteers in maternal health services not only helps coverage but works toward increased equity and sustainability. Sustainability needs clear definition in all its aspects, among which is the networking with MOH and other organizations. Sustainability depends on many community factors.

2.3.1 The participation of the community is critical to project sustainability. The community that has expressed its priority needs and is eager to continue service activities can facilitate sustainability.

To maintain and even enhance their motivation, health volunteers should work with formal and informal leaders and women's groups in the communities. Good community relationships, cultural sensitivity, encouragement of active community participation, and effectiveness are basic conditions for sustainability.

2.3.2. To facilitate sustainability, design measures to counter the constraints and obstacles encountered by the MOH referral center and local NGOs in regard to collaboration and networking.

Plan and negotiate with the government, local referral center, and local NGOs from the very beginning; agree on respective roles, responsibilities, and areas of operation. Establish a reporting system to the government and local NGO that informs them of decisions and accomplishments. Train and use local NGO and government workers; integrate them in the team; give them key roles in service activities. Use government and local resources wherever possible (vaccines, essential drugs, teaching materials, etc.). Establish responsibilities and two-way communication with the NGO and the referral center. Conduct annual "lessons learned" workshops both at the local and national levels. Use the mass media, where possible, to popularize the activities and the project giving full credit to government and local NGO.

2.3.3 Institutional sustainability is encouraged through increasing the capacity of local NGOs or groups in the community to raise funds, lobby, manage the program, and develop commitment among all health workers for child survival and maternal health.

Transfer of knowledge and skills must occur at all levels. For example, Child Survival PVOs have found that it is important to train people within a local NGO to manage the program. Others train the health workers and try to get government commitment to continue training. Some PVOs adopt a "training of trainers" approach and train the health team to be able to train TBAs and volunteers. Some PVOs choose to motivate church and mosque leaders and local NGOs in child survival principles and activities, hoping that will strengthen the community long-term commitment to maternal health.

2.3.4 There is a tension between sustainability and innovation. Time-tested ways of viewing maternal nutrition or delivery practices are difficult to change, even if they are much less effective than new strategies. The MOH may exert undue pressure on local areas to expand quickly to boost its own performance. Middle-level health workers, responsible for supervision in the local area, may be insecure with management of the new strategies, and may become

hostile or not acknowledge the new strategies. A project must balance the contradictory forces of achieving the coverage goals of new interventions quickly, while, at the same time, promoting sustainability.

2.3.5 There are limits to cost recovery as a means of sustainability. Those who most need maternal services have the least amount of disposable cash. PVOs find it necessary to go beyond collection of a fee for service. When planning financial sustainability, consider the possibilities of insurance, fund raising, and revenue generation from collective activities in combination with a fee for service. It is especially important to increase disposable cash at the family level so that the family has the income to purchase services. PVOs are experimenting with women's savings groups and other ways to increase family income. Most recently, Child Survival PVOs are broadening their approach to women and getting involved directly or indirectly with literacy and numeracy to enhance the skills and self-esteem of women.

3. ACTIVITIES TO PREVENT MATERNAL AND NEONATAL MORTALITY

The objective of a maternal health strategy is to improve the health of mothers and children. In most developing countries, attaining this objective demands a judicious mix of advocacy and health education on promotion and prevention. The success of advocacy for new government policies on women's education, age at marriage, employment, maternity leave, right to breastfeed, etc., will be limited by the government's ability to enforce these policies.

Direct health education messages on safe motherhood and promotion of maternal care and emergency obstetric services to the women themselves, their husbands and family members, opinion leaders at local and national levels, and to adolescents. If these communities are not educated, maternal health services will be offered in a social and cultural vacuum, thereby rendering them ineffective.

Maternal health is not limited to maternal care (antenatal, intrapartum, and postpartum activities). Health care that will significantly influence maternal and newborn outcomes affects the whole age range: good nutrition of prepubescent and adolescent girls assures better growth, reducing the possibility of obstructive labor; better protein, calorie, and iron reserves reduce the number of future low birth weight infants; prepubescent and adolescent health and sex education prevents STDs, unwanted pregnancies, abortions, and

high-risk pregnancies; and early care of STDs in youngsters prevents complications including female infertility.

It is important to remember to focus maternal health activities on a number of health problems that have direct relevance to maternal and neonatal survival. Tables 1 and 2 are checklists of relevant problems and interventions developed by Dr. Luis Tam, MD, MPH, of PLAN International for use in PLAN's field projects in Latin America.

In each region or district it will be necessary to prioritize according to local importance and feasibility.

3.1 Antenatal Care

Antenatal care must be linked with a referral system that is equipped to handle obstetric emergencies. Antenatal care activities, such as nutrition promotion, malaria prophylaxis, and iron tablets, prevent low birth weight. Antenatal care linked to a referral center that is staffed and equipped to take care of obstetrical emergencies can

Table 1.

List of health problems related to maternal and neonatal mortality

Health Problems	Relevance for Maternal Mortality	Relevance for Neonatal Mortality
Obstetric hemorrhage (both antepartum and postpartum bleeding)	X	X
Pre-eclampsia/eclampsia	X	X
Obstetric infection (e.g. chorioamnionitis)	X	X
Malaria during pregnancy	X	X
Iron deficiency during pregnancy	X	X
Iodine deficiency during pregnancy	X	X
Protein-calorie malnutrition during pregnancy	X	X
Vitamin A deficiency during pregnancy	X	X
Genitourinary infections during pregnancy	X	X
Obstructed labor/ruptured uterus	X	X
Maternal tetanus	X	
Neonatal tetanus		X
Neonatal hypoglycemia and hypothermia		X

Table 2.
Potential relative effectiveness of the interventions aimed to decrease maternal and neonatal mortality

Problem-oriented interventions	Relevance for reducing maternal mortality	Relevance for reducing neonatal mortality
Prevention and case management of obstetric hemorrhage, infection, and pre-eclampsia/eclampsia	+++	+++
Prevention and case management of obstructed labor/ruptured uterus	+++	+++
The use of family planning to decrease the exposure to pregnancy and to increase the inter-gestational period	+++	+ to ++
Prevention and case management of malaria and/or genitourinary infections during pregnancy	++ to +++	+++
Prevention and case management of iron, iodine, and vitamin A deficiency during pregnancy	++ to +++	+++
Promotion of the avoidance of smoking and alcohol consumption	+ to ++	+++
Tetanus toxoid immunizations to women of reproductive age	+ to ++	+++
Increase of the energy balance among pregnant women	+ to ++	++ to +++
Improvement of the nutrition of the adolescents, both in qualitative and quantitative terms	+ to ++	+
Promotion of hygienic birth deliveries (i.e., the "3 Cleans")	+	+++
Prevention and case management of the low birth weight's hypothermia and hypoglycemia	-	+++

prevent maternal mortality. The rationale of antenatal care is twofold:

- (1) To screen a predominantly healthy population to detect early signs of disease or high-risk factors for both maternal and neonatal outcome.
- (2) To offer timely intervention.

In developing countries, many women are seen at least once during the antenatal period. Far fewer women, however, are delivered by trained health care providers. Thus, antenatal visits offer an opportunity to address other health-related issues like nutrition, STDs, child health, and family planning. It is essential to maximize the benefit of these contacts by making effective use of staff, resources, and women's time.

Constraints

The majority of the PVOs are providing some form of antenatal services in a variable package. PVOs have identified the following constraints in the provision of antenatal care:

- (1) Inability to provide full coverage of antenatal care services.
- (2) Lack of equipment or failure of equipment (hemoglobinometer, sphygmomanometer, weighing scales).
- (3) Supply constraints (tetanus toxoid, iron and folic acid tablets).
- (4) Women did not want antenatal care.
- (5) Shortage of trained staff.
- (6) Lack of supervision.
- (7) No established mechanisms for referral and transport of obstetric emergencies.

Recommendations for Antenatal Care Strategy

In order to provide adequate antenatal care ("adequacy" encompasses accuracy in measurement, effective communication to mothers, and trained assistance), the following is recommended:

- (1) Culturally appropriate health education.
- (2) Early identification of pregnancy.
- (3) At least three antenatal visits (one during each trimester.)
Monitor when in the gestation period the woman first appears for antenatal care.

-
- (4) Regular weight monitoring or use of other anthropometric indicators (such as pre-pregnancy weight, height, or mid-arm circumference) to prevent low birth weight.
 - (5) Adequate prevention and screening measures, and treatment when needed, for common conditions responding to interventions: anemia, malaria, infections, and malnutrition.
 - (6) A definition of high risk and conditions for close monitoring or referral, such as maternal age (under 18, over 35), height (under 1.50 m or 1.45 m), poor obstetric history, other medical illnesses, malpresentations, hypertensive disease of pregnancy, etc.
 - (7) Use of home-based maternal records where possible—mothers tend to keep their records safer than do either institutions or health workers, and the records may act as an impetus to seeking antenatal care.
 - (8) Repeated in-service training, support, and effective supervision for TBAs.
 - (9) A trained group of workers to provide services at the first referral center and to manage emergencies.
 - (10) Integration of preventive and curative traditional care that is effective and safe.
 - (11) Education of mothers and other key family members about danger signs during pregnancy.
 - (12) Collaboration with Ministry of Health and other health/development organizations to strengthen referral and transport systems.
 - (13) Decisions that acknowledge local situations, cost and community needs, for example:
 - a. Where anemia is common, make a decision to either supplement all women with iron and folic acid, *or* test all and supplement all women having <11 gms hemoglobin *or* treat those with pale conjunctiva.
 - b. Where vitamin A deficiency is common among women, modify diet where possible. Beta-carotene, alternatively, can be used as a supplement during pregnancy at any dosage level. A pregnant woman with night blindness, or Bitot's spots, should be supplemented daily for two weeks with 10,000 IU vitamin A orally (1 sugarcoated tablet).
 - c. Where all women of reproductive age have not been systematically immunized against tetanus, and tetanus is

still a problem, offer TT at least twice during the antenatal period.

- d. Where many women have low weight for height, a key intervention is calorie supplementation with protein coverage either in the village or waiting house or maternity unit.
- e. Prepare the woman with respect to hygiene and sterile equipment in the home during the eighth month if her choice is home delivery.

3.2 Referral and Transport

Assuming a good screening system is in place, the crucial next step in the management of complicated pregnancies at the community level is an adequate system of referral and transport. Identifying a woman as being high risk will not help by itself. The means to reach and to treat obstetrical emergencies at a higher facility must be available. Referring a woman to a center where there is no blood transfusion or anesthesia, for instance, can have a very negative impact. Women may refuse transfer to a distant referral center if they have heard of anyone referred there who has had a poor outcome.

When undertaking negotiations with the community, remember that transport of referrals is needed for a variety of cases other than maternal emergencies, but that maternal emergencies may pose special problems related to ritual pollution.

The key elements of a good referral and transport system include:

- (1) An effective risk identification system and early identification of complications.
- (2) Trained personnel to screen and recognize signs of high risk or complication.
- (3) Reliable means of transport (village volunteers, truckers union, etc.)
- (4) Cost recovery mechanism for transport so as not to slow down or inhibit transfer.
- (5) Adequately equipped referral facility.
- (6) Effective system of information exchange between levels of care.

Recommendations for Referral and Transport

- (1) Involve village health committee and/or key leaders in arranging to have emergency transport on a permanent basis; consider a community fund to pay or advance transport costs.
- (2) Foster effective collaboration with MOH or other personnel at the referral facility.
- (3) Develop a cadre of trained workers at the village level to stabilize the patient before transfer, and accompany her whenever possible.
- (4) Consider the possibility of training staff and other workers (at MOH level) to diagnose labor disorders by the use of the partogram, and provide services for common obstetric emergencies (such as IV infusions, manual removal of the placenta). Provide these services as close to the home as possible, rather than transferring patients to the health center or district hospital. If this is not feasible, establish "maternity waiting homes" near the referral center.

3.3 Intrapartum Care

Problems and emergencies that develop during labor need to be taken care of by personnel trained in life saving skills. Assure transport to an equipped referral center for a woman having an emergency that cannot be dealt with by a local TBA. Normal deliveries should continue to be taken care of by the community. The PVO must learn about current birthing practices and practitioners and eventually develop appropriate training (see chapter 4.)

3.4 Prevention and Management of the Low Birth Weight Newborn

Low birth weight (currently defined as being < 2,500 gms at birth) presents one of the clearest risks for subsequent infant mortality. A LBW newborn has a perinatal mortality 30 times higher than that of a normal weight newborn. Thus, the prevention and management of the LBW newborn should be an important goal in programs to improve infant and child mortality. Among the causes of LBW are malnutrition, especially anemia; infection; very young mothers; hypertensive disease in pregnancy; maternal malaria; premature labor; alcohol; smoking or chewing tobacco; and unwanted pregnancy.

Recommendations for Control of Low Birth Weight

- (1) Increase the availability and access to antenatal care.
- (2) Provide nutrition counseling (see page 30.)
- (3) Provide prophylaxis and treatment of malaria.
- (4) Improve provision of family planning services for birth spacing and prevention of conception.
- (5) Train TBAs and health workers to recognize a LBW new born.
- (6) Dry and wrap the newborn; provide warmth for the LBW newborn using the kangaroo technique or light bulbs.
- (7) Encourage frequent breastfeeding; if the infant has a poor suck, it should be fed expressed breast milk with a spoon; or clean cotton wicks soaked in milk should be squeezed into the child's mouth. In both cases, cleanliness is essential.
- (8) Train workers to identify when to refer the child to hospital.
- (9) Keep the family informed before, during and after referral.

3.5 Postnatal Care

Most projects so far do not have a very systematic approach to postnatal care. Ideally postnatal care should start in the first 24 hours after delivery. The provision of care, therefore, relies heavily on TBAs and family members, and preparations should be made in the antenatal period.

Postnatal care activities in the first 24 hours carried out by a TBA or family member:

- (1) Check regularly for excessive bleeding or discharge and fever. If these problems exist, the TBA or family member needs to follow established protocols regarding the correct action to take.
- (2) Assure early breastfeeding with colostrum.
- (3) Promote exclusive breastfeeding and discourage use of other fluids.
- (4) Assure appropriate hygiene of mother and child.
- (5) Assure appropriate nutrition of the mother.

After the first 24 hours, postnatal care aims at optimizing maternal nutrition and workload, the provision of means for childspacing, gynecological care as needed, and care of maternal anemia.

Recommendations

- (1) PVOs that provide neonatal care or TBA delivery should seriously undertake to improve postnatal care services and quality.
- (2) PVOs should integrate promotion of breast feeding, family planning, and postnatal care.

4. TRADITIONAL BIRTH ATTENDANTS

Community-based PVOs have learned that traditional birth attendants who are properly trained and supported will reinforce women's self-esteem; preserve the culture of the community; and maintain safety and technical soundness of delivery care. These three themes—the recipient's self-esteem, the preservation of culture, and technical safety—should guide a project in making decisions about selection of those to be trained as birth attendants; training of birth attendants; and ongoing support of birth attendants.

4.1 Selection

Projects must decide whom to train as birth attendants. The spectrum of choices ranges from a family member or neighbor, to a traditional birth attendant or TBA, to a health professional, physician, or nurse. In most communities, the choice is determined locally and culturally, and in accordance with availability and access. In those societies where a hierarchy exists among birth attendants, it would be appropriate to train those older and more experienced, who would, in turn, influence the younger ones. Some PVOs (such as PCI/Papua New Guinea) have initiated Child Survival projects in communities where there is no tradition of local birth attendants and the woman delivers alone, with no assistance. In such communities, a PVO may attempt to create a role for a trained person to assist a mother with delivery. A PVO in such a situation must consider the potential strengths and weaknesses of TBAs drawn from various groups, and then ask, "What might each contribute to supporting the recipient's self-esteem, the preservation of culture, and technical safety?"

4.2 Training

Before developing a training program for birth attendants, PVOs have found it important to learn about the culture and cultural practices surrounding pregnancy, birthing, and early infant care (nutrition and hygiene). The local birth attendants can teach the PVO about what is going on in the community: number of women pregnant, any

problems, any infant deaths, etc. With this information, the PVO can reinforce the importance of positive local practices, and educate and motivate better care of the mother and baby, in the local context.

The following components form the content of a good training program for birth attendants:

- (1) Antenatal care (considered in the local context)
 - a. Screening and early detection of complications of pregnancy (such as pre-eclampsia).
 - b. Preterm labor, antepartum bleeding, and infection.
 - c. Anemia screening and distribution of iron and/or folic acid.
- (2) Safe delivery
 - a. Hygienic preparation for birth, use of clean equipment, and cord care.
 - b. Early detection of complications, especially prolonged labor, malpresentation.
- (3) Postnatal care
 - a. Early identification of bleeding, fever, discharge, and treatment.
- (4) Infant care
 - a. Breastfeeding; immunization; and family planning.
- (5) Logistics and reporting
 - a. Supplies.
 - b. Means of communication and transport.
 - c. Supervision and evaluation.
- (6) Messages for mothers
 - a. Messages may be about self-esteem, knowledge about pregnancy, care of mother and child (hygiene and nutrition), or birth spacing. Complement the health education given by the birth attendant with other channels of communication such as radio, community drama, posters, etc.

4.3 Principles of Successful Training

Experienced projects have learned to keep training short, simple, and at a level that the trainees can understand. They focus training on problem solving (ideally, problems identified by trainees), and on actions the birth attendant is to perform in the community. A key part of their training programs is to discuss how trainees will be

supervised once they are working and how actions in the field will be evaluated.

4.4 Support

Support of trained birth attendants can be provided in a number of ways. PVOs with functioning maternal health programs believe that it is necessary to give prompt attention to health needs of birth attendants. Maintain regular contact with the trained birth attendants and reduce their isolation. Schedule regular meetings where TBAs can report on their work, identify problems, and participate in refresher training. Continue to provide in-service education to increase their knowledge and skills. This helps to provide a sense of direction, membership and a commonality of purpose. Set goals with the birth attendants and celebrate steps reached toward these goals. Be a practical help to the trained birth attendant. Ensure that means of communication and transport are available when needed. Make certain that the attendants always have enough supplies in their delivery kits and are able to obtain more supplies when necessary.

The trained birth attendant often accompanies a woman she refers to the health center. This is an opportunity for the PVO to reinforce the birth attendants' knowledge and sense of worth. Make contacts with health center personnel positive experiences. Sensitize health personnel to the nature of the project's work with the traditional birth attendants. Encourage networking between the health center personnel and the TBAs in the community. Ask the health center's personnel to be the trainers of the birth attendants and prepare them for that role. Some PVOs have a portion of the training take place in the health center so the birth attendant can observe deliveries and meet health center personnel. Promote team building between traditional birth attendants and the health workers supervising and training them, in order to maximize complementary roles. Give appropriate constructive criticism when necessary, but make sure that the birth attendant is not publicly criticized when she brings a patient to the health center. On occasion it may be necessary for project personnel to accompany the local birth attendant and the woman to the health center, to make sure this is a positive experience for both the pregnant woman and the birth attendant.

Finally, experienced PVOs report that successful maternal health programs promote recognition of trained TBAs by leaders and organizations in the community. Some Child Survival projects have considered organizing the trained birth attendants in associations such as TBA unions.

5. COPING WITH SEXUALLY TRANSMITTED DISEASES

Sexually transmitted diseases have been a quiet epidemic in the developing world since the 1960s. With the pandemic of AIDS raging since 1981, many people find it no longer possible to deny the physical harm and social trauma these causes of illness bring. Worldwide, the most important sexually transmitted diseases are gonorrhea, chlamydia, syphilis, HIV infection, and AIDS. These conditions cause chronic illness, infertility in women and men, and are passed on to children of infected parents.

Sexually transmitted diseases spread with the seasonal and more permanent urban-rural migrations. They are related to increasing (in the last 30 years) freedom from parental and communal control over premarital and extramarital sex. Paradoxically, in some urban and peri-urban poor communities, adolescent girls are placed under very great pressures to provide sexual services to men, old and young, in the community.

5.1 Diagnosis and Treatment

In community-based programs differential diagnosis of these diseases is difficult because laboratory tests are usually not available, but it is possible to construct meaningful diagnosis and treatment protocols based on clinical symptoms for some of the conditions, particularly as they manifest in men. Care for individuals infected by sexually transmitted diseases is important not just in terms of curative care for that individual, but in order to prevent disease transmission, infertility, and infection of newborns.

Infertility is a sequela of pelvic inflammatory disease. Where a woman's status is determined by her ability to bear children, the social stigma of being barren renders her vulnerable to many forms of abuse. But in most communities the link between sexually transmitted disease and infertility is not yet well understood. PVOs have the opportunity to provide better health education that can increase community understanding of this relationship.

5.2 Health Education

The most important task for a community project is health education which aims at the primary prevention of sexually transmitted diseases, as HIV infection and AIDS have no cure. Many countries are still in a denial phase of the AIDS epidemic, not wanting to recognize its reality or the reality of changing multiple partners in urban and rural areas.

Adolescent girls are the group being infected most rapidly. It is therefore important that PVO projects work in the community to educate adolescents and use peer-group counseling before the young people engage in sexual activity. Fortunately, adolescents may not yet have formed sexual habits that cannot be changed. Ultimately, health education aims for changes in behavior. Community health projects have added health education on sexually transmitted diseases in hopes that the program will:

- (1) Increase acceptance of the discussion of sexual matters between partners and spouses.
- (2) Increase knowledge of youth and adults about the reproductive system, conception, pregnancy, and birthing.
- (3) Increase awareness of sexually transmitted diseases and awareness that men and women are responsible for the safety of their spouses (partners) and offspring.
- (4) Increase adherence to the practice of safe sex in and outside of marriage or permanent unions.
- (5) Increase capacity of the community to provide ongoing sex education programs.

Health education programs need to be accompanied by increased condom availability. It is also desirable to achieve peer and adult support for the idea that males and females should have the freedom to refuse sex when conditions of safety or commitment are not present.

Recommendations for Coping with Sexually Transmitted Diseases

- (1) Learn about the community's norms on sexuality, sexual terminology, and perceptions about sexual relationships. Respect the cultural norms.
- (2) Learn about if and how symptoms of sexually transmitted diseases (like vaginal discharge) are regarded by the person experiencing the symptom. Some women and men may consider some abnormal symptoms as normal.
- (3) Educate the whole community. Involve leaders. Involve adolescents. Wherever possible, involve religious leaders in sex education.
- (4) Integrate education on sexually transmitted disease with other health curricula existing in local schools, churches, informal education, youth movements, age groups clubs, sport clubs, etc.

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- (5) Offer a forum for adolescents to share and talk about sex, partnerships, and courting, the "dream" family, and perceptions and fears related to these. Learn the language and values of the adolescents being addressed and educate them within that context.
 - (6) Talk about sexually transmitted diseases and other consequences of unsafe sex, such as abortions and child abuse. But, talk not just about diseases and negative experiences; talk about the values of the family. Stress the positive side of sex and love.
 - (7) PVO Child Survival projects can be pioneers in qualitative studies on cultural, social, and behavioral factors in transmission of sexual transmitted diseases; seroprevalence studies are the responsibility of the government.
 - (8) In the Child Survival project, be sensitive to the increased risks to traditional birth attendants for HIV and hepatitis B infection. Project staff should discuss the risks with local birth attendants, and PVOs should provide reusable gloves or acceptable alternatives to the local birth attendants.
 - (9) Exchange experiences and lessons learned between groups dealing with sex education and sexually transmitted diseases.
 - (10) Health education on STDs aims for changes in knowledge, attitude, and behaviors. Its goals are:
 - a. Increased capacity of the community to provide sex education; increased acceptance of the discussion of sexual matters between partners and spouses; increased knowledge of youth and adults about the reproductive system, conception, pregnancy and birthing and STDs; achievement of a community consensus that men and women are responsible for the safety of their spouses (partners) and offspring.
 - b. Adherence to the rules of safe sex in and outside of marriage/permanent relationships.
 - (11) Health education needs to be accompanied by increased options (condom availability, male and female freedom to refuse sex when conditions of safety or commitment are not fulfilled).
 - (12) Wherever possible, involve religious leaders in sex education.

6. W O M E N & A I D S

The problem of HIV/AIDS is growing in magnitude. The World Health Organization (WHO) estimates that there were approximately 10 million HIV infections and 1.6 million adult AIDS cases in the world by early 1992. By the mid-1990s, more than 90% of all AIDS cases will be in developing countries. At this time, the majority of AIDS cases are found in sub-Saharan Africa, but WHO estimates that given present trends in HIV transmission in Asia, AIDS will be growing faster in Asia than in Africa by the end of the decade.

Developing countries have only recently addressed issues of women and AIDS, despite the fact that the male/female ratio of HIV infections and AIDS cases is nearly equal in most developing countries. This lack of knowledge is due, in part, to insufficient laboratory facilities for HIV testing, lack of ability to diagnose AIDS in women, and few epidemiological studies which focus on women. What is known is that HIV infection has grave consequences for female morbidity and mortality. By the mid-1990s, AIDS may surpass maternal mortality as a cause of death for women of reproductive age.

6.1 The Status of Women and AIDS Prevention

Sexual transmission of HIV is the most prevalent form of transmission among women in developing countries. Efforts to protect women from HIV infection are difficult for the following reasons:

- (1) Men resist condom use.
- (2) Even when women themselves are monogamous, decision-making about a partner's behavior with other sexual partners, drug use, etc. is out of a woman's control.
- (3) There is no "high-risk profile" of women particularly susceptible to HIV in high prevalence developing countries—virtually all women are at risk of sexual transmission.
- (4) There is little legislation or custom in developing countries which protects women from sexual exploitation.
- (5) Economic necessity often compels women to undertake high-risk sexual behavior.

6.2 AIDS and Child Survival

It is predicted that in some countries, AIDS-related mortality of children under five years will wipe out child survival gains made implementing Child Survival strategies of childhood immunization and oral rehydration therapy. AIDS in infants and children has probably been underestimated because of inadequate diagnosis, lack of laboratory facilities for HIV testing, and exclusion of children in most HIV surveillance systems.

AIDS-related mortality in women also threatens the survival of uninfected children. Studies have shown that infants whose biological mothers have died face a high probability of early mortality. Even if the infant survives, the quality of nurturance of the child may be severely affected. AIDS-related mortality in women will, in many developing countries, cause millions of "AIDS orphans."

Perinatal transmission (the major form of HIV transmission to infants and young children) is difficult to prevent because:

- (1) Women usually do not know they are infected.
- (2) Social norms dictate large families.
- (3) The risk of perinatal transmission (20-30%) may not be appreciated.

More studies are needed on women's attitudes toward reproduction in the face of HIV/AIDS.

6.3 Implications for MCH Programs

HIV/AIDS will strain already weak health infrastructures in many countries, and will pose particular challenges to TBAs and midwives. HIV/AIDS will challenge the credibility of many child survival interventions because children who are HIV positive are immunocompromised and thus do not respond well to standard treatment regimens.

Recommendations for PVOs in HIV/AIDS Prevention and Care

- (1) Be aware of issues related to women and AIDS in project beneficiary populations, and incorporate HIV/AIDS prevention activities.
- (2) Review policy implications of HIV/AIDS (including policies for PVO staff, health care, voluntary testing and counseling, sex

education, caring for orphans, etc.).

- (3) Advocate the AIDS-related needs of women and children (through collection and dissemination of data; encouraging national AIDS programs to involve women; and promoting aggressive AIDS-education programs for women and youth).
- (4) Integrate AIDS prevention and care activities into MCH and other programs of assistance.
- (5) Where possible, prepare for the provision of care and social services for AIDS-affected families and AIDS orphans.
- (6) Collaborate in government AIDS programs and with other providers.
- (7) Attempt multisectoral programs that respond to the HIV/AIDS pandemic.
- (8) Identify groups most vulnerable to HIV/AIDS infection at the community level and develop ways to combat this vulnerability.

6.4 Lessons Learned by Projects Working with AIDS

PVO projects working with AIDS have identified the following issues:

- (1) Integration of AIDS with family planning, child survival, or other programs requires careful planning.
- (2) PVO staff must learn to talk about sex in order to talk about AIDS.
- (3) PVOs must educate their own staff about HIV/AIDS, and develop personnel policies concerning HIV-positive staff and staff with AIDS.
- (4) PVOs will need a stable source of funding for AIDS activities.
- (5) Village-based workers can be effective in STD/AIDS education and can supply condoms.
- (6) PVOs should be attentive to condom supply and demand.
- (7) Home-based care and support for AIDS-affected women and their families is important.
- (8) Youth are an important target group for PVOs.
- (9) Coordination with government can strengthen the program.
- (10) Training of trainers is an effective strategy, but requires continuous close supervision.
- (11) Do not be too ambitious in selecting target groups; staff and/or resources can easily be overstretched.

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- (12) The sense of urgency created by AIDS often causes overly ambitious programming.
 - (13) PVOs should attempt to improve rural development policies to reduce rural to urban migration (which is associated with increased high-risk sexual behavior and HIV transmission).

7. M A T E R N A L N U T R I T I O N

Maternal malnutrition is common in many communities served by Child Survival projects. Maternal depletion occurs when women experience many pregnancies with short periods of time between pregnancies. Moreover, many communities, realizing that improved maternal nutrition increases an infant's birth weight, and fearing obstructed labor, have introduced strong taboos against increased calorie or protein intake during pregnancy. Efforts to improve maternal nutrition can and should try to build on the existing knowledge, but must underscore the need to protect both mother and child through balanced and adequate nutrition of the mother. Efforts should also recognize and address the fear of obstructed labor, but stress the benefits of improved birth weight to infant survival and improved nutrition to maternal survival.

Determine messages to mothers and the community that convince them of the value of:

- (1) Appropriate weight gain in pregnancy and its importance to birth weight.
- (2) Increased caloric intake during pregnancy and lactation.
- (3) Increased protein intake, because of its role in body building.
- (4) Work/rest, both are important.
- (5) Practicing methods which overcome anorexia/vomiting in the first trimester of pregnancy.
- (6) Transmission of vitamin A and iron reserves to the fetus.
- (7) Iron, folic acid, vitamin A supplementation for the mother.

Mothers must understand that:

- (1) The quantity of breast milk relates to the nutritional reserves of the mother.
- (2) The vitamin content of breast milk is determined by mother's intake and reserves.
- (3) The baby's birth weight needs to be above 2500 gms.

Recommendations for the Maternal Nutrition Strategy

- (1) In areas with malnutrition of mothers or teen pregnancies (these are areas with high maternal death rate from hemorrhage, low weight/height, adult height of less than 150 cm); antenatal and postnatal care without attention to nutrition (calorie, protein, micronutrient) is a cart without a horse.
- (2) Nutrition education needs to start with prepubescent and adolescent girls so that they may attain normal height and pelvis development and know what to do when pregnant.
- (3) Prioritize nutrition messages to be delivered during antenatal and postnatal visits, customized by need.
- (4) Provide good nutrition education for couples on staff and for volunteers and collaborators first; only the convinced and committed can teach by word and example.
- (5) Teach maternal nutrition by demonstrating the benefit to the child and to the mother.
- (6) Involve all community members who have power over women's nutrition.
- (7) Evaluate compliance and impact; give feedback to the community.
- (8) Remember that AIDS can imitate malnutrition but resists nutrition rehabilitation!

Recommendations for Prevention and Treatment of Vitamin A Deficiency

- (1) Assess vitamin A status in the community; feedback findings to community and policy makers.
 - a. Clinical/ocular signs of deficiency.
 - b. Other (dietary, behavioral).
- (2) Persuade policy makers to develop policy and protocol.
- (3) Develop and use social marketing activities directed at
 - a. Increased consumption of dark green leafy vegetables and orange fruits.
 - b. Increased coverage for vitamin A supplementation (capsules, syrup).

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- (4) Provide vitamin A supplementation.
 - a. 200,000 IU within one month after delivery of baby.
 - b. Where the woman has night blindness or Bitot's spots, up to 10,000 IU daily for two weeks can be given during pregnancy.
 - (5) Teach the importance of dietary consumption as an adequate approach to reach maternal needs (promoting the consumption of liver is a good example).
 - (6) Train medical and health staff.
 - (7) Examine local cooking habits. (How long is food cooked? Are covered pans used?)
 - (8) Assure vitamin A procurement. (Arrange to get adequate supplies from UNICEF, the local government, Helen Keller International, or local pharmacies.)

8. Women's Rights

In the settings in which most health professionals work, the tendency has been to think of a woman's needs only in terms of physical health. But this is changing. Now, innovative community health programs are including spiritual, mental, social, and economic components in programming. SEARCH/India's approach to prevention of sexually transmitted diseases is an example of this. SEARCH recognized that they could not design activities to treat and prevent sexually transmitted diseases without incorporating the philosophy of women's rights into all aspects of the program.

Some PVO health and child survival projects have chosen to expand their women's health activities to address the inequities that exist for the girl child and the adult woman. They believe that women's rights must not be a separate activity from health of women.

The root causes of the unequal status accorded women are embedded in culture. The belief that a female child is not as worthy as a male child results in a girl child who feels ashamed of herself and vulnerable. From the beginning, she is taught to consider herself inferior. Her identity comes through marriage and childbirth. But "inside" that wife/mother is a tentative child, anxious about her future, lacking a sense of self-worth.

Low levels of self-esteem act as a barrier to seeking health care, and can have a negative impact on a woman's reproductive and sexual health. The manager of the World Vision/India Child Survival

project recognized this dilemma when she said:

"I believe the hands that rock the cradle will rule the world; but if those hands are not strong enough, how can they rule the world?"

Projects must initiate programs that increase awareness among women and build their self-confidence. It takes a strong person to initiate *and maintain* health behavior change; the individual woman can find that strength in a supportive women's group.

In recent years, more PVO Child Survival projects have begun to collaborate with women's rights organizations. For example, the Save the Children project in Nepal has special activities for adolescent girls at risk for prostitution, and cooperates in these activities with local women's rights organizations. Other PVOs have encountered women injured due to domestic violence, and have responded not just to the women's health needs, but also by helping them to learn more about their legal alternatives. Of special interest to women's organizations in some areas of the world is the need to raise awareness and concern about the practice of female excision and infibulation. These practices adversely affect women's health in general and maternal health in particular.

The mobilization, organization, and education of women are essential to effect a positive change in women's status and achieve equity. Programs which reduce female illiteracy have a positive impact on child health care and build self-esteem. The World Bank has enthusiastically supported the benefits of educating women. Its managing director has said: "Getting more girls into school is probably the single most effective anti-poverty policy in the developing world." Furthermore, a former chief economist at the Bank reported that "educating girls quite possibly yields a higher rate of return than any other investment available in the developing world."

Empowering women is but one side of a complex issue. Educating men, and fostering a dialogue between men and women on status of women, is equally important. This is not easy and will take time. But, to address the problem, one has to first talk about the problem, and see it as a problem. PVO projects with interventions in family planning, HIV/AIDS prevention, and maternal health should actively involve men. The aim is to encourage male support for women's health, and cooperation between both partners in sexual and reproductive decisions. Contrary to the suggestion that men don't care, field research has shown a level of concern for wives' health and a willingness by men to help out with contraception. Male support for women rights may be underestimated. In order to

foster this dialogue, PVOs can learn what men know and fear, and what men need and want, in relation to women's rights. Then PVOs can design and provide information which addresses those fears and needs that men identified in small group discussions. New or revised training materials should strengthen the skills of providers to increase the involvement of men and couples in family planning, maternal health, and HIV/AIDS prevention programming.

In modern society, women are slowly becoming more educated and asserting their right to be treated with dignity and respect. Clearly, women's rights must not be a separate activity from health of women. Starting this education and dialogue early speeds this social process. PVOs need to target adolescent girls and boys by working through the family, community, school system, religious and youth organizations, and other relevant institutions.

Each PVO should also look at its own organization in terms of equity of compensation for women, sufficient maternal leave (including breaks for breastfeeding), availability of day care, and access to decision-making within the organization. Women on the PVO staff, as well as women from the community, should be actively participating in the planning, implementation, and evaluation of Child Survival project activities.

For PVO Child Survival projects wishing to take a more holistic approach to development programming for women, some of the principles are listed below.

Recommendations for Promoting Women's Rights

- (1) Recognize that women's health is a human right, and affirm that principle in action.
- (2) Initiate interpersonal and communication skills training for women. Such skills are needed by women, not only to better communicate health messages, but to increase an individual woman's ability to negotiate in difficult situations in the home and community—with her partner, or mother-in-law, or any other key person influencing her sense of self-esteem.
- (3) Literacy and income generation are very important to empower women, to increase their self-esteem, and to increase their awareness about their rights. Give special attention to these strategies in programming.
- (4) The effort is strengthened when PVOs partner with women's groups and other groups that are genuinely interested in the

welfare of women. Where no local women's organizations exist, PVOs can actively support and encourage the formation of such groups.

- (5) PVOs can facilitate, through advocacy and collaboration with government and other NGOs, the reduction of the workload of women (e.g., by providing day care, water, fuel, etc.)

ANNEX 1: VIDEO SUPPLEMENT

The Mothers & Child Survival Conference generated two videos on the views of country project managers on the status of maternal health care in their countries (South America, Southeast Asia, and Africa) and their experiences in project management in different areas.

Fifteen project managers were asked a set of questions related to maternal care, and were asked to relate their experience in their respective areas. PVO field participants were asked to talk about the situation of women in their countries, their feelings about the validity of maternal health interventions in child survival programs, and project management issues particular to them. The response of each manager was recorded on video. The results of these interviews were edited into two tapes, which were shown at the conference and used as the basis of further discussion.

These videos have been further edited and are currently being used to introduce new project personnel to practical and relevant maternal health issues. The videos can serve as background information for new project managers and starting points for discussion. The Mothers & Child Survival Report and the Shiprock Conference videos—"Thoughts about Women's Health and Maternal Care" and "Thoughts about Project Management", are available from PVO Child Survival Support Program.

Following is a summary of the main points made by each video. The experiences which the project managers describe on the videos can serve as "talking points" for discussion and staff training. PVOs will find the videos a useful supplement to this report on lessons learned when introducing maternal health to Child Survival programs.

A. VIDEO ONE "THOUGHTS ABOUT WOMEN'S HEALTH AND MATERNAL CARE"

1. *Lalita Edwards - WV/India* talks about...

- a. The importance of maternal health to a family in general and to a child's growth and development in particular; the need for frequent dialogue with husband/family on common high-risk factors that can be identified or recognized by them and the importance of cultivating their agreement and assistance.
- b. A personal and project success story involving a successful outcome with a high-risk mother.

2. *Najma Khatun - SCF/Bangladesh* talks about...

- a. How she overcame her fear during a political uprising to assist home delivery.

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- b. The cultural bias toward the male child; constraints on the life of the female child: less attention and care, a heavier workload, more domestic responsibility, malnourishment and early pregnancy.
 - c. The low status of women.
3. *Francisco Moreno Oleas - Project Hope/Ecuador* talks about....
- a. His project's approach to the community through the involvement of youth in gardening activities in order to develop a nutritional support program and to obtain community trust and confidence.
 - b. The low status of women, heavy work load, and responsibility.
4. *Ellen Tagwtreyt - WV/Zimbabwe* talks about....
- a. The hard life of women in the project area.
 - b. The importance of healthy mothers and maternal health as the basis of family well-being.
 - c. Paying attention to health need priorities articulated by the community.
5. *Rama Basnet - ADRA/Nepal* talks about....
- a. Pregnant women's problems accessing health care services; they often must walk more than five hours to a health center.
 - b. The cultural preference for male children compels women into repeated pregnancies when a boy is not produced. Women become pregnant repeatedly even when they are at high risk.
 - c. The general lack of sympathy for women.
6. *Reny Benjamin - PATH/Indonesia* talks about....
- a. Her experience using an inexpensive weight scale to identify low birth weight babies by the illiterate TBAs in the project area.
 - b. How the status of women impacts on maternal health, especially nutrition and obtaining early health care.
 - c. The continuous effort and dialogue needed to make positive changes in the customs of rural communities which could improve health.
7. *Ronald Gutierrez - PLAN/Bolivia* talks about....
- a. How he was able to overcome the constraints of medical training and career and come to an understanding of community health needs and the value of working in public health.
 - b. Cultural practices that constrain maternal health care, such as the refusal of husbands to allow any male health worker or doctor to examine their wives, a constraint that contributes to the extremely low coverage (about 3%) of prenatal care.

B. VIDEO TWO "THOUGHTS ABOUT PROJECT MANAGEMENT"

1. *Abdel Rahim Ahmed - CARE/Sudan* talks about...
 - a. Using a locally available and accepted resource like the ORT measuring glass.
 - b. Community participation as a management strategy for better sustainability of the project.
 - c. The importance of good relationships with local government representatives in order to obtain continuous support and government assumption of the project when the donor phases out.
 - d. The importance of retraining the MOH staff personnel in the project area, as well as updating their skills through regular supervision.
 - e. His belief that community-based activities assist the people to be independent about their health care and facilitate better sustainability.
3. *Lois Miano - MIHV/Kenya* talks about...
 - a. How project activities have been introduced through existing income-generating activity.
 - b. Income needs of volunteers conflicting with program needs for volunteer services; the need to make volunteers understand why their contributions are necessary.
 - c. The fact that community-based activity/needs have a better chance of being sustained than donor-based activity/needs.
4. *Philip Posanau - PCI/Papua New Guinea* talks about...
 - a. Cultural beliefs and superstitions which are major health care obstacles.
 - b. The responsibility of health care workers to continuously educate the community in order to change concepts which impact negatively on health care.
5. *Paul Robinson - CARE/Bangladesh* talks about...
 - a. An incident he observed which illustrated inadequate basic skills training; the need for refresher training and regular supervision.
 - b. Sharing experiences, taking risks, trying again.
6. *Nurul Fazrie - PCI/Indonesia* talks about...
 - a. The impact of training and certification of TBAs on the success of the Child Survival project and the integration of maternal health in his project area.
 - b. The importance of field observation before taking over as a project manager as an effective approach to know and understand the process, strength, and constraints of the program.

-
- c. The necessity of a close relationship with local government.
 - d. His belief that project sustainability depends upon what the people want, care about, and know how to do.

7. *Chanda D. Rai - SCF/Nepal* talks about....

- a. The successes of ORS distribution and its use to reduce incidence of diarrheal disease in the project area.
- b. The need for frequent dialogue with the community and the provision of guidance/encouragement to identify their health problems and needs; as well as to help them find solutions by themselves, without creating dependence.

ANNEX 2: DEFINITIONS

Maternal Death

A maternal death is defined as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration or site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental causes." *World Health Organization. "Definitions and Recommendations." In Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death, Vol. 1. Geneva, 1977, pp. 763-764.*

Maternal Mortality Ratio

The maternal mortality ratio is the most commonly used measure to express the risk of death among women once they are pregnant. This statistic is defined as maternal deaths per 100,000 live births. Note that the numerator (maternal deaths) is not part of the denominator (live births).

Maternal Mortality Rate

The maternal mortality rate indicates the impact of maternal deaths on the population of women of reproductive age (usually defined as ages 15-49). This statistic is defined as maternal deaths per 100,000 women of reproductive age per year.

For further information on the availability of additional statistics and factors influencing the measurement of maternal mortality see *Safe Motherhood Programs: Options and Issues*, available from the Center for Population and Family Health, Columbia University, 60 Haven Avenue, New York, New York 10032.

ANNEX 3: SUGGESTED READINGS

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ANNEX 4: CONFERENCE PARTICIPANTS

Roosye Raranta-Senduk, MHS
ADRA/Indonesia
Manado Indonesia

V.A. Walter Phiri
ADRA/Malawi
Chiromo Malawi

Rama Basnet, RN
ADRA/Nepal
Kathmandu Nepal

Dr. Abdel Rahim Ahmed el Mustafa
Bara Child Health Project
CARE/Sudan
Khartoum Sudan

Dr. Paul Robinson, MTS, MPH
CARE/TICA Project
Dhaka Bangladesh

Dr. Cecilia Garcia-Barrios, MSc
National Institute of Public Health
Cuernavaca Mexico

Lois Miano, KRM, KRN, PHN
MIHV/Kenya
Nairobi Kenya

Dr. Reny Bunjamin, MPH
PATH/Indonesia
Lombok Indonesia

Dr. Ronald Gutierrez Michel
PLAN/Bolivia Altiplano
La Paz Bolivia

Nurul Fazrie
Project Concern International/Indonesia
Pekanbaru
Riau Indonesia

Harumi Karel, MPH, PhD
Project Concern International/Papua New Guinea
Boroko Papua New Guinea

Philip Posanau
Project Concern International/Papua New Guinea
Lae Papua New Guinea

Dr. Donald Kaminsky, MPH, TM
Project Alternatives/Honduras
Tegucigalpa Honduras

Dr. Francisco Moreno-Oleas, MPH
Project HOPE/Ecuador
Quenca Ecuador

Dr. Najma Khatun
Save the Children/Bangladesh
Dhaka Bangladesh

Chanda D. Rai
Save the Children/Nepal
Kathmandu Nepal

Dr. Rani Bang, MPH
SEARCH/India
District Gadchiroli, Maharashtra State India

Dr. Lalita Edwards
Integrated Child Survival Project Nawapur
World Vision/India
Nawapur, Maharashtra State India

Dr. Sri Chander, MPH
World Vision/International
Singapore

Ellen Tagwireyi
World Vision/Zimbabwe
Harare Zimbabwe

Dr. Ranjit Attapatu
Primary Health Care
UNICEF
New York, New York USA

Rose Miles Robinson
Child Survival and Health
USAID/BHR/PVC
Washington, D.C. USA

Nurmaulina Suprijanto
USAID/VHP/Indonesia
Jakarta Indonesia

Uche Amazigo, PhD
Department of Zoology
University of Nigeria
Nsukka Nigeria

Dr. Cecile De Sweemer-Ba, DrPH
Dakar Senegal

Susan J. Eastman, MPH
San Francisco, California USA

Elizabeth Preble, MPH
North Oaks, Minnesota USA

Dale Flowers
Rio del Mar, California USA

Dr. Victor Lara, MPH
Lima Peru

Dr. Han Xiao Ming, MPH
Department of Maternal Health
Ministry of Health
Beijing People's Republic of China

Asresu Misikir, DrPH
Johns Hopkins University
Baltimore, Maryland USA

Dr. Michele Strachan
U.S. Indian Health Service
Rapid City, South Dakota USA

Gail M. Ormsby, MPH
ADRA/International
Silver Spring, Maryland USA

Zoe Kopp, RN, MPH
CARE/International
Atlanta, Georgia USA

Donna Robinett, RN, MPH
PATH
Seattle, Washington USA

Dr. Luis Tam, DrPH
PLAN International
East Greenwich, Rhode Island USA

Barbie Rasmussen, RN
Project Concern International
San Diego, California USA

Marguerite Farrell, MPH
Project HOPE
Millwood, Virginia USA

Dr. Loren Galvao, MPH
Save the Children
Westport, Connecticut USA

Leslie Hornung Walstrom
World Vision International
Monrovia, California USA

Herbert Clah
Navajo Community College at Shiprock
Shiprock, New Mexico USA

Larry Curley
Navajo Nation Division of Health
Window Rock, Arizona USA

Carol Milligan, CNM
Navajo Area MCH Division
Window Rock, Arizona USA

Marc Bauer
Navajo Community College at Shiprock
Shiprock, New Mexico USA

Georgia Crawford
Navajo Nation Family Planning Center
Window Rock, Arizona USA

Sarah Ellsworth, CNM
U.S. Indian Health Service
Shiprock, New Mexico USA

Dr. Fung Lam
Obstetrics and Gynecology
Gallup, New Mexico USA

Dr. Kathleen Masis
Navajo Tribe Department of Behavioral Health Service
Tuba City, Arizona USA

Dr. Christopher Percy
U.S. Indian Health Service
Shiprock, New Mexico USA

James Pobrislo, CNM
U.S. Indian Health Service
Shiprock, New Mexico USA

Dr. Robert Shengold
U.S. Indian Health Service
Shiprock, New Mexico USA

Dr. Jonathan Steinhart
U.S. Indian Health Service
Shiprock, New Mexico USA

Dr. Jonathan Sugarman
IHS Epidemiology Program
U.S. Indian Health Service
Seattle, Washington USA

Dr. Emily Suttcliffe
U.S. Indian Health Service
Shiprock, New Mexico USA

Dr. Alan Waxman
Obstetrics and Gynecology
Gallup Indian Medical Center
Gallup, New Mexico USA

Dr. Ann Wright
Arizona Health Service Center
Department of Pediatrics
Tucson, Arizona USA

Dory Storms, ScD
PVO Child Survival Support Program
The Johns Hopkins University
School of Hygiene and Public Health
Baltimore, Maryland USA

Penny Altman
PVO Child Survival Support Program
The Johns Hopkins University
School of Hygiene and Public Health
Baltimore, Maryland USA

Cynthia Carter, MPH
PVO Child Survival Support Program
The Johns Hopkins University
School of Hygiene and Public Health
Baltimore, Maryland USA

Dr. Marcelo Castrillo, MPH
PVO Child Survival Support Program
The Johns Hopkins University
School of Hygiene and Public Health
Baltimore, Maryland USA

Richard Scott
PVO Child Survival Support Program
The Johns Hopkins University
School of Hygiene and Public Health
Baltimore, Maryland USA

Dr. Rajani Ved, MPH
PVO Child Survival Support Program
The Johns Hopkins University
School of Hygiene and Public Health
Baltimore, Maryland USA

Gary Leventhal
Baltimore, Maryland USA

Sheldon Preston
Tuba City, Arizona USA

GLOSSARY OF ACRONYMS

USAID	United States Agency for International Development
ADRA	Adventist Development & Relief Agency
CS	Child Survival
HKI	Helen Keller International
LBW	Low birth weight
MCH	Maternal and child health
MIHV	Minnesota International Health Volunteers
MOH	Ministry of Health
NGO	Non-governmental organization
ORS	Oral rehydration solution
ORT	Oral rehydration therapy
PATH	Program for Appropriate Technology in Health
PCI	Project Concern International
PVO	Private Voluntary Organization
RTI	Reproductive tract infection
SCF	Save the Children Foundation
STD	Sexually transmitted disease
TBA	Traditional birth attendant
UNICEF	United Nations Children's Fund
WV	World Vision

