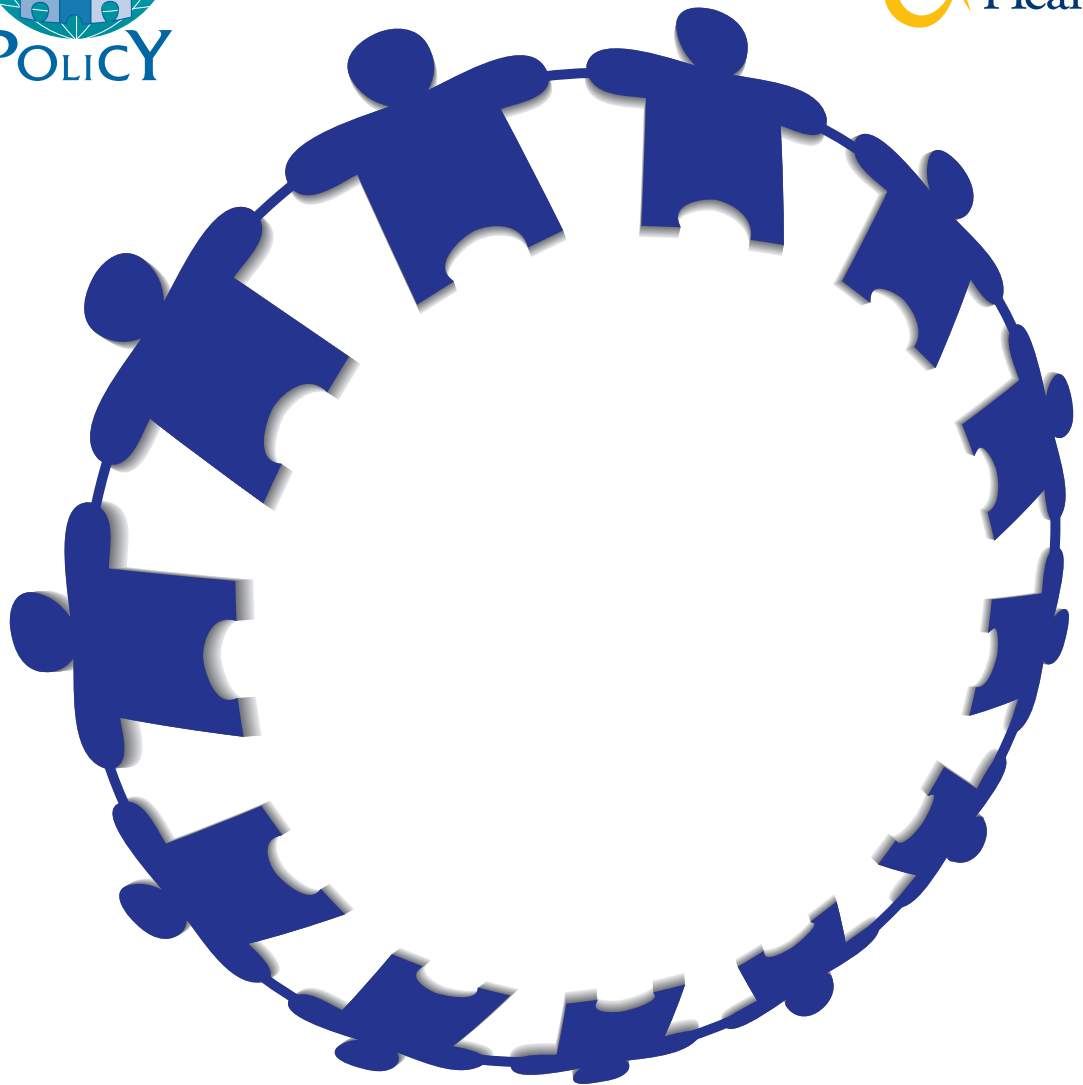


Networking for Policy Change: An Advocacy Training Manual Maternal Health Supplement



The POLICY Project

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Introduction

Purpose of the Advocacy Manual

This document serves as a supplement to *Networking for Policy Change: An Advocacy Training Manual*, a resource for trainers of family planning and reproductive health advocacy issues worldwide. The training manual includes information on networking, communications, and policy environments; exercises on conceptualizing, implementing, monitoring, and evaluating advocacy campaigns; and relevant materials for advocates working in any area of reproductive health. Trainers can use the training techniques employed in the manual in various contexts, including when maternal health is the focus of advocacy.

Why a Supplement on Maternal Health?

In creating this series of supplements and training modules, the POLICY Project recognizes that certain reproductive health topics require specific information that goes beyond the examples and materials included in the original manual. Maternal health is one of those issues. Other topics in the supplement series include the Adolescent Reproductive Health Supplement, the HIV/AIDS Supplement, and the Human Rights Supplement. The training module series consist of the following: Reproductive Health Planning and Finance: Challenges, Approaches and the Advocate's Role, Sustainability: Ensuring the Advocacy Network's Future, and Building Effective NGO-Public Sector Partnerships. As with any area, there are special concerns that must be addressed when talking about advocacy for maternal health. The goal of maternal health is to ensure that every woman has access to a full range of high-quality, affordable sexual and reproductive health services—especially maternal care and treatment of obstetric emergencies to reduce deaths and disabilities.¹ Issues surrounding pregnancy, childbirth, and the postpartum period are integrally related to the status of women, and their ability to seek health care. Maternal health is a human right and must be underpinned by laws and policies that support effective action to increase women's access to basic education, adequate nutrition, economic resources, as well as appropriate health services.

Who Should Use This Supplement?

This supplement is intended to reach essentially the same audiences as the original manual. It is not intended that the exercises be used only by advocacy networks concerned exclusively with maternal health issues (which are relatively few). It is also intended to serve those advocacy networks that advocate for family planning and reproductive health issues and have identified maternal health as a key focus area.

¹Based on commitments made at the World Summit for Children, International Conference on Population and Development, World Summit on Social Development, Fourth World Conference on Women, and the Convention on the Elimination of All Forms of Discrimination Against Women.

Structure of the Supplement

Following a general overview of maternal health issues, the supplement follows the same structure as the manual and is divided into three main sections:

- *The Power of Numbers: Networking for Impact*
- *Actors, Issues, and Opportunities: Assessing the Policy Environment*
- *The Advocacy Strategy: Mobilizing for Action*

The three sections contain a total of 27 units. Each unit includes supplemental background notes, handouts, and suggestions to the trainer to tailor each activity to the subject of maternal health. Many of the manual's activities apply equally to maternal health as to other topic areas, while other activities are enhanced by a specific focus on maternal health.

General Guidance to the Trainer

- Use the materials flexibly. Many of the notes and handouts can be used in more than one activity.
- In many cases, where the manual uses an approach that is applicable to all audiences, the activities need not be changed.
- Encourage participants to give their own examples of maternal health issues and advocacy opportunities. The issues vary from country to country and community to community, and the voices of workshop participants will make the subject real and create and maintain the advocacy programs that are so critical to society.
- Many advocates are already fighting for greater attention to maternal health concerns and you can bring out these experiences to enrich the training dialogue.

MATERNAL HEALTH ISSUES

A. *Why Address Maternal Health?*

- There are an estimated 170 million pregnancies every year around the world,¹ and every time a woman is pregnant she risks a sudden and unpredictable complication that could result in her death or injury and the death or injury of her infant.
- At least 40 percent of all pregnant women will experience some type of complication during their pregnancies. For about 15 percent, the complication will be potentially life-threatening and will require prompt obstetric care (Koblinsky et al., 1993).
- About 60 million women suffer from some complications from pregnancy, also known as maternal morbidity. For more than 15 million women, these morbidities are long-term and often debilitating (Ashford, 2002).
- About 500,000 women die of pregnancy-related causes each year (Hill et al., 2001).
- Safe motherhood is a human right and must be underpinned by laws and policies that support effective action to increase women's access to basic education, adequate nutrition, economic resources, as well as appropriate health services.

B. *What Is Safe Motherhood?*

Safe motherhood refers to a woman's ability to have a safe and healthy pregnancy and delivery. The goal of safe motherhood is to ensure that *every* woman has access to a full range of high-quality, affordable sexual and reproductive health services—especially maternal care and treatment of obstetric emergencies to reduce deaths and disabilities.²

C. *What Do Maternal Health Programs Try to Do?*

Maternal health programs typically focus on achieving the following three outcomes:

- Preventing unwanted pregnancy
- Reducing maternal mortality and morbidity
- Reducing neonatal mortality and morbidity

¹This figure is calculated based on estimated global number births for 2000 (133,284,000) as cited in the UN's World Population Prospects: The 2002 Revision Population Database and assumes 20 percent pregnancy wastage.

²Based on commitments made at the World Summit for Children, International Conference on Population and Development, World Summit on Social Development, Fourth World Conference on Women, and the Convention on the Elimination of All Forms of Discrimination Against Women.

These outcomes can be achieved through:

- Meeting the need for family planning;
- Increasing the percentage of births attended by skilled attendants;
- Increasing access to essential obstetric care;
- Preventing unsafe abortion and managing postabortion complications; and
- Increasing access to effective antenatal care.

D. *What Is the Magnitude of Maternal Health Issues?*

- About 500,000 women die each year due to pregnancy-related causes (Hill et al., 2001).
- Ninety-nine percent of pregnancy-related deaths occur in the developing world (WHO/UNICEF, 1996).
- Globally, there are an estimated 170 million pregnancies each year.³
- Nearly 123 million women want to stop having children or postpone their next pregnancy but are not using contraception (Ross and Winfrey, 2002).
- Approximately 75 million pregnancies are unwanted each year (UNFPA, 1997).
- A woman's lifetime risk of dying from pregnancy-related complications or during childbirth is one in 48 in the developing world versus one in 1,800 in the developed world (Population Reference Bureau, 1998).
- At least 35 percent of women in developing countries receive no antenatal care during pregnancy, and 70 percent receive no postpartum care during the six weeks following delivery (WHO, 1997b).
- In 1996, only 53 percent of deliveries in developing countries took place with a skilled birth attendant (WHO, 1997b).
- In some countries, as many as 95 percent of deliveries are performed with no skilled birth attendant (WHO, 1997b).
- About 40 percent of all pregnant women will experience some type of complication during their pregnancy (Koblinsky et al., 1993).
- An estimated 1 in 12 women die of pregnancy-related causes in West Africa compared with 1 in 4,000 in Northern Europe (United Nations, 1995).
- There are remarkable similarities in the main causes of maternal deaths in developed and developing countries, including hemorrhage, sepsis, and hypertensive disorders such as eclampsia (Maine, 2000).
- Abortion-related complications result in nearly 80,000 maternal deaths and hundreds of thousands of disabilities (WHO, 1997a).
- Abortion-related causes of maternal death account for 13 percent of maternal deaths in developing countries (Maine, 2000).
- Obstructed labor accounts for about 8 percent of maternal deaths in developing countries but is almost unknown as a cause of death in developed countries due to the use of cesarean sections (Maine, 2000).

³This figure is calculated based on estimated global number births for 2000 (133,284,000) as cited in the UN's World Population Prospects: The 2002 Revision Population Database and assumes 20 percent pregnancy wastage.

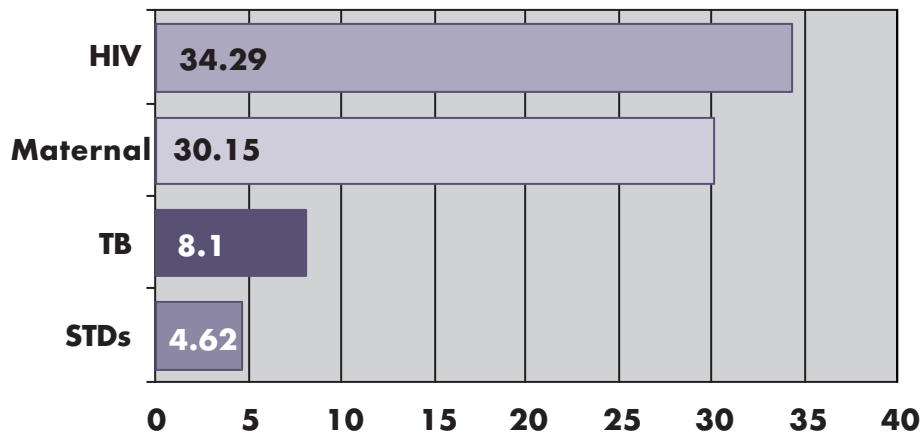
E. What Are the Consequences of Poor Maternal Health?

The consequences of poor maternal health are widespread, affecting women, families, communities, and society.

Unwanted pregnancies. Without adequate access to family planning information and services, women may have unplanned and unwanted pregnancies. Unwanted pregnancies can threaten a woman’s health or well-being, and many unwanted pregnancies are terminated using unsafe procedures that can lead to death or disability.

Long-term maternal morbidities. Limited access to antenatal care and skilled attendance at birth can lead to long-term maternal morbidities. About 60 million women suffer from some maternal morbidity, and these morbidities are long-term and often debilitating for more than 15 million women (Ashford, 2002). Women of reproductive age in the developing world lose more disability-adjusted life years (DALYs)⁴—30 million—to maternal causes than to any other cause other than HIV/AIDS (see Figure 1)⁵ (WHO, 2001a). The number of DALYs due to HIV/AIDS has almost tripled in just ten years, from 12 million in 1990⁶ to over 34 million in 2001.

Figure 1. Number of DALYs Lost to Women Aged 15-44 Due to Maternal Causes, HIV, STDs, and TB



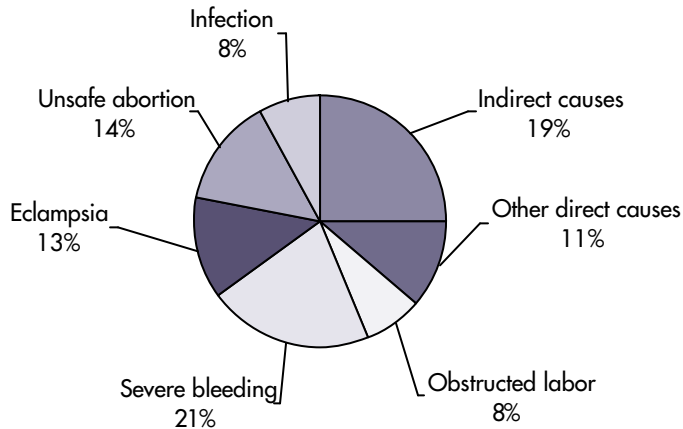
⁴DALYs is the measurement used by the World Bank and WHO to express how a healthy person is affected by disease. This measurement combines years of life lost because of premature death and disability.

⁵To estimate DALYs for women in the developing world, data for three WHO regions: AMRO A, EURO A and WPRO A were subtracted from global DALYs for women of reproductive age (15-44).

⁶DALYs for 1990 were presented in the World Development Report 1993.

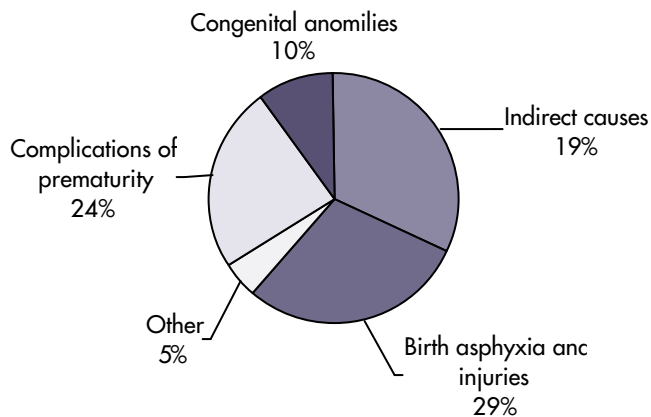
Maternal mortality. Lack of antenatal and postnatal care and assistance during delivery can lead to maternal death. Maternal deaths have both direct and indirect causes (see Figure 2) (UNFPA, 2001). About 80 percent of maternal deaths are due to direct causes, which include obstetric complications such as severe bleeding, infection, unsafe abortion, hypertensive disorders (eclampsia), and obstructed labor. Women also die of indirect causes, such as malaria, diabetes, hepatitis, heart disease, and anemia; these diseases or causes of ill health can be exacerbated during pregnancy.

Figure 2. Medical Causes of Maternal Death



Neonatal mortality. Some of the same factors that cause maternal mortality and morbidity, such as complications of pregnancy and childbirth and poor management of those complications, also cause or contribute to a significant proportion of stillbirths and newborn deaths. There are more than 7 million infant deaths per year (WHO, 2001). Approximately half of infant deaths occur during the neonatal period (the first month of life) (WHO, 2001). Of neonatal deaths, nearly 75 percent occur in the first week (WHO, 2001). Almost 30 percent of neonatal deaths are due to birth asphyxia and injuries, and another 24 percent due to complications of prematurity (see Figure 3) (JHU, 1999). Significant additional reductions in infant mortality can be achieved with interventions designed to improve the health of the mother and her access to care during labor, birth, and the critical hours immediately afterward (World Bank, 1999).

Figure 3. Medical Causes of Neonatal Death



Child mortality. A mother’s death has profound consequences for her family. In some developing countries, if the mother dies, the risk of death for her children younger than five is doubled or tripled. In Bangladesh, children up to age 10 whose mothers die have three to five times the mortality rate of children whose mothers are alive or whose fathers die (World Bank, 1999).

Increased poverty, weakened households, and communities. A woman suffering long-term disabilities from pregnancy or childbirth may not be able to participate in the workforce or be economically productive. Children of disabled or sick mothers may have inferior nutrition, hygiene, and health than children of healthy mothers. Also, some children drop out of school to work, further contributing to the cycle of poverty. Losing productive members of society affects governments because of the loss of investments made in education, health care, and job training. A study in Uganda estimated the productive years lost due to various maternal disabilities, assuming a total work life of 65 years per woman (Table 1). Postpartum hemorrhage (severe bleeding), hypertensive disorders (eclampsia), and obstructed labor each can lead to 35 productive years lost per woman (SARA Project, 2000).

Table 1: Productive Years Lost Per Woman Due to Maternal Morbidity, Uganda

Complication	Productive Years Lost Per Woman
Postpartum Hemorrhage (Severe bleeding)	
-Severe anemia	2.5
-Sheehan’s Syndrome	35.5
Sepsis (Infection)	
-PID/PPP	0.04
Hypertensive disorder (Eclampsia)	
-Neurosequalea	35.5
Obstructed labor	
-Stress incontinence	36.5
-Fistula	46
Abortion	
-Severe anemia	2.5
-PID/PPP	0.04
Maternal malaria/anemia	0.75

F. Why Should Countries Invest in Maternal Health?

Good maternal health is an economic investment. A healthy mother can be highly productive and contribute to the well-being of her family and community. Poverty increases at the family level when a woman is sick and cannot work. Consequently, less money is available for health care and education for children, which in turn has an impact on the greater society. Increasing access to maternal health services will help ensure that women remain vital participants in the economic well-being of their country. A model application in Uganda projected that implementing a set of

interventions described in the “mother-baby package” would, in 10 years, save 250,000 women from disability and avert 12,000 maternal deaths, resulting in productivity gains of US\$90 million (Burkhalter, 2000).

Maternal health interventions are highly cost-effective. Safe motherhood interventions, which are designed to reduce maternal death and disability, are highly cost-effective. Basic maternal care costs in low-income settings have been estimated to be as little as US\$3 per person per year. This includes health care during pregnancy, delivery, and after birth; postpartum family planning; and newborn care (WHO, 1997c). However, a review of available costing information indicates that antenatal care costs typically range from US\$2-\$15 per visit (Borghi, 2001). On average, the cost of a normal delivery at a health center ranges between US\$3-\$15 in African, Asian, and Latin American countries. Costing studies in these countries indicate that a normal delivery in a hospital costs between US\$12-US\$81 (Borghi, 2001).

“Women are the mainstays of families, the key educators of children, healthcare providers, carers of young and old alike, farmers, traders, and often the main, if not the sole, breadwinners. A society deprived of the contribution made by women is one that will see its social and economic life decline, its culture impoverished, and its potential for development severely limited.”

-*Reduction of Maternal Mortality: A Joint WHO/UNFPA/UNICEF/World Bank Statement, WHO, Geneva, 1999.*

International consensus support maternal health. In the last 10 years, international forums, conferences, and corresponding agreements support the inclusion of the right to safe pregnancy and childbirth as an integral part of reproductive health. The Safe Motherhood Initiative (1987), Convention on the Rights of the Child (1990), Convention on the Elimination of all Forms of Discrimination Against Women (1992), the World Conference on Human Rights *Programme of Action* (1993), the International Conference on Population and Development (ICPD) *Programme of Action* (1994), the Fourth World Conference on Women *Platform of Action* (1995), the World Summit on Social Development (1995), and the Joint WHO/UNFPA/UNICEF/World Bank Statement on Reduction of Maternal Mortality (1999) all helped institutionalize the need to set priorities and address the needs of women and their families before and during the childbearing years. These international forums and agreements also identify roles for different sectors, help identify linkages, and create common goals with a unified language to address the problem. (For details on specific agreement language see Maternal Health Handout II.1.3.)

G. What Are Factors that Influence Maternal Health?

Inadequate health care. Maternal deaths are strongly associated with substandard health services and a lack of available medical equipment and supplies at the time of labor, delivery, and immediately after birth. For example, a community-based investigation to assess the preventability of maternal deaths in rural and urban areas of Zimbabwe, identified the lack of appropriately trained personnel as contributing significantly to maternal deaths (Fawcus et al., 1996). Suboptimal clinic and

hospital management was identified in 67 percent of rural and 70 percent of urban deaths (Fawcus et al., 1996).

Inaccessible health care. There is a strong correlation between maternal death and disability and distance to health services. Most rural women (80 percent) live more than five kilometers from the nearest hospital. In Zimbabwe, unavailability of transport contributed to 28 percent of the rural maternal deaths in a study of 105 maternal deaths (Fawcus et al., 1996). Vehicle shortages and poor road conditions mean that the main mode of transportation, even for women in labor, includes walking, being carried in hammocks, or traveling via rickshaw or motorcycle. A study in Maputo, Mozambique, compared 133 consecutive eclamptic patients with 393 non-eclamptic referent women. Eclamptic cases occurred more often among women without access to transport who had to walk to reach antenatal clinics (Bugalho et al., 2001). However, successful transportation systems linked to essential obstetric care have decreased the numbers of deaths. For example, in Uganda a tricycle-radio program funded by UNFPA enabled TBAs and midwives to arrange transportation for pregnant women to the hospital 24 hours a day. Maternal deaths were more than halved in the first year of the project (Amooti-Kaguna, 2000).

Costs for services are prohibitive. Recent estimates from a study costing maternal health care services show that user fees (in US dollars) ranged from \$0.97 to \$2.79 in Uganda, \$0.15 to \$8.70 in Malawi, and \$0.62 to \$3.15 in Ghana per visit for antenatal care at a health center or hospital. For vaginal delivery at a health center or hospital, women were asked to pay from \$2.26 to \$22.75 in Uganda, \$0.35 to \$7.86 in Malawi, and \$12.52 to \$20.64 in Ghana. Fees for midwife services were lower for both antenatal care, at an average cost of \$1.05 in Uganda and \$2.08 in Ghana, and vaginal delivery, at an average of \$7.80 in Uganda and \$8.99 in Ghana (Levin et al., 2000). Even when formal fees are low or nonexistent, women often face expenses for transport, drugs, food, and lodging for themselves or their family members. The same costing study found that travel fees to obtain antenatal care services ranged from \$0.56 to \$1.26 in Uganda, \$0.12 to \$1.13 in Malawi, and \$0.08 to \$0.64 in Ghana. Travel fees to obtain vaginal delivery services were higher, ranging from \$0.52 to \$4.06 in Uganda, \$0.30 to \$2.37 in Malawi, and \$0.75 to \$1.35 in Ghana (Levin et al., 2000).

Poor quality of care. Poor quality of care is one of the most common reasons women provide for choosing *not* to use available maternal health services. Health facilities in developing countries face chronic shortages of equipment, drugs, and basic supplies, including blood for transfusion. Health facility staff are often poorly trained, may lack essential clinical skills, and may not observe hygienic practices. Also, health workers may be rude, unsympathetic, and uncaring; thus, women prefer to use the services of traditional birth attendants (TBAs) and healers. Other factors that result in non-use include the lack of privacy, run-down physical facilities, inconvenient operating hours, and restrictions on who can stay with a woman at the health facility (AbouZahr et al., 1996).

Lack of skilled care at childbirth. Skilled care at childbirth refers to “the process by which a pregnant woman is provided with adequate care during labor, birth, and the postpartum and immediate newborn periods. [To give skilled care], the

attendant must have the necessary skills and must be supported by an enabling environment at the domiciliary, primary (health center), or first referral (hospital) levels, which includes adequate supplies, equipment, and infrastructure as well as an efficient and effective system of communication and referral/transport” (“Saving Lives: Skilled Attendance at Childbirth,” 2000). Skilled care during childbirth is important because millions of women and newborns develop serious and difficult-to-predict complications during or immediately after delivery. A critical component of skilled care in childbirth is the skilled birth attendant. “The term ‘skilled attendant’ refers to people with midwifery skills (for example, doctors, midwives, nurses) who have been trained in the skills necessary to manage normal deliveries and diagnose, manage, or refer obstetric emergencies. They must be able to manage normal labor and delivery, recognize the onset of complications, perform essential interventions, start treatment, and supervise the referral of mother and baby for interventions that are beyond their competence or not possible in the particular setting” (WHO et al., 1999).

Low status of women. Socioeconomic and cultural norms contribute to women’s unequal access to resources, including health care, food, and preventive services. Social expectations and pressures define what is or is not acceptable for a woman to do, making it difficult for a woman to protect herself from unwanted pregnancy or seek timely care in labor in order to prevent death. Furthermore, in many settings, women often lack decision-making power in families, communities, and societies (WHO et al., 1999). Thus, social taboos and unequal power relations between men and women often prevent women from using contraceptives, for example. Opposition from husbands is one of the most common reasons women give for not using contraception.

Gender-based violence. Between 20 and 50 percent of women and girls report having been subject to sexual coercion, abuse, or rape (Heise, 1995). These women are at high risk for unwanted pregnancy and other sexual and reproductive health problems. Globally, as many as one in every four women is physically or sexually abused during pregnancy, usually by her partner (Heise, 1999). Violence before and during pregnancy seriously impacts pregnancy outcomes and health consequences for women and their children. Pregnant women who have experienced violence are more likely to delay seeking prenatal care and gain insufficient weight. They are also more likely to have unwanted or mistimed pregnancies and bleeding during pregnancy. Violence has been linked with increased risk of miscarriages and abortions, premature labor, fetal distress, and low birth weight (Heise, 1999). In India, verbal autopsies from a surveillance study of all maternal deaths in over 400 villages and 7 hospitals in three districts of Maharashtra revealed that 16 percent of deaths during pregnancy were due to domestic violence (Ganatra, 1996).

Delays in seeking services. Women may delay or not seek treatment because of lack of recognition of a problem or because of logistical, social, or cultural barriers. Most births in developing countries take place in locations other than health facilities. If a woman’s family and her birth attendant can recognize the signs of labor and delivery complications and if complications occur, the family should move the woman to a facility where trained professionals can provide adequate care. In far too many cases, women are not brought to facilities in time. The

warning signs of complications may not be recognized, or families may fear being treated badly, being charged high fees, or receiving substandard care at such health facilities. Indeed, even deliveries in health facilities may be needlessly risky because the quality of obstetric care is insufficient (Population Reference Bureau, 1998). The “Three Delays Model” groups delay-related barriers to obtaining emergency obstetric services into three major categories: 1) delay in deciding to seek care, 2) delay in reaching a medical facility, and 3) delay in receiving treatment (Maine et al., 1997). This model has been expanded into the “Four Delays Model” by dividing the first delay into two: 1) delay in recognizing danger signs, and 2) delay in seeking care (Ransom and Yinger, 2002). (See Maternal Health Handout III.5.7: The Four Delays Model for more information.)

H. What Can Be Done to Improve Safe Motherhood?

Building political commitment. Providing information on the extent of maternal health issues creates an environment of enhanced problem recognition and focuses attention on the need for action. Advocates can use information to raise awareness, increase knowledge and motivation, and build capacity. Data such as national statistics (e.g., percent skilled attendance at birth) as well as single events (e.g., a law prohibiting early marriage) can demonstrate to what extent a government is adequately addressing maternal health. Reports can also provide data on the activities of a government to address safe motherhood as a component of reproductive health. Maternal health advocates can use data to hold governments accountable for government-signed documents, such as the 1994 ICPD *Programme of Action* and the 1995 Fourth World Conference on Women in Beijing *Platform of Action*. (See Section F for a list of international meetings, and Maternal Health Handout II.1.3: Key Language from International Agreements Related to Maternal Health for specific agreement language.)

The protection and promotion of the human rights of women can help ensure that all women have the right to

- Make decisions about their own health, free from coercion or violence and based on full information; and
- Have access to quality services and information before, during, and after pregnancy and childbirth.

-Safe Motherhood Fact Sheet: A Matter of Human Rights and Social Justice, 1998

Developing and implementing national policies. A positive policy environment is crucial to the promotion of maternal health and the reduction of maternal deaths. If a country does not have a national policy on safe motherhood, one could be developed. For the many countries that have such policies in place, advocacy could focus on developing implementation plans and committing necessary resources to programs and services.

The policy environment can be improved to protect maternal health in many ways, such as the following:

- Ensure inclusion of maternal health programs in national policies.
- Advocate for allocation of resources for maternal health.

- Advocate for financing policies to promote access (e.g., health insurance for pregnancy, birth and family planning, or transport for emergencies)
- Reform policies that contribute to maternal mortality (e.g., laws that require husband's authorization).
- Implement policies to protect women's health interests (e.g., laws regarding rape).
- Amend policies to promote the role of midwives, nurses, and community physicians in providing life-saving interventions and prescribing medicine.
- Eliminate policies that limit contraceptive delivery to young adults or unmarried women.
- Promote midwifery training for more personnel.
- Develop and use protocols for the management of obstetrical complications.
- Set standards for service delivery.
- Develop and use tools for improving quality of care.
- Establish or strengthen mechanisms to evaluate the quality of services.
- Address regulatory, social, economic, and cultural factors that limit women's control over their sexuality and reproduction, including their access to contraception.

Changing social norms. The low status of women and gender disparities leave women powerless over sexual relations and contraceptive use in many settings. Advocates can promote women's rights and empower women to make informed choices. They can also work to empower women economically through microcredit or increasing employment opportunities. Literacy and increased educational opportunities for girls and women are imperative to improving women's status.

Involving men. With the permission of the pregnant woman, the man's participation can be welcomed at each stage of pregnancy, labor, delivery, and postpartum. Men who understand the risks of pregnancy are more likely to obtain emergency obstetric care to save the mother's life. "Research suggests that... improving awareness of obstetric complications among members of a pregnant woman's immediate and wider social network is an important step in improving her chances of survival when ... complications occur" (Roth and Mbitzo, 2001). A study of 211 women in Uganda who had given birth in the previous year found that educating fathers about safe delivery discouraged home deliveries (Nuwaha and Amooti-Kaguna, 1999). Focus-group discussions in Moldova revealed that both women and men said that they were given little information about birth, yet both desired more information about these topics and about newborn care (Mercer, 2000). Initial results from a Population Council research project in India found that training physicians on involving men in maternity care has led to more husbands accompanying their wives to antenatal clinics (Varkey, 2001). Including male partners during antenatal care, with the knowledge and consent of pregnant woman, has been shown to increase supportive behavior for mothers and infants. In India, the provision of antenatal education to prospective fathers resulted in a significantly higher frequency of antenatal visits (Bhalero et al., 1984).

Providing access to quality information and services. Access means that information and services are available and within the reach of women who need them. Clients need to receive information and counseling on their health and health needs in order to make timely informed decisions about their reproductive health. Solid information and positive interaction between client and provider can contribute to client confidence and compliance. Evidence supports the idea that women who are given the power and information to make decisions can save their own lives in cases of obstetric emergencies. For example, in India, the Rural Women's Social Education Centre undertook an intensive health education campaign covering more than 20,000 rural, poor agricultural laborers. The campaign identified pregnant women, who were then given health advice and encouraged to deliver in the hospital. A series of workshops and pamphlets explained the process of childbirth, appropriate self-care, and danger signals in pregnancy. As a result, three-quarters (76 percent) of those with complications, such as prolonged or obstructed labor, heavy loss of blood during labor or postpartum, and hypertensive disorders of pregnancy, delivered in the hospital (Sundari, 1993). In rural Bangladesh, pictorial cards were used to raise community awareness about the complications of pregnancy and childbirth and encourage women to use health facilities in emergencies. Pregnant women who received a pictorial card were more likely to use institutional facilities for the management of their obstetric complications compared with those who did not receive the card (Khanum et al., 2000).

Good quality services require that health care providers have adequate clinical skills and are sensitive to women's needs, facilities have necessary equipment and supplies, and referral systems function well enough to ensure that women with complications get essential treatment. Advocates can work to increase women's access to information or work to remove operational constraints in providing effective services.

Services for safe motherhood should include:

- Family planning counseling, information, and services;
- Health care before, during, and after childbirth;
- Skilled assistance during delivery;
- Care for obstetric complications, including emergencies;
- Health education for women, adolescents, and communities; and
- Services to prevent and manage the complications of unsafe abortion.

Improving financial coverage for the poor. Cost is often a barrier to accessing skilled maternal health care. Advocacy for financial coverage for the poor, such as pooled funds for transportation, mutual help organizations, insurance coverage, and vouchers, can improve access and ultimately health outcomes for mothers and newborns. For example, the Indonesian Ministry of Health implemented a voucher program for low-income women for maternal health care services provided by government trained midwives. An evaluation of the program indicates that more women are using midwives' services (Ransom and Yinger, 2002). The Government of Bolivia established a national insurance program for pregnant women. As a result, antenatal visits increased by 80 percent, and deliveries at public facilities increased by almost 50 percent (Ransom and Yinger, 2002).

I. *Can maternal health outcomes improve?* Yes! Good quality health care during the critical periods of labor and delivery is the single most important intervention for preventing maternal and newborn mortality and serious morbidity (WHO, 1997b). Most maternal deaths could be prevented if women had access to basic medical care during pregnancy, childbirth, and the postpartum period. This implies strengthening health systems and linking communities, health centers, and hospitals to provide care where women need it (WHO, 1994).

For example:

- In Honduras, maternal deaths decreased from 182 per 100,000 live births in 1990 to 108 in 1997. The decrease was attributed to making emergency obstetric care available in more health centers and district hospitals. Birth centers were established in remote areas and the number of health personnel was increased. Emergency transportation, roads, and communication were also improved (UNFPA, 2000).
- Egypt's maternal mortality declined from 174 to 84 per 100,000 live births between 1992 and 2000 through building and equipping more hospitals in rural areas, creating access to skilled attendance, and teaching TBAs and communities to seek prompt care for emergency obstetric care. By 2000, even in rural areas, 99 percent of women live within 30 kilometers of a hospital. The proportion of births attended by a doctor or nurse increased. Even among the 36 percent of women who had home deliveries with TBAs, 93 percent sought medical care when they experienced problems (Ministry of Health, 2001).
- In Thailand, the introduction of 18,314 certified trained midwives was correlated with the reduction of maternal mortality levels from more than 400 per 100,000 live births in the 1960s to 98 in 1980 (Wilbulpolprasert, 2000).
- In Egypt, the reported number of neonatal tetanus cases dropped from 6,000 per year to fewer than 400 because of increases in routine tetanus toxoid coverage of pregnant women (UNICEF et al., 2000).
- A study in Guatemala trained hospital staff to be supportive and understanding of TBAs and mothers referred by TBAs. Referrals increased by more than 200 percent (O'Rourke, 1995).

J. *Continuous advocacy is critical.* More follow-up and continuous advocacy for educational and service delivery programs are critical even *after* the enactment of positive maternal health policies. Implementation of policies has often proved more difficult than enacting the policy in the first place. For example, in Lao People's Democratic Republic, a national safe motherhood policy was approved in 1998 but has still not been implemented, and a strategic plan has not been formulated to meet the policy's goals (Regional Technical Assistance 5825, 2002).

Despite these challenges, advocates for maternal health can count a number of victories at the international, national, and local levels. Advocacy networks have played and will continue to play a key role in replicating and building on those successes.

MATERNAL HEALTH ISSUES

A. *Why Address Maternal Health?*

- There are an estimated 170 million pregnancies every year around the world,¹ and every time a woman is pregnant she risks a sudden and unpredictable complication that could result in her death or injury and the death or injury of her infant.
- At least 40 percent of all pregnant women will experience some type of complication during their pregnancies. For about 15 percent, the complication will be potentially life-threatening and will require prompt obstetric care (Koblinsky et al., 1993).
- About 60 million women suffer from some complications from pregnancy, also known as maternal morbidity. For more than 15 million women, these morbidities are long-term and often debilitating (Ashford, 2002).
- About 500,000 women die of pregnancy-related causes each year (Hill et al., 2001).
- Safe motherhood is a human right and must be underpinned by laws and policies that support effective action to increase women's access to basic education, adequate nutrition, economic resources, as well as appropriate health services.

B. *What Is Safe Motherhood?*

Safe motherhood refers to a woman's ability to have a safe and healthy pregnancy and delivery. The goal of safe motherhood is to ensure that every woman has access to a full range of high-quality, affordable sexual and reproductive health services—especially maternal care and treatment of obstetric emergencies to reduce deaths and disabilities.²

C. *What Do Maternal Health Programs Try to Do?*

Maternal health programs typically focus on achieving the following three outcomes:

- Preventing unwanted pregnancy
- Reducing maternal mortality and morbidity

¹This figure is calculated based on estimated global number births for 2000 (133,284,000) as cited in the UN's World Population Prospects: The 2002 Revision Population Database and assumes 20 percent pregnancy wastage.

²Based on commitments made at the World Summit for Children, International Conference on Population and Development, World Summit on Social Development, Fourth World Conference on Women, and the Convention on the Elimination of All Forms of Discrimination Against Women.

- Reducing neonatal mortality and morbidity

These outcomes can be achieved through:

- Meeting the need for family planning;
- Increasing the percentage of births attended by skilled attendants;
- Increasing access to essential obstetric care;
- Preventing unsafe abortion and managing postabortion complications; and
- Increasing access to effective antenatal care.

D. What Is the Magnitude of Maternal Health Issues?

- About 500,000 women die each year due to pregnancy-related causes (Hill et al., 2001).
- Ninety-nine percent of pregnancy-related deaths occur in the developing world (WHO/UNICEF, 1996).
- Globally, there are an estimated 170 million pregnancies each year.³
- Nearly 123 million women want to stop having children or postpone their next pregnancy but are not using contraception (Ross and Winfrey, 2002).
- Approximately 75 million pregnancies are unwanted each year (UNFPA, 1997).
- A woman's lifetime risk of dying from pregnancy-related complications or during childbirth is one in 48 in the developing world versus one in 1,800 in the developed world (Population Reference Bureau, 1998).
- At least 35 percent of women in developing countries receive no antenatal care during pregnancy, and 70 percent receive no postpartum care during the six weeks following delivery (WHO, 1997b).
- In 1996, only 53 percent of deliveries in developing countries took place with a skilled birth attendant (WHO, 1997b).
- In some countries, as many as 95 percent of deliveries are performed with no skilled birth attendant (WHO, 1997b).
- About 40 percent of all pregnant women will experience some type of complication during their pregnancy (Koblinsky et al., 1993).
- An estimated 1 in 12 women die of pregnancy-related causes in West Africa compared with 1 in 4,000 in Northern Europe (United Nations, 1995).
- There are remarkable similarities in the main causes of maternal deaths in developed and developing countries, including hemorrhage, sepsis, and hypertensive disorders such as eclampsia (Maine, 2000).
- Abortion-related complications result in nearly 80,000 maternal deaths and hundreds of thousands of disabilities (WHO, 1997a).
- Abortion-related causes of maternal death account for 13 percent of maternal deaths in developing countries (Maine, 2000).

³This figure is calculated based on estimated global number births for 2000 (133,284,000) as cited in the UN's World Population Prospects: The 2002 Revision Population Database and assumes 20 percent pregnancy wastage.

- Obstructed labor accounts for about 8 percent of maternal deaths in developing countries but is almost unknown as a cause of death in developed countries due to the use of cesarean sections (Maine, 2000).

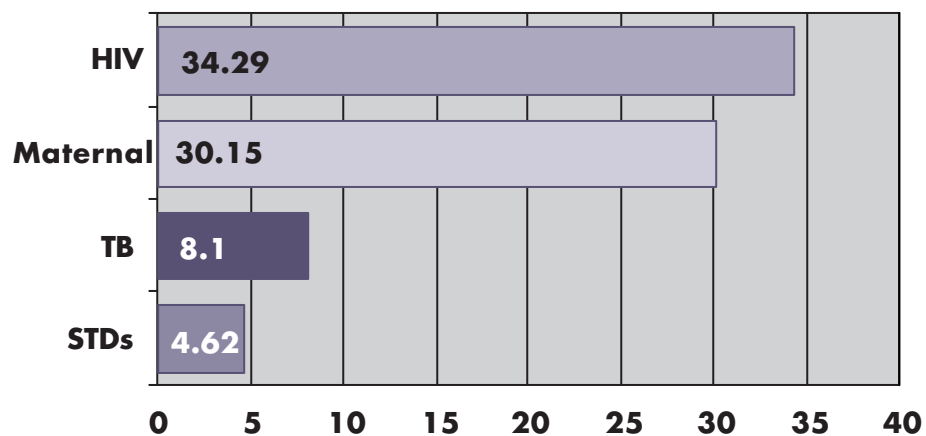
E. What Are the Consequences of Poor Maternal Health?

The consequences of poor maternal health are widespread, affecting women, families, communities, and society.

Unwanted pregnancies. Without adequate access to family planning information and services, women may have unplanned and unwanted pregnancies. Unwanted pregnancies can threaten a woman's health or well-being, and many unwanted pregnancies are terminated using unsafe procedures that can lead to death or disability.

Long-term maternal morbidities. Limited access to antenatal care and skilled attendance at birth can lead to long-term maternal morbidities. About 60 million women suffer from some maternal morbidity, and these morbidities are long-term and often debilitating for more than 15 million women (Ashford, 2002). Women of reproductive age in the developing world lose more disability-adjusted life years (DALYs)⁴—30 million—to maternal causes than to any other cause other than HIV/AIDS (see Figure 1)⁵ (WHO, 2001a). The number of DALYs due to HIV/AIDS have almost tripled in just ten years, from 12 million in 1990⁶ to over 34 million in 2001.

Figure 1. Number of DALYs Lost to Women Aged 15-44 Due to Maternal Causes, HIV, STDs, and TB



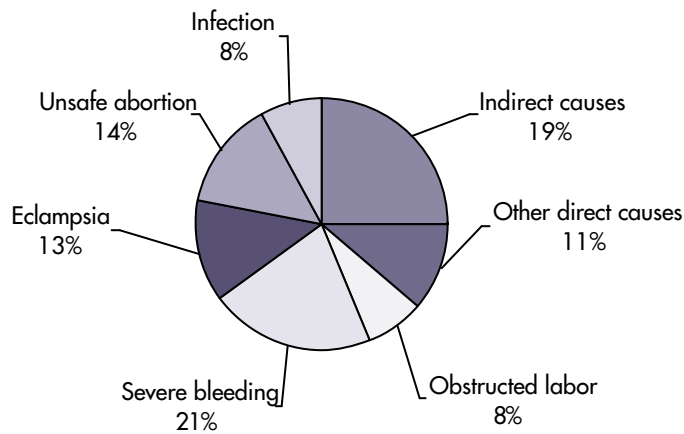
⁴DALYs is the measurement used by the World Bank and WHO to express how a healthy person is affected by disease. This measurement combines years of life lost because of premature death and disability.

⁵To estimate DALYs for women in the developing world, data for three WHO regions: AMRO A, EURO A and WPRO A were subtracted from global DALYs for women of reproductive age (15-44).

⁶DALYs for 1990 were presented in the World Development Report 1993.

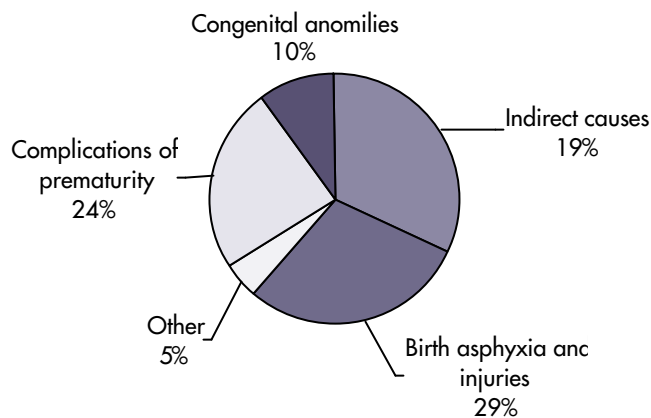
Maternal mortality. Lack of antenatal and postnatal care and assistance during delivery can lead to maternal death. Maternal deaths have both direct and indirect causes (see Figure 2) (UNFPA, 2001). About 80 percent of maternal deaths are due to direct causes, which include obstetric complications such as severe bleeding, infection, unsafe abortion, hypertensive disorders (eclampsia), and obstructed labor. Women also die of indirect causes, such as malaria, diabetes, hepatitis, heart disease, and anemia; these diseases or causes of ill health can be exacerbated during pregnancy.

Figure 2. Medical Causes of Maternal Death



Neonatal mortality. Some of the same factors that cause maternal mortality and morbidity, such as complications of pregnancy and childbirth and poor management of those complications, also cause or contribute to a significant proportion of stillbirths and newborn deaths. There are more than 7 million infant deaths per year (WHO, 2001). Approximately half of infant deaths occur during the neonatal period (the first month of life) (WHO, 2001). Of neonatal deaths, nearly 75 percent occur in the first week (WHO, 2001). Almost 30 percent of neonatal deaths are due to birth asphyxia and injuries, and another 24 percent due to complications of prematurity (see Figure 3) (JHU, 1999). Significant additional reductions in infant mortality can be achieved with interventions designed to improve the health of the mother and her access to care during labor, birth, and the critical hours immediately afterward (World Bank, 1999).

Figure 3. Medical Causes of Neonatal Death



Child mortality. A mother’s death has profound consequences for her family. In some developing countries, if the mother dies, the risk of death for her children younger than five is doubled or tripled. In Bangladesh, children up to age 10 whose mothers die have three to five times the mortality rate of children whose mothers are alive or whose fathers die (World Bank, 1999).

Increased poverty, weakened households, and communities. A woman suffering long-term disabilities from pregnancy or childbirth may not be able to participate in the workforce or be economically productive. Children of disabled or sick mothers may have inferior nutrition, hygiene, and health than children of healthy mothers. Also, some children drop out of school to work, further contributing to the cycle of poverty. Losing productive members of society affects governments because of the loss of investments made in education, health care, and job training. A study in Uganda estimated the productive years lost due to various maternal disabilities, assuming a total work life of 65 years per woman (Table 1). Postpartum hemorrhage (severe bleeding), hypertensive disorders (eclampsia), and obstructed labor each can lead to 35 productive years lost per woman (SARA Project, 2000).

Table 1: Productive Years Lost Per Woman Due to Maternal Morbidity, Uganda

Complication	Productive Years Lost Per Woman
Postpartum Hemorrhage (Severe bleeding)	
-Severe anemia	2.5
-Sheehan’s Syndrome	35.5
Sepsis (Infection)	
-PID/CPF	0.04
Hypertensive disorder (Eclampsia)	
-Neurosequalea	35.5
Obstructed labor	
-Stress incontinence	36.5
-Fistula	46
Abortion	
-Severe anemia	2.5
-PID/CPF	0.04
Maternal malaria/anemia	0.75

F. Why Should Countries Invest in Maternal Health?

Good maternal health is an economic investment. A healthy mother can be highly productive and contribute to the well-being of her family and community. Poverty increases at the family level when a woman is sick and cannot work. Consequently, less money is available for health care and education for children, which in turn has an impact on the greater society. Increasing access to maternal health services will help ensure that women remain vital participants in the economic well-being of their country. A model application in Uganda projected that implementing a set of interventions described in the “mother-baby package” would, in 10 years, save

250,000 women from disability and avert 12,000 maternal deaths, resulting in productivity gains of US\$90 million (Burkhalter, 2000).

Maternal health interventions are highly cost-effective. Safe motherhood interventions, which are designed to reduce maternal death and disability, are highly cost-effective. Basic maternal care costs in low-income settings have been estimated to be as little as US\$3 per person per year. This includes health care during pregnancy, delivery, and after birth; postpartum family planning; and newborn care (WHO, 1997c). However, a review of available costing information indicates that antenatal care costs typically range from US\$2-\$15 per visit (Borghi, 2001). On average, the cost of a normal delivery at a health center ranges between US\$3-\$15 in African, Asian, and Latin American countries. Costing studies in these countries indicate that a normal delivery in a hospital costs between US\$12-US\$81 (Borghi, 2001).

“Women are the mainstays of families, the key educators of children, healthcare providers, carers of young and old alike, farmers, traders, and often the main, if not the sole, breadwinners. A society deprived of the contribution made by women is one that will see its social and economic life decline, its culture impoverished, and its potential for development severely limited.”

-Reduction of Maternal Mortality: A Joint WHO/UNFPA/UNICEF/World Bank Statement, WHO, Geneva, 1999.

International consensus support maternal health. In the last 10 years, international forums, conferences, and corresponding agreements support the inclusion of the right to safe pregnancy and childbirth as an integral part of reproductive health. The Safe Motherhood Initiative (1987), Convention on the Rights of the Child (1990), Convention on the Elimination of all Forms of Discrimination Against Women (1992), the World Conference on Human Rights Programme of Action (1993), the International Conference on Population and Development (ICPD) Programme of Action (1994), the Fourth World Conference on Women Platform of Action (1995), the World Summit on Social Development (1995), and the Joint WHO/UNFPA/UNICEF/World Bank Statement on Reduction of Maternal Mortality (1999) all helped institutionalize the need to set priorities and address the needs of women and their families before and during the childbearing years. These international forums and agreements also identify roles for different sectors, help identify linkages, and create common goals with a unified language to address the problem. (For details on specific agreement language see Maternal Health Handout II.1.3.)

G. What Are Factors that Influence Maternal Health?

Inadequate health care. Maternal deaths are strongly associated with substandard health services and a lack of available medical equipment and supplies at the time of labor, delivery, and immediately after birth. For example, a community-based investigation to assess the preventability of maternal deaths in rural and urban areas of Zimbabwe, identified the lack of appropriately trained personnel as contributing significantly to maternal deaths (Fawcus et al., 1996). Suboptimal clinic and hospital management was identified in 67 percent of rural and 70 percent of urban deaths (Fawcus et al., 1996).

Inaccessible health care. There is a strong correlation between maternal death and disability and distance to health services. Most rural women (80 percent) live more than five kilometers from the nearest hospital. In Zimbabwe, unavailability of transport contributed to 28 percent of the rural maternal deaths in a study of 105 maternal deaths (Fawcus et al., 1996). Vehicle shortages and poor road conditions mean that the main mode of transportation, even for women in labor, includes walking, being carried in hammocks, or traveling via rickshaw or motorcycle. A study in Maputo, Mozambique, compared 133 consecutive eclamptic patients with 393 non-eclamptic referent women. Eclamptic cases occurred more often among women without access to transport who had to walk to reach antenatal clinics (Bugalho et al., 2001). However, successful transportation systems linked to essential obstetric care have decreased the numbers of deaths. For example, in Uganda a tricycle-radio program funded by UNFPA enabled TBAs and midwives to arrange transportation for pregnant women to the hospital 24 hours a day. Maternal deaths were more than halved in the first year of the project (Amooti-Kaguna, 2000).

Costs for services are prohibitive. Recent estimates from a study costing maternal health care services show that user fees (in US dollars) ranged from \$0.97 to \$2.79 in Uganda, \$0.15 to \$8.70 in Malawi, and \$0.62 to \$3.15 in Ghana per visit for antenatal care at a health center or hospital. For vaginal delivery at a health center or hospital, women were asked to pay from \$2.26 to \$22.75 in Uganda, \$0.35 to \$7.86 in Malawi, and \$12.52 to \$20.64 in Ghana. Fees for midwife services were lower for both antenatal care, at an average cost of \$1.05 in Uganda and \$2.08 in Ghana, and vaginal delivery, at an average of \$7.80 in Uganda and \$8.99 in Ghana (Levin et al., 2000). Even when formal fees are low or nonexistent, women often face expenses for transport, drugs, food, and lodging for themselves or their family members. The same costing study found that travel fees to obtain antenatal care services ranged from \$0.56 to \$1.26 in Uganda, \$0.12 to \$1.13 in Malawi, and \$0.08 to \$0.64 in Ghana. Travel fees to obtain vaginal delivery services were higher, ranging from \$0.52 to \$4.06 in Uganda, \$0.30 to \$2.37 in Malawi, and \$0.75 to \$1.35 in Ghana (Levin et al., 2000).

Poor quality of care. Poor quality of care is one of the most common reasons women provide for choosing not to use available maternal health services. Health facilities in developing countries face chronic shortages of equipment, drugs, and basic supplies, including blood for transfusion. Health facility staff are often poorly trained, may lack essential clinical skills, and may not observe hygienic practices. Also, health workers may be rude, unsympathetic, and uncaring; thus, women prefer to use the services of traditional birth attendants (TBAs) and healers. Other factors that result in non-use include the lack of privacy, run-down physical facilities, inconvenient operating hours, and restrictions on who can stay with a woman at the health facility (AbouZahr et al., 1996).

Lack of skilled care at childbirth. Skilled care at childbirth refers to “the process by which a pregnant woman is provided with adequate care during labor, birth, and the postpartum and immediate newborn periods. [To give skilled care], the attendant must have the necessary skills and must be supported by an enabling environment at the domiciliary, primary (health center), or first referral (hospital) levels, which includes adequate supplies, equipment, and infrastructure as well as

an efficient and effective system of communication and referral/transport” (“Saving Lives: Skilled Attendance at Childbirth,” 2000). Skilled care during childbirth is important because millions of women and newborns develop serious and difficult-to-predict complications during or immediately after delivery. A critical component of skilled care in childbirth is the skilled birth attendant. “The term ‘skilled attendant’ refers to people with midwifery skills (for example, doctors, midwives, nurses) who have been trained in the skills necessary to manage normal deliveries and diagnose, manage, or refer obstetric emergencies. They must be able to manage normal labor and delivery, recognize the onset of complications, perform essential interventions, start treatment, and supervise the referral of mother and baby for interventions that are beyond their competence or not possible in the particular setting” (WHO et al., 1999).

Low status of women. Socioeconomic and cultural norms contribute to women’s unequal access to resources, including health care, food, and preventive services. Social expectations and pressures define what is or is not acceptable for a woman to do, making it difficult for a woman to protect herself from unwanted pregnancy or seek timely care in labor in order to prevent death. Furthermore, in many settings, women often lack decision-making power in families, communities, and societies (WHO et al., 1999). Thus, social taboos and unequal power relations between men and women often prevent women from using contraceptives, for example. Opposition from husbands is one of the most common reasons women give for not using contraception.

Gender-based violence. Between 20 and 50 percent of women and girls report having been subject to sexual coercion, abuse, or rape (Heise, 1995). These women are at high risk for unwanted pregnancy and other sexual and reproductive health problems. Globally, as many as one in every four women is physically or sexually abused during pregnancy, usually by her partner (Heise, 1999). Violence before and during pregnancy seriously impacts pregnancy outcomes and health consequences for women and their children. Pregnant women who have experienced violence are more likely to delay seeking prenatal care and gain insufficient weight. They are also more likely to have unwanted or mistimed pregnancies and bleeding during pregnancy. Violence has been linked with increased risk of miscarriages and abortions, premature labor, fetal distress, and low birth weight (Heise, 1999). In India, verbal autopsies from a surveillance study of all maternal deaths in over 400 villages and 7 hospitals in three districts of Maharashtra revealed that 16 percent of deaths during pregnancy were due to domestic violence (Ganatra, 1996).

Delays in seeking services. Women may delay or not seek treatment because of lack of recognition of a problem or because of logistical, social, or cultural barriers. Most births in developing countries take place in locations other than health facilities. If a woman’s family and her birth attendant can recognize the signs of labor and delivery complications and if complications occur, the family should move the woman to a facility where trained professionals can provide adequate care. In far too many cases, women are not brought to facilities in time. The warning signs of complications may not be recognized, or families may fear being treated badly, being charged high fees, or receiving substandard care at such health facilities. Indeed, even deliveries in health facilities may be needlessly risky because the quality of obstetric care is insufficient (Population Reference Bureau, 1998). The

“Three Delays Model” groups delay-related barriers to obtaining emergency obstetric services into three major categories: 1) delay in deciding to seek care, 2) delay in reaching a medical facility, and 3) delay in receiving treatment (Maine et al., 1997). This model has been expanded into the “Four Delays Model” by dividing the first delay into two: 1) delay in recognizing danger signs, and 2) delay in seeking care (Ransom and Yinger, 2002). (See Maternal Health Handout III.5.7: The Four Delays Model for more information.)

H. What Can Be Done to Improve Safe Motherhood?

Building political commitment. Providing information on the extent of maternal health issues creates an environment of enhanced problem recognition and focuses attention on the need for action. Advocates can use information to raise awareness, increase knowledge and motivation, and build capacity. Data such as national statistics (e.g., percent skilled attendance at birth) as well as single events (e.g., a law prohibiting early marriage) can demonstrate to what extent a government is adequately addressing maternal health.

The protection and promotion of the human rights of women can help ensure that all women have the right to

- Make decisions about their own health, free from coercion or violence and based on full information; and
- Have access to quality services and information before, during, and after pregnancy and childbirth.

-Safe Motherhood Fact Sheet: A Matter of Human Rights and Social Justice, 1998

Reports can also provide data on the activities of a government to address safe motherhood as a component of reproductive health. Maternal health advocates can use data to hold governments accountable for government-signed documents, such as the 1994 ICPD Programme of Action and the 1995 Fourth World Conference on Women in Beijing Platform of Action. (See Section F for a list of international meetings, and Maternal Health Handout II.1.3: Key Language from International Agreements Related to Maternal Health for specific agreement language.)

Developing and implementing national policies. A positive policy environment is crucial to the promotion of maternal health and the reduction of maternal deaths. If a country does not have a national policy on safe motherhood, one could be developed. For the many countries that have such policies in place, advocacy could focus on developing implementation plans and committing necessary resources to programs and services.

The policy environment can be improved to protect maternal health in many ways, such as the following:

- Ensure inclusion of maternal health programs in national policies.
- Advocate for allocation of resources for maternal health.
- Advocate for financing policies to promote access (e.g., health insurance for pregnancy, birth and family planning, or transport for emergencies)
- Reform policies that contribute to maternal mortality (e.g., laws that require husband’s authorization).
- Implement policies to protect women’s health interests (e.g., laws

- regarding rape).
- Amend policies to promote the role of midwives, nurses, and community physicians in providing life-saving interventions and prescribing medicine.
 - Eliminate policies that limit contraceptive delivery to young adults or unmarried women.
 - Promote midwifery training for more personnel.
 - Develop and use protocols for the management of obstetrical complications.
 - Set standards for service delivery.
 - Develop and use tools for improving quality of care.
 - Establish or strengthen mechanisms to evaluate the quality of services.
 - Address regulatory, social, economic, and cultural factors that limit women's control over their sexuality and reproduction, including their access to contraception.

Changing social norms. The low status of women and gender disparities leave women powerless over sexual relations and contraceptive use in many settings. Advocates can promote women's rights and empower women to make informed choices. They can also work to empower women economically through microcredit or increasing employment opportunities. Literacy and increased educational opportunities for girls and women are imperative to improving women's status.

Involving men. With the permission of the pregnant woman, the man's participation can be welcomed at each stage of pregnancy, labor, delivery, and postpartum. Men who understand the risks of pregnancy are more likely to obtain emergency obstetric care to save the mother's life. "Research suggests that... improving awareness of obstetric complications among members of a pregnant woman's immediate and wider social network is an important step in improving her chances of survival when ... complications occur" (Roth and Mbitzo, 2001). A study of 211 women in Uganda who had given birth in the previous year found that educating fathers about safe delivery discouraged home deliveries (Nuwaha and Amooti-Kaguna, 1999). Focus-group discussions in Moldova revealed that both women and men said that they were given little information about birth, yet both desired more information about these topics and about newborn care (Mercer, 2000). Initial results from a Population Council research project in India found that training physicians on involving men in maternity care has led to more husbands accompanying their wives to antenatal clinics (Varkey, 2001). Including male partners during antenatal care, with the knowledge and consent of pregnant woman, has been shown to increase supportive behavior for mothers and infants. In India, the provision of antenatal education to prospective fathers resulted in a significantly higher frequency of antenatal visits (Bhalero et al., 1984).

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Improving financial coverage for the poor. Cost is often a barrier to accessing skilled maternal health care. Advocacy for financial coverage for the poor, such as pooled funds for transportation, mutual help organizations, insurance coverage, and vouchers, can improve access and ultimately health outcomes for mothers and newborns. For example, the Indonesian Ministry of Health implemented a voucher program for low-income women for maternal health care services provided by government trained midwives. An evaluation of the program indicates that more women are using midwives' services (Ransom and Yinger, 2002). The Government of Bolivia established a national insurance program for pregnant women. As a result, antenatal visits increased by 80 percent, and deliveries at public facilities increased by almost 50 percent (Ransom and Yinger, 2002).

I. Can maternal health outcomes improve? Yes! Good quality health care during the critical periods of labor and delivery is the single most important intervention for preventing maternal and newborn mortality and serious morbidity (WHO, 1997b). Most maternal deaths could be prevented if women had access to basic medical care during pregnancy, childbirth, and the postpartum period. This implies strengthening health systems and linking communities, health centers, and hospitals to provide care where women need it (WHO, 1994).

For example:

- In Honduras, maternal deaths decreased from 182 per 100,000 live births in 1990 to 108 in 1997. The decrease was attributed to making emergency obstetric care available in more health centers and district hospitals. Birth centers were established in remote areas and the number of health personnel was increased. Emergency transportation, roads, and communication were also improved (UNFPA, 2000).
- Egypt's maternal mortality declined from 174 to 84 per 100,000 live births between 1992 and 2000 through building and equipping more hospitals in rural areas, creating access to skilled attendance, and teaching TBAs and communities to seek prompt care for emergency obstetric care. By 2000, even in rural areas, 99 percent of women live within 30 kilometers of a hospital. The proportion of births attended by a doctor or nurse increased. Even among the 36 percent of women who had home deliveries with TBAs, 93 percent sought medical care when they experienced problems (Ministry of Health, 2001).
- In Thailand, the introduction of 18,314 certified trained midwives was correlated with the reduction of maternal mortality levels from more than 400 per 100,000 live births in the 1960s to 98 in 1980 (Wilbulpolprasert, 2000).
- In Egypt, the reported number of neonatal tetanus cases dropped from 6,000 per year to fewer than 400 because of increases in routine tetanus toxoid coverage of pregnant women (UNICEF et al., 2000).
- A study in Guatemala trained hospital staff to be supportive and understanding of TBAs and mothers referred by TBAs. Referrals increased by more than 200 percent (O'Rourke, 1995).

J. Continuous advocacy is critical. More follow-up and continuous advocacy for educational and service delivery programs are critical even after the enactment of positive maternal health policies. Implementation of policies has often proved more difficult than enacting the policy in the first place. For example, in Lao People's Democratic Republic, a national safe motherhood policy was approved in 1998 but has still not been implemented, and a strategic plan has not been formulated to meet the policy's goals (Regional Technical Assistance 5825, 2002).

Despite these challenges, advocates for maternal health can count a number of victories at the international, national, and local levels. Advocacy networks have played and will continue to play a key role in replicating and building on those successes.

THE POWER OF NUMBERS: NETWORKING FOR IMPACT

Supplemental Introductory Material

For two decades, advocates have worked to bring the devastating impact of poor maternal health to the forefront of the reproductive health agenda. Every year about 500,000 women die unnecessarily of causes related to pregnancy and childbirth (Hill et al., 2001). Advocacy networks have long been successful in family planning/reproductive health (FP/RH), yet there are relatively few networks working specifically to improve maternal health. There is an urgent need to initiate programs in which advocacy efforts are lacking and to continue the advocacy efforts that have already been developed.

The Safe Motherhood Initiative (1987) marked the first advocacy effort to bring together international organizations to focus global attention on increasing maternal safety and reducing the number of deaths and illnesses associated with pregnancy and childbirth. The United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), the World Bank, the International Planned Parenthood Federation (IPPF), and the Population Council joined forces and developed the Inter-Agency Group (IAG) for Safe Motherhood to assess and recommend solutions to safe motherhood issues. In May 1999, the International Confederation of Midwives and the International Federation of Gynecology and Obstetrics were added; and in December 1999, two developing country organizations, the Regional Prevention of Maternal Mortality Network (Africa) and the Safe Motherhood Network of Nepal, also joined the IAG. These agencies work together to raise awareness, set priorities, stimulate research, mobilize resources, provide technical assistance, and share information according to each organization's mandate. Their cooperation and commitment have enabled governments and nongovernmental (NGO) partners from more than 100 countries to act to make motherhood safer.

The White Ribbon Alliance (WRA) for Safe Motherhood is another example of a global network working to build support for safe motherhood. Formed in 1999, the group focuses its efforts on building awareness and coalitions around the world at the grassroots level. Since its inception, networks have been formed in

Advocacy Networks at Work

The Zambia White Ribbon Alliance for Safe Motherhood is a network of 13 NGOs, two government agencies and one international donor formed with the aim to contribute to the improvement of maternal health in Zambia. In May, June and July 2001, the Zambia White Ribbon Alliance for Safe Motherhood, Zambia Integrated Health Program (ZIHP), and the Maternal and Neonatal Health (MNH) Program conducted a safe motherhood competition for journalists that generated 40 entries (25 newspaper articles, 12 two-part radio broadcasts, and three TV special news broadcasts). The competition began on May 22 with an orientation for 22 journalists on key issues in maternal and newborn healthcare. Many of the submissions reported on aspects of the maternal health crisis in Zambia.

seven countries: Ghana, India, Indonesia, Malawi, Nepal, Vietnam, and Zambia. In addition to these networks, WRA is active in 20 countries.

Through advocacy, networks can engage audiences in dialogue regarding various aspects of maternal health. For example, at the national level, goals might focus on allocating resources to implement activities described in safe motherhood implementation plans. At the operational policy level, maternal health networks might work to focus on goals such as establishing training programs for midwives and other medical personnel on ways to handle obstetrical emergencies.

What Are Advocacy Networks?

Supplemental Background Notes

The following examples of national and regional maternal health networks may be drawn on at any time in this section.

- The Regional Prevention of Maternal Mortality (RPMM) Network is an African network of NGOs working to prevent maternal deaths in sub-Saharan Africa. RPMM, founded in 1997, rose out of an operations research program conducted in Africa by Columbia University between 1988 and 1996. Currently, RPMM Network members include groups from 18 countries in sub-Saharan Africa. Five disciplines form the RPMM Network, including community physicians, nurse-midwives, obstetricians, social scientists, and anesthetists. The network's projects focus on interventions that improve the availability, quality, and use of emergency obstetric care. Activities range from improving services at health facilities to improving access to care. Objectives of the network are to (1) disseminate network results and lessons learned through publications, conferences, and seminars; (2) strengthen capacity and expand network approaches to all districts in Ghana, Nigeria, and Sierra Leone; (3) expand and build capacity of national teams in sub-Saharan African countries; and (4) provide technical assistance and consultant services to other NGOs, agencies, and organizations in the field of reproductive health on operations research. The RPMM Network promotes multidisciplinary and multisectoral teamwork. It emphasizes collaboration with local governments, ministries of health, NGOs, traditional leaders, communities, and the private sector to ensure the sustainability of their activities. The network also continues to maintain international partnerships with foreign universities, international agencies, and NGOs.
- In 1999, the network *Pita Putih* was formed in Indonesia, which includes more than 45 NGOs, individuals, and private organizations. The mission of *Pita Putih* is to increase awareness and concern of community members to the gravity of maternal deaths in Indonesia. Their slogan is "Mother is safe, baby is healthy, and the family is healthy." Activities have included media campaigns and events to elicit the support of high-level leaders, including the Minister of Health. *Pita Putih* also raises awareness of safe motherhood on R.A. Kartini Day, dedicated to an Indonesian women's emancipation heroine who fought for girls' education in the early 1900s. R.A. Kartini died as a result of childbirth complications, and the network takes advantage of this occasion to draw the public's attention to the fact that pregnancy and childbirth should not be taken for granted.
- The White Ribbon Alliance for Safe Motherhood of India (WRAI) unites individuals, organizations and communities who are committed towards increasing public awareness on how to prevent maternal mortality and

promote Safe Motherhood. Goals of the White Ribbon Alliance of India are to raise awareness among citizens, international NGOs, national NGOs and governments of the need to ensure safe pregnancy and childbirth; build alliances through wide-ranging, intersectoral partnerships with non-traditional groups, recognizing that a large and united effort is critical to effect change and act as a catalyst for action to address the tragedy of maternal deaths and sustain the current Safe Motherhood effort. Today, the alliance has 52 member organizations.

The WRAI organized the international conference, “Saving Mothers’ Lives: What Works” October 3-6, 2002 where about 500 world renown experts and champions in safe motherhood from 35 nations came together to share best practices. Leading specialists from the United States, United Kingdom, Belgium, Indonesia, India, Egypt, Nepal, Malaysia and Sri Lanka reported on how they have been able to reduce maternal deaths. Participants and special guests including international NGOs, local NGOs, donors, medical professionals, and government representatives participated in the conference. During the conference *Saving Mothers’ Lives: What Works - Best Practices for Safe Motherhood Field Guide* was officially launched by Dr. Dinesh Sarangi, Minister of Health and Family Welfare, Government of Jharkhand.

Modifications to Activities

ACTIVITY 1

Opening Remarks

- No need for changes in your opening remarks. If the workshop is centered on maternal health, that will emerge naturally in the discussion of objectives and participant expectations.

ACTIVITY 2

Introduction to Networks

- The messages in your presentation stay essentially the same. Flavor your remarks with examples of maternal health advocacy networks, or networks that have maternal health as one of their focus areas. Draw on the write-ups of networks contained throughout the module and included in Maternal Health Handouts I.1.1: Examples of Maternal Health Networks and I.1.2: Goals and Objectives of the Nepal Safe Motherhood Network. If such a network already exists for the particular country where you are holding the workshop, be sure to highlight its activities.

ACTIVITY 3

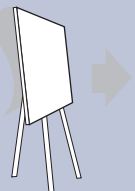
Defining Network

- Proceed as instructed in the manual.

ACTIVITY 4

Mapping Individual Networks

- By this activity, the variety of individuals and organizations working in maternal health should become apparent. This activity will be an opportunity for the facilitator to address issues associated with organizational and occupational diversity (clinicians, community, women’s NGOs, TBAs, educators, etc.). For examples of network



ACTIVITY 5

ACTIVITY 6

ACTIVITY 7

ADDITIONAL HANDOUTS

membership, see Maternal Health Handouts I.1.3: Membership List of an International Network: The White Ribbon Alliance and I.1.4: Membership List of a National Network: Malawi White Ribbon Alliance for Safe Motherhood.

Defining Advocacy

- Proceed as instructed in the manual.

Thinking Ahead

- When small groups present their headlines to the full group, allow individuals whose issues did not make the headline the opportunity to say what they would have written had the decision been left to them. The exercise is a way to illustrate not only the diversity of actors, but also the diversity of issues associated with maternal health.
- Try this twist: Once the group has decided on a successful advocacy result, ask participants to write two different headlines and two different lead paragraphs, one for each of two newspapers from opposing ends of the political spectrum in their country. The dueling headlines would show how differently various segments of society view “progress” in achieving maternal health.

Practical Considerations for Successful Networks

- Proceed as instructed in the manual.
- Maternal Health Handout I.1.1: Examples of Maternal Health Networks
- Maternal Health Handout I.1.2: Goals and Objectives of the Nepal Safe Motherhood Network
- Maternal Health Handout I.1.3: Membership List of an International Network: The White Ribbon Alliance
- Maternal Health Handout I.1.4: Membership List of a National Network: Malawi White Ribbon Alliance for Safe Motherhood

Maternal Health Handout I.1.1

EXAMPLES OF MATERNAL HEALTH NETWORKS

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and governments of the need to ensure safe pregnancy and childbirth; build alliances through wide-ranging, intersectoral partnerships with non-traditional groups, recognizing that a large and united effort is critical to effect change and act as a catalyst for action to address the tragedy of maternal deaths and sustain the current Safe Motherhood effort. Today, the alliance has 52 member organizations.

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Goals and Objectives of the Nepal Safe Motherhood Network

Goal: To improve the status of women by contributing to safe motherhood through advocacy and awareness creation.

Objectives:

1. To sensitize policymakers about the importance of safe motherhood as a priority to ensure adequate government, donor, and private sector resources/services for maternal health.
2. To strengthen commitment, capacity, and coordination between His Majesty's Government (HMG), donors, and NGOs/INGOs for greater effectiveness toward achieving the objectives of the Safe Motherhood Network.
3. To establish and sustain district networks to advocate for safe motherhood and to disseminate safe motherhood messages at the family and community levels.
4. To contribute to the dissemination of standardized messages (using HMG guidelines) at the family and community levels.
5. To positively influence knowledge, attitudes, and behavior (intentions) for improved safe motherhood (pregnancy, delivery, and postpartum care).
6. To manage the finances of the Safe Motherhood Network and raise funds to support network activities.

Maternal Health Handout I.1.3

**MEMBERSHIP LIST OF AN INTERNATIONAL NETWORK:
The White Ribbon Alliance**

United Nations High Commissioner for Refugees, Azerbaijan
 ONG Ocean, Benin
 L'Association Maternité Sans Risques, Burkina Faso
 Cameroon Link Human Assistance Programme
 PNLs/AMPS, Chad
 Shaanxi Provincial People's Hospital, China
 Ministry of Health, Côte d'Ivoire
 Pray Without Ceasing, Tropical Africa Research & Development Centre, Democratic
 Republic of the Congo
 UNICEF, Macedonia
 Divisional Health Team, Gambia
 White Ribbon Alliance c/o ADRA Georgia
 White Ribbon Campaign, Ghana
 Médecin Responsable de la Prise en charge des IST/VIH/SIDA, Guinea
 Hong Kong Polytechnic University, Dept. of Nursing and Health Sciences
 Department of Community Medicine, Mahatma Gandhi Institute of Medical
 Sciences, India
 Gujarat State Crime Prevention Trust
 Geeyes Trust
 MAMTA Health Institute for Mother and Child
 White Ribbon Alliance for Safe Motherhood, India
 Pita Putih, The White Ribbon Alliance of Indonesia
 Japanese Organization for International Cooperation in Family Planning (JOICFP)
 Kiribati's White Ribbon Campaign
 Organization for Student Health Care Services (OSHECS), Liberia
 Malagasy White Ribbon Campaign, Madagascar
 Thunga Community Day Secondary School Girls Club, Malawi
 State Department of Health, Malaysia
 AFESIM-SWAA, Mali
 Maternal and Child Health Research Center, Mongolia
 Aamaa Milan Kendra (The Mothers' Club), Nepal
 Nepal Johns Hopkins University/Population Communications Services, Nepal
 Lalitpur Nursing Campus, Nepal
 Safe Motherhood Network in Nepal
 Child Health Organization (CHO), Nigeria
 Community Life Project, Nigeria
 Ilmata Health Organization, Nigeria
 Lifescope Africa, Nigeria
 Safe Motherhood Action Group (SMAG), Nigeria
 The Adolescent Project (TAP), Nigeria
 Women Action Research Organization, Nigeria
 National Committee for Maternal Health (NCMH), Pakistan
 Safe Motherhood Alliance, Pakistan
 John Snow Research and Training Institute, Inc. (JSI/RTI), Philippines
 Well-Family Midwife Clinic Project/JSI-RTI, Philippines
 Association Twisungane des Seropositifs Voice of America, Rwanda

Association AWA, Senegal
Christian Children's Fund, Inc., Sri Lanka
World Health Organization (WHO), Switzerland
Association de Personnes Vivant avec le VIH/SIDA, Togo
White Ribbon Campaign, Togo
Regional Salus Foundation, Ukraine
White Ribbon Alliance for Safe Motherhood, Vietnam
Al-Sabeen Maternity & Child Hospital, Yemen
Zambia Nurses Association
Zambia White Ribbon Alliance for Safe Motherhood

USA

Academy for Educational Development (AED)
ADVANCE Africa
Adventist Development and Relief Agency (ADRA)
American College of Nurse-Midwives (ACNM)
American International Health Alliance (AIHA)
Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN)
CARE
Catholics for a Free Choice
Centre for Development and Population Activities (CEDPA)
Center for Development Communication
Center for Population and Family Health, Columbia University, Mailman School of Public Health
CORE Group
Department of Nursing, Humboldt State University
Engenderhealth
Family Care International (FCI)
George Washington University
Global Health Council
International Women's Health Coalition
IPAS
John Snow, Inc.
Johns Hopkins University, School of Public Health
La Leche League International
Loma Linda University, School of Public Health, Department of International Health Maternal & Neonatal Health (MNH) Program/JHPIEGO
Maternity Care Coalition
Midwives Alliance of North America (MANA)
Monitoring, Evaluation & Design Support (MEDS)
National Minority AIDS Council
NEKTI
NGO Networks for Health
Pacific Institute for Women's Health (PIWH)
PACT
Pan-American Health Organization (PAHO)
Pan American Sanitary Bureau
Regional Office of the World Health Organization
Pathfinder International
PLAN International USA

Population Reference Bureau
Population Services International
Postpartum Support International
Program for Appropriate Technology in Health (PATH)
Project HOPE
Safe Motherhood Initiative, USA/ICM
Salvation Army
Save the Children, USA
Saving Newborn Lives Initiative
The Manoff Group
U.S. Agency for International Development (USAID)
U.S. Pharmacopeia
United Nations Population Fund (UNFPA)
University of Michigan
University Research Co., LLC
World Bank
World Health Organization

Maternal Health Handout I.1.4

**MEMBERSHIP LIST OF A NATIONAL NETWORK:
Malawi White Ribbon Alliance for Safe Motherhood**

Adventist Health Services
Bowler Beverage Company Limited
DAPP
Ekewendeni CCAP Hospital
MACRO
Malamulo SDA Hospital
MANASO
Manet Plus
NAPHAM
Umoyo Network
Word Alive
Kamuzu College of Nursing
Nurses and Midwives Council
Mudzi wa Ana Orphan Care Project
UNICEF
UNFPA
Save the Children - USA
Lilongwe City Assembly - Health Department
College of Medicine
Family Planning Association of Malawi (FPAM)
National Women's Lobby and Rights Group
Friends of Kawale Health Centre
Information Department

Network Contact Information:

Kumbukani Kintaya, Coordinator
C/O Save the Children Federation - USA
1st Floor - Amina House
P.O. Box 30374
Lilongwe 3, Malawi
Email: mwrasm@sdp.org.mw
Tel/Fax: 265-1-758 312

Effective Communication: Understanding One Another

Supplemental Background Notes

Effective communication among advocates for maternal health relies on essentially the same elements as effective communication among participants in any advocacy network.

Modifications to Activities

ACTIVITY 1

Introduction to Communication

- Emphasize that participants in a maternal health advocacy network likely come from a wide range of institutions, often with divergent views about the causes of and solutions to maternal health issues such as what constitutes skilled care.
- For Activity 1, incorporate information on the importance of communicating in a style that promotes the value of women and mothers as producers in the household and the larger national economy. Emphasize the need for collaboration.

ACTIVITY 2

Effective Communication

- Although not absolutely necessary, you may decide to tailor the role play to a situation in which maternal health advocacy network members are communicating about a difficult issue. Example: Two network members are discussing competing priorities (i.e., resources for family planning commodities versus resources for treating obstetric complications). Role-play ought to illustrate the difference between poor listening skills and effective communication.

ACTIVITY 3

Practicing Communication Skills (Role-playing)

- Try this twist: Alter the second scenario by replacing the “Women’s Health Association” with the “National Midwifery Association.”
- Alternatively, you could ask participants to generate their own role-playing based on potentially difficult situations in a maternal health coalition.

Cooperation Not Competition: Building a Team

Supplemental Background Notes

The exercises in this section are applicable to team building on any kind of issue, including maternal health.

Building Global Alliance Through Cooperation

Advocacy networks are groups of organizations and individuals working together to achieve changes in policy, law, or programs on particular issues. The White Ribbon Alliance (WRA) is an international coalition of organizations formed to promote increased public awareness of the need to make pregnancy and childbirth safe for all women in developing and developed countries. Because the WRA recognizes that the strength of a large and united effort can effect change, the WRA encourages individual countries to form national and local WRA networks. Since the initial launch of the Alliance, seven countries have initiated their own WRAs in collaboration with international and local NGOs and governments. In some countries, multiple organizations conduct activities under the auspices of the WRA. For example, in India six different organizations have worked independently to achieve WRA goals.

The numerous responses of the WRA for Safe Motherhood around the world provide excellent examples of the good work that can be done even in the face of competing interests and controversy. The Alliance raises the awareness of safe motherhood among citizens, international NGOs, government agencies, and community-based organizations in developing countries. These broad-based partnerships address the tragedy of maternal deaths and expand current safe motherhood efforts.

Modifications to Activities

ACTIVITY 1

Introduction to Team-Building

- Proceed as instructed in the manual.

ACTIVITY 2

Broken Squares Exercise

- Proceed as instructed in the manual.

ACTIVITY 3

Behaviors that Contribute to Team Success

- Proceed as instructed in the manual.

ACTIVITY 4

Stages of Team Growth

- Proceed as instructed in the manual.

ADDITIONAL HANDOUT

Maternal Health Handout I.3.1: Building Global Alliance Through Cooperation

Maternal Health Handout I.3.1

Building Global Alliance Through Cooperation

Advocacy networks are groups of organizations and individuals working together to achieve changes in policy, law, or programs on particular issues. The White Ribbon Alliance (WRA) is an international coalition of organizations formed to promote increased public awareness of the need to make pregnancy and childbirth safe for all women in developing and developed countries. Because the WRA recognizes that the strength of a large and united effort can effect change, the WRA encourages individual countries to form national and local WRA networks. Since the initial launch of the alliance, seven countries have initiated their own WRAs in collaboration with international and local NGOs and governments. In some countries, multiple organizations conduct activities under the auspices of the WRA. For example, in India six different organizations have worked independently to achieve WRA goals.

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Decision Making: Reaching Group Consensus

Supplemental Background Notes

The same general principles apply equally to decision making within networks advocating for maternal health.

Modifications to Activities

ACTIVITY 1

Introduction to Decision Making

- Proceed as instructed in the manual.

ACTIVITY 2

Exercise on Group Decision Making

- Proceed as instructed in the manual using the following scenarios:

Scenario 1

You are members of the executive management committee of a health clinic. You must weigh the value-added of community interventions versus clinical interventions. Resources can either be allocated to support a community outreach program providing antenatal care or provide a local clinic with iron supplements, vitamins, malaria prophylaxis, and folic acid.

Task: Discuss why you would support one cause and not the other, and reach a decision on which cause to support.

Scenario 2

Network members serve on a policy advisory group for the Ministry of Health. The group has been asked to help the Ministry of Health set priorities for health interventions for the coming year. Since funding has been cut, the ministry must decide whether to provide additional staff to the district-referral hospitals to provide 24-hour care or create blood banks in these hospitals.

Task: Prepare your recommendation to the Ministry of Health.

Scenario 3

Your advocacy network is asked to help develop a better maternal mortality surveillance system. The group knows that maternal deaths in the district hospital are often misreported or under-reported.

Task: Discuss the situation and prepare a recommendation for the hospital board on the best ways to improve the surveillance system.

- Maternal Health Handout I.4.1: Group Decision Making Exercise

ADDITIONAL HANDOUT

Group Decision Making Exercise

Scenario 1

You are members of the executive management committee of a health clinic. You must weigh the value-added of community interventions versus clinical interventions. Resources can either be allocated to support a community outreach program providing antenatal care or provide a local clinic with iron supplements, vitamins, malaria prophylaxis, and folic acid.

Task: Discuss why you would support one cause and not the other, and reach a decision on which cause to support.

Scenario 2

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Mission Statements: Creating a Common Purpose

Supplemental Background Notes

For many reproductive health networks, advocacy for maternal health may be just one facet of a broader advocacy effort. Thus, a mission statement for the network may not mention maternal health specifically.

Modifications to Activities

What is a Mission Statement?

- Proceed as instructed in the manual.

Characteristics of Good Mission Statements

- Proceed as instructed in the manual.

Writing a Mission Statement for the Network

- Proceed as instructed in the manual.

Creating a Network Identity: Name and Logo

- Proceed as instructed in the manual.
- Maternal Health Handout I.5.1: Examples of Mission Statements of Maternal Health Organizations
- Maternal Health Handout I.5.2: Examples of Logos of Maternal Health Networks

ACTIVITY 1

ACTIVITY 2

ACTIVITY 3

ACTIVITY 4

ADDITIONAL
HANDOUTS

Maternal Health Handout I.5.1

Examples of Mission Statements of Maternal Health Organizations

- “To advance worldwide the aims and aspirations of midwives in the attainment of improved outcomes for women in their childbearing years, their newborn and their families, wherever they reside.”

-International Confederation of Midwives
<http://www.internationalmidwives.org>
- “Safe Motherhood is a global effort to increase maternal safety and reduce the number of deaths and illnesses associated with pregnancy and childbirth.”

-Safe Motherhood Initiative
<http://www.safemotherhood.org>
- “To mobilize the obstetric and gynecological community in developed and developing countries to work in partnership to demonstrate the most cost-effective way to save mothers’ lives.”

-Save the Mothers Initiative
<http://www.figo.org/sav-moth.asp>
- “To promote increased public awareness of the need to make pregnancy and childbirth safe for all women-in developing as well as developed countries.”

-White Ribbon Alliance
<http://www.whiteribbonalliance.org>
- “Networks’ vision is to empower and enable individuals, families, and communities to improve their health. Networks pursues its vision by creating innovative and enduring NGO partnerships and fostering and supporting networks that enhance the scale and quality of FP/RH/CS/HIV programs.”

-NGO Networks for Health
<http://www.ngonetworks.org>
- “To increase access and reduce barriers to quality health services, especially family planning and maternal and neonatal care, for all members of their society.”

-JHIEPGO Corporation
<http://www.jhpiego.org>

Maternal Health Handout I.5.2

Examples of Logos of Maternal Health Networks



Putting It All Together: Managing the Network

Supplemental Background Notes

Maternal health advocacy networks face the same management concerns as other types of networks.

Modifications to Activities

ACTIVITY 1

Introduction to Managing the Network

- Proceed as instructed in the manual.

ACTIVITY 2

Resource Inventory

- Proceed as instructed in the manual.

ACTIVITY 3

Network Organization and Structure

- Proceed as instructed in the manual.

ACTIVITY 4

Follow-Up Meeting

- Proceed as instructed in the manual.

ADDITIONAL HANDOUT

- Maternal Health Handout I.6.1: Organizational Structure for a Maternal Health-focused Advocacy Network

Organizational Structure for a Maternal Health-focused Advocacy Network

World Alliance for Breastfeeding Action (WABA)

(<http://www.waba.org.br/wwaba.htm>)

Goals

- Re-establish and maintain a global breastfeeding culture
- Eliminate all obstacles to breastfeeding
- Promote more regional and national-level cooperation
- Advocate for breastfeeding in development, women's, and environmental programs

Structure

WABA is an umbrella organization that encompasses all working at the international, regional, national, and community levels to protect, promote, and support breastfeeding. Everyone who is committed to a breastfeeding culture can be part of WABA: NGOs, community activists, health care workers, professional associations, university teaching staff, researchers, health officials, and others.

WABA Secretariat

WABA's work consists of the activities of the Secretariat and its seven Task Forces. The Secretariat coordinates and maintains the flow of information between Task Forces and the wider constituency of WABA. Its small office serves mainly to network and facilitate action in support of World Breastfeeding Week in the first week of August.

WABA General Assembly

The WABA General Assembly consists of the following:

- **Steering Committee:** The Steering Committee is the principal management and policymaking body of WABA.
- **Regional Focal Points:** The role of the Regional Focal Points is to facilitate information support, translation, and dissemination of materials, advocacy, co-ordination of World Breastfeeding Week and the Glopar. Regional Focal Points serve as WABA's Social Mobilization and Information Task Force. Regional Focal Points are also linked with the UNICEF and WHO regional offices.
- **Task Force Coordinators and Co-Coordinators**
- **Advisory Council**

The WABA General Assembly plays a larger role in policymaking and has the right to vote on Steering Committee members.

ACTORS, ISSUES, AND OPPORTUNITIES: ASSESSING THE POLICY ENVIRONMENT

“While developing countries need policies, they also must have the will to implement them. They need money, other resources, and operational policies to make implementation possible.”

Cross et al., 2001

Supplemental Introductory Material

Safe motherhood is not considered a priority in many settings, and too often high-level officials do not believe that maternal health is a serious social and economic problem for their countries. Lack of action may be due to diversion of resources to other equally urgent public health problems, such as malaria, HIV/AIDS, or tuberculosis. High-level support is critical in order to improve the policy environment for maternal health.

Most developing countries now have some national family planning/reproductive health law, policy, or strategy. In some cases, safe motherhood is included as a component of the broader reproductive health policy. Where countries have not addressed safe motherhood explicitly, a comprehensive stand alone policy and program is an important step. Such a mechanism will facilitate program coordination and help eliminate inconsistencies in programs or policies.

Where maternal health laws and policies do exist, they are often fragmented, and operational barriers may impede the implementation of a national policy or plan. For example, regulatory barriers may exist for midwives. These barriers, such as skilled attendants not being able to suture vaginal tears after delivery (even though they can suture episiotomies), can cost women their lives or result in debilitating injuries. Lifting these barriers and allowing trained midwives to perform such procedures not only requires a change in policy but also requires advocates to bring such discrepancies to the attention of decision makers. To ensure country standards are updated with current scientific information on maternal and reproductive health, some international communities have recognized the need to promote the development of not only safe motherhood but also overall reproductive health guidelines.

Streamlining Reproductive Health Protocols

A survey in Ghana found more than 15 different sets of guidelines, standards, or protocols for reproductive health. The standards were hard to enforce or may even have been contradictory. This information was used to persuade the Ministry of Health to develop a revised and comprehensive set of Reproductive Health Service and Policy Standards.

The Policy Process: Government in Action

Supplemental Background Notes

Draw on the supplemental introductory notes for Section II above.

Modifications to Activities

ACTIVITY 1

Introduction to the Policy Process

- In essence, the policy process is the same for maternal health as for other areas of reproductive health.
- Discuss the question of *When is a policy a maternal health policy?*

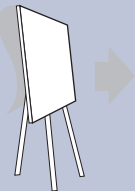
ACTIVITY 2

How Policy is Made

- The guest speaker should be familiar with policymaking for maternal health, in addition to the general policymaking climate in his/her country.
- Under “Examples of Policies,” supplement with policies provided in the box below.

Examples of Maternal Health Policies

- ✓ National Safe Motherhood Policy
- ✓ Minimum of eight years of formal education
- ✓ Minimum age at marriage
- ✓ Policy providing midwives autonomy in managing third stage of labor



ACTIVITY 3

Mapping the Policy Process

- Consider expanding on the current version of the exercise, which is a national-level policy process map, and base it on real examples.
- Maternal Health Handout II.1.1: Types of Maternal Health Policies
- Maternal Health Handout II.1.2: Historical Context of Safe Motherhood
- Maternal Health Handout II.1.3: Key Language from International Agreements Related to Maternal Health

ADDITIONAL HANDOUTS

Maternal Health Handout II.1.1

Types of Maternal Health Policies

Maternal health issues have been included in the following types of national-level policies:

- National Policy on Safe Motherhood
- National Population Policy
- National Women's Policy
- National Health Policy
- National Plan of Action on Population and Development
- National Reproductive Health Strategy

Maternal Health Handout II.1.2

Historical Context of Safe Motherhood

The launch of the *Safe Motherhood Initiative (SMI)* in 1987 marked a shift in the strategic focus of how maternal and child health (MCH) and family planning programs were formulated and implemented. To achieve a reduction in maternal mortality, the SMI emphasized a new, multipronged approach that included recognition of the importance of improving the status of women. Many national programs set new targets of achievement based on the international goal of reducing the number of deaths by 50 percent within a decade. In many countries, the process of organizing the SMI at the country level took time.

The *Programme of Action (POA)*, resulting from the 1994 International Conference on Population and Development (ICPD), shifted the basis for maternal health programs. Safe motherhood is one of the services defined in the POA. At the country level, the POA spurred a proliferation of working groups, task forces, and national meetings all aimed at transforming traditional MCH and family planning programs into real reproductive efforts. Unfortunately, many countries never emerged from the policy planning stage or the discussion of how to implement the agenda. One year after ICPD, in 1995, the United Nations held the Fourth World Conference on Women in Beijing. Participants reinforced the broader approach to reproductive health endorsed at the ICPD, incorporating human rights related to women and female children into its *Platform for Action*.

Yet another policy shift occurred in 1997 with the Technical Consultation on Safe Motherhood held in Colombo, Sri Lanka. The Colombo delegates agreed on 10 “action messages,” some diverging significantly from both the earlier SMI and ICPD while others supported existing policy approaches.¹ The POA messages were articulated under two headings: changing the political environment of women’s health and empowerment issues, and redesigning and implementing programs. These shifts left countries in a reactive mode with respect to international debates, discouraging them from acting on their own national policies and priorities for maternal health. Additionally, the translation into action at the national level is time-consuming and difficult.

Adapted from Regional Technical Assistance Project 5825, *Strengthening Safe Motherhood Programs Final Report*. 2002. Submitted to Asian Development Bank by the Futures Group International.

¹For example, risk screening during antenatal care and large-scale training of TBAs were recommended strategies in 1987. In 1997, the focus had shifted towards ensuring skilled attendance at birth.

Maternal Health Handout II.1.3

Key Language from International Agreements Related to Maternal Health

This table provides references to paragraphs and sections of international agreements related to each of the main topics highlighted on the left. Blank boxes indicate that there is no language on the topic in the specified agreement.

	Convention of the Elimination of Discrimination against Women (CEDAW)	Convention of the Rights of the Child (CRC)	Declaration on the Elimination of Violence Against Women (DEVAW)	World Conference on Human Rights (WCHR), Vienna, Austria	International Conference on Population and Development (ICPD), Cairo, Egypt	Fourth World Conference on Women, (FWCW), Beijing, China	World Summit on Social Development (WSSD), Copenhagen, Denmark
	1979	1989	1993	1993	1994	1995	1995
International Commitment to Safe Motherhood							
Develop a comprehensive national strategy	12.1				1.12, 7.2, 7.4, 7.5(a), 7.6, 8.3(a), 8.5, 8.8	PI106 (e,i)	
Establish or strengthen integrated safe motherhood programs	12.2, 14.2(b)				7.24, 8.8, 8.17, 8.18, 8.21, 8.22, 8.23, 8.25, 8.26, 13.14	PI106 (l,k) 108(l)	DC 6(p) Pr 36(d)

Key: PL = Platform; PR = Programme; D =Declaration; DC = Declaration Commitment

For more information on these commitments and for specific document language please see the following websites:

- Convention of the Elimination of Discrimination Against Women: <http://www.un.org/womenwatch/daw/cedaw/>
- Convention of the Rights of the Child: <http://www.unicef.org/crc/>
- Declaration on the Elimination of Violence Against Women: [http://193.194.138.190/huridocda/huridoca.nsf/\(Symbol\)/A.RES.48.104.En?Opendocument](http://193.194.138.190/huridocda/huridoca.nsf/(Symbol)/A.RES.48.104.En?Opendocument)
- World Conference on Human Rights: <http://193.194.138.190/html/menu5/wchr.htm>
- International Conference on Population and Development: <http://www.unfpa.org/icpd/>
- Fourth World Conference on Women: <http://www.un.org/womenwatch/daw/beijing/official.htm>
- World Summit on Social Development: <http://www.un.org/esa/socdev/wssd/>

SECTION II UNIT 1

II. ACTORS, ISSUES, AND OPPORTUNITIES

1. THE POLICY PROCESS

	CEDAW	CRC	DEVAW	WCHR	ICPD	FWCW	WSSD
Advance Safe Motherhood through Human Rights							
Recognize the right of women to control all aspects of their health including fertility					Principle 4	D 17 PI92, 97	
Reform laws and institutions to enable men and women, on the basis of equality, to take responsibility for and exercise their reproductive rights	2(f), 12.1, 16.1(e)				4.4 (c), 7.36(b)	PI 107(d)	DC 1(a), 73(e)
Eliminate discrimination against women on the grounds of motherhood	2(a), 11.1(f), 11.2 (intro. a)				4.4(f)	PI 29, 165(c)	
Safe guard the rights of adolescents		16.1, 16.2			6.15, 7.45	107(e)	
Protect women, youth and children from all forms of violence and abuse	6	19.1, 34, 35, 36	4(intro. c,f)	D 18 Pr48, 49	Principle 11, 4.4 (e), 4.9, 4.23, 6.9, 6.10, 7.39, 10.16(c), 10.18	PI 107(q), 113(a), 115, 130(e), 230 (m,n), 283 (b,d)	DC 5(h) Pr 17(b), 39(d), 79(b)
	CEDAW	CRC	DEVAW	WCHR	ICPD	FWCW	WSSD
Empower Women, Ensure Choices							
Ensure the equitable representation of men and women in all sectors and levels of national and international policymaking and implementation	7(b)			D 18 Pr 43	3.18, 4.3(b), 4.4(a), 4.8, 7.7, 13.9(a), 13.18, 15.19	PI 5, 107(l), 109(c), 311	D 7, 26(e), C 5(a,b) Pr 14 (i), 73(d)
Promote equal partnerships between men and women	Preambl e 5(a), 11.2 (c)	18.3			4.1, 4.11, 4.13, 4.24- 29, 5.3, 5.9	PI 107(c), 173(g), 170 (c,d), 180(b), 192(e), 274(c)	D5(a,g) Pr 7, 56(d,e) 81(d)

SECTION II UNIT 1

II. ACTORS, ISSUES, AND OPPORTUNITIES

1. THE POLICY PROCESS

	CEDAW	CRC	DEVAW	WCHR	ICPD	FWCW	WSSD
Guarantee Access to High-Quality Maternal Health Services							
Remove barriers to women's access to health services	12.1				Principle 8, 1.11, 3.18, 5.5, 6.7(b), 6.25, 6.30, 7.6, 7.19, 8.31, 8.6, 9.22, 10.11, 13.22	PI 106 (c)	Pr 7, 70, 73
Strengthen and increase government investments in infrastructure and transportation					13.14(a), 3.15	PI 106 (e,i,y), 110(a)	Pr 25, 27(b), 34(c)
Decentralize sexual and reproductive health services					7.9, 7.26, 9.4	PI 106 (c,g), 110 (c)	14(d), 72(c)
Ensure services conform to human rights, ethical and professional standards					6.24,(a, b), 7.5(a), 7.12, 7.14(c), 7.17, 7.21, 7.23(a-g), 7.45, 11.21,12.1 9, 13.9(a)	106 (e,f,u), 107(p)	
	CEDAW	CRC	DEVAW	WCHR	ICPD	FWCW	WSSD
Delay Marriage and First Birth							
Eliminate early and child marriages	16.2				4.21, 5.5, 6.11	107(a), 274(e), 277(d)	
Keep girls and adolescents in school					11.8		
Provide education and counseling to delay premature sexual activity and first pregnancy		17, 8.24			6.7(b), 7.3, 7.41, 7.44(a,b), 7.45, 7.47	83(k,l), 107(g), 108(k), 267	DC 6(l)

	CEDAW	CRC	DEVAW	WCHR	ICPD	FWCW	WSSD
Address Unwanted Pregnancy and Unsafe Abortion							
Assign high priority to preventing unwanted pregnancy and reducing need for abortion					8.25	PI106 (k)	
Remove all barriers to family planning	12.1				7.2, 7.4, 7.6, 7.14(a), 7.16, 7.19, 7.20	PI106 (e,i)	Pr36 (h)
Link family planning programs to reproductive health programs					7.6, 7.16, 8.8		
Ensure FP services support voluntary informed choice and consent					7.6, 7.12, 7.15, 7.17, 7.23(a,b,c, f,h), 7.30, 7.32, 7.33, 7.41, Principle 8, 8.17, 8.18, 8.25, 8.31, 8.35	PI 97, 106(g,h, k,u,r), 108(m)	
Develop policies and programs in terms of unmet need					Principle 8, 6.4, 6.25, 7.12, 7.16, 7.22		
	CEDAW	CRC	DEVAW	WCHR	ICPD	FWCW	WSSD
Measure Progress							
Monitor the achievement of goals and targets cited in international commitments					4.8, 12.4, 12.7	PI 110(e), 111(c), 296	Pr 29(b), 83(g,j)
Develop national monitoring systems to assess progress in reducing maternal mortality					8.22	PI 109 (d)	
Establish quantitative and qualitative database to meet research and policy needs					4.8, 7.23(g), 12.3-12.5, 12.7, 12.13, 12.20(b)	PI 109(g), 206(i), 289, 295	Pr 16(e), 29(a), 86(f)

Decision Making for Reproductive Health: Analyzing the Policy Climate

Supplemental Background Notes

The Maternal and Neonatal Program Effort Index (MNPI) is a tool that reproductive health care advocates, providers, and program planners can use to assess maternal health program features and create a baseline to track progress over time. The index rates program inputs and services, political and popular support, and assesses the magnitude of efforts devoted to the reduction of maternal mortality and morbidity and closely related neonatal items. The index is designed to assess only the inputs, process, and outputs as they relate to the “supply” or program side of the conceptual framework. It does not measure the social/cultural or individual context nor does it measure the outcomes.

The MNPI was developed by the Futures Group International to help those involved with maternal and neonatal issues gain an initial understanding of cross-national indicators of service adequacy and sufficiency of associated program elements. This tool relies on expert judgments and is intended to serve as a diagnostic tool, to identify strengths and weaknesses in a program; as a planning tool, to indicate where and how program effort should be concentrated; and as a research tool, to provide insights into contrasts between countries and relationships between types of services and health outcomes. This section can use information from the MNPI to generate a discussion on policy issues surrounding maternal health.

MNPI Illustrative Indicators

In the context of a true application of the MNPI, a number of key informants would complete a detailed questionnaire about the status of maternal health policies and programs at the national level in their country. When time and resources permit, this may be a viable option for advocacy networks interested in a detailed analysis of the policy environment for maternal health. However, in many cases, the time and resources are not available, and network members could then look at the questions and indicators in order to guide their thinking about the policy environment, even if an MNPI application is not feasible.

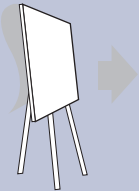
The MNPI includes questions drawn from 13 categories:

- Health center capacity
- District hospital capacity
- Access to services
- Antenatal care
- Delivery care
- Newborn care
- Family planning services at health centers
- Family planning services at district hospitals
- Policies toward safe pregnancy and delivery
- Adequacy of resources
- Health promotion
- Staff training
- Monitoring and research

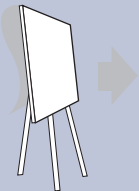
There are also less formal but equally informative ways to understand the policy environment for maternal health at the national level. For example, advocates can try to collect information on whether high-level government officials have attended international meetings on safe motherhood issues. Advocates could also look at media coverage of safe motherhood in their country to get a sense of the media's ability to report accurately on the issues and generate community support for safe motherhood programs. It may be useful to have network members brainstorm on the availability of different information sources as they start the process of analyzing the policy environment.

Modifications to Activities

ACTIVITY 1



ACTIVITY 2



ACTIVITY 3

ADDITIONAL HANDOUTS

The Reproductive Health Policy Process

- Using the framework of the existing exercise, the facilitator should focus introductory remarks on maternal health, perhaps provide a few examples of the climate for maternal health policy in a variety of countries. See Maternal Health Handout II.2.1: Malaysia: A Maternal Health Success Story.
- In small group work, be sure to tailor the questions to maternal health. Perhaps add a question, “What are the characteristics of setting maternal health policy that differentiates it from making broader RH policy?”

Mapping the Reproductive Health Policy Process

- Adapt the “possible RH policy issues” to be specific to maternal health. Rather than focusing on RH issues broadly, focus on producing a consensus maternal health-specific policy map by the end of the session. Using the MNPI as a springboard, identify several issues for this small group exercise.

Reproductive Health Issues in the News

- Modify this exercise by focusing on maternal health issues. Make sure that, in addition to asking about the 1994 ICPD, the participant playing the role of journalist also inquires about the government's involvement in more recent international safe motherhood conferences such as the 1997 Technical Consultation on Safe Motherhood in Colombo, Sri Lanka.
- Maternal Health Handout II.2.1: Malaysia: A Maternal Health Success Story
- Maternal Health Handout II.2.2: Indicators for Measuring Maternal Health
- Maternal Health Handout II.2.3: Maternal and Neonatal Program Effort Index
- Maternal Health Handout II.2.4: Additional Readings for Assessing the Policy Environment

Maternal Health Handout II.2.1

Malaysia: A Maternal Health Success Story

Excerpt from World Bank. 1999. *Safe Motherhood and The World Bank: Lessons From 10 Years of Experience*. World Bank, Washington, D.C.: World Bank.

Until the 1970s, most Malaysian women delivered at home, assisted by untrained traditional birth attendants. Maternal mortality ratios were high. By 1996, childbirth practices had changed dramatically, with more than 95 percent of Malaysian women using prenatal care. Of the 98 percent of women who delivered with a skilled attendant in 1995 (compared to 57 percent in 1980), 66 percent delivered in government hospitals, 20 percent in private hospitals or maternity homes, and 12 percent at home. By 1996, the maternal mortality ratio had dropped to 43 out of 100,000 live births. What accounts for these changes?

Two factors at the policy level were especially important:

- Sustained political commitment over four decades aimed at increasing the acceptability of publicly provided health services for the rural poor, and at improving access to those services.
- Investments in primary education and primary health care received high priority within a generally buoyant economy.

In the health sector, evolution has been steady, though gradual:

Clinical midwives conduct home deliveries. The backbone of the rural health services is a strong network of government rural midwives supervised by public health nurses. Rural midwives have 18 months of clinical midwifery training, and public health nurses have five years of training in nursing, clinical midwifery, and public health. Attention during the 1960s and 1970s focused on establishing this network. The push for more rural doctors came only in the mid-1980s.

Communities now prefer clinical midwives. In the 1970s, literate traditional birth attendants were registered and trained in basic clean and safe practices. The relationship between traditional birth attendants and rural midwives evolved gradually, from early days of suspicion to a collaborative system in which birth attendants worked alongside rural midwives. Today, the traditional birth attendants have almost disappeared.

District maternal and child health committees use adverse obstetric events to mobilize and educate communities. Since the 1980s, the district maternal and child health committees, headed by a district hospital-based obstetrician and anchored by the district public health nurse, have investigated every adverse event, including maternal and perinatal death, eclampsia, and puerperal sepsis. Contributing factors to these events, such as delays in seeking appropriate care or referral, are explained to rural midwives, community leaders, and family members to educate them about the importance of appropriate treatment.

Care systems placed joint responsibility on the district hospital and rural health service to prevent maternal deaths. Village health committees listened when the hospital-based obstetrician visited to explain how an untoward event could have been prevented.

Every maternal death is reviewed. Hospital practices have changed to become more user-friendly. Nurse midwives oversee normal pregnancies and conduct normal deliveries, allowing doctors to focus on complications. Obstetric practices are regularly updated, and early warning systems are continually strengthened.

Maternal Health Handout II.2.2

Indicators for Measuring Maternal Health

Policy-specific Indicators

1. Existence of a safe motherhood strategic or operational plan to promote access and/or quality of safe motherhood services
2. Maternal and neonatal program effort index

Service Delivery Indicators

1. Number of facilities per 500,000 providing essential obstetric functions
2. Percent of facilities that conduct case review/audits into maternal death/near miss
3. Percent of pregnant women attending antenatal clinics screened for syphilis
4. Percent of women with obstetrical complications treated within two hours at a health facility
5. Cesarean sections as a percent of all live births
6. Case fatality rate-all complications
7. Percent of audience that know three primary warning/danger signs of obstetric complications
8. Percent of women who attended at least once during pregnancy for reasons related to the pregnancy
9. Percent of women who were given or purchased malaria prophylaxis treatment during their most recent pregnancy
10. Percent of pregnant women who receive antihelminthic treatment during pregnancy
11. Percent of births attended by skilled health personnel
12. Percent of women attended during the postpartum period by skilled personnel
13. Maternal mortality ratio
14. Met need for essential obstetric care (EOC)

“These indicators are intended mainly for use at the national level or in the context of large scale programs. However, many can serve in a much wider monitoring and evaluation context...Not all indicators included [here] are equally strong or provide the same quality of information. Certain indicators are included because of the potential importance of the information, even though the feasibility of collecting valid information at the national level may be low...In addition, the program level indicators are included because they are now used rather widely, and they provide useful information about local planning and decision-making. However, several are clearly not intended for national level use” (Bertrand and Escudero, 2002).

Source: Bertrand, Jane and Gabriela Escudero. 2002. *Compendium of Indicators for Evaluating Reproductive Health Programs*. Measure Evaluation Manual Series No. 6.

Maternal Health Handout II.2.3

Maternal and Neonatal Program Effort Index

The Maternal and Neonatal Program Effort Index (MNPI) is a tool that reproductive health care advocates, providers, and program planners can use to assess maternal health program features and create a baseline to track progress over time. The index rates program inputs and services, political and popular support, and assesses the magnitude of efforts devoted to the reduction of maternal mortality and morbidity and closely related neonatal items. The index is designed to assess only the inputs, process, and outputs as they relate to the “supply” or program side of the conceptual framework. It does not measure the social/cultural or individual context nor does it measure the outcomes.

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The MNPI includes questions drawn from 13 categories:

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- District hospital capacity
- Access to services
- Antenatal care
- Delivery care
- Newborn care
- Family planning services at health centers
- Family planning services at district hospitals
- Policies toward safe pregnancy and delivery
- Adequacy of resources
- Health promotion
- Staff training
- Monitoring and research

Below are selected questions from each topic within the MNPI that can be used to analyze the policy environment.¹

Political Support

- Do high-level figures in the government publicly support safe motherhood policies and programs?
- Do key religious figures publicly support maternal health programs?
- What about private sector leaders, government planning officials, and NGO leaders?

Policy Formulation

- Is there a national coordinating body to guide the maternal health programs? Does it have the power to coordinate or are there in reality numerous and disconnected programs?
- Are the public and private sectors collaborating on the safe motherhood policies and goals?
- Is there consultation with interested parties, such as NGOs, professional associations, private practitioners, and women's groups?
- Are there national safe motherhood standards and guidelines (these standards may be imbedded in reproductive health standards)? If so, are the policies and standards vigorously implemented through regular high-level reviews and updated?
- Are programs managed out of the Ministry of Health, or are other ministries involved?
- Does maternal health or safe motherhood have a position within the Ministry of Health commensurate with other areas of reproductive health? For example, if there are separate divisions for child health and family planning, is there a division for maternal health?

Laws and Regulations

- Are the laws and regulations updated to allow midwives to provide services needed to save women's lives (provision of antibiotics, life-saving procedures)?
- Do adequate laws and policies exist toward the treatment of complications of abortions, including complications seen from illegal abortions?
- Is female genital cutting/mutilation illegal?

Program Resources

- Do guidelines and priorities exist for resource allocation?
- Is the current funding mechanism flexible enough to support new programs?
- Does the program have technically competent, dedicated staff, and are there enough information resources available to them?

¹These questions are modified from the actual MNPI questionnaire and are not intended to replace the MNPI application. They can be used as a starting point for analyzing the policy environment.

- Does the funding for safe motherhood programs come from the Ministry of Health, the private sector, international organizations, or NGOs, and what is the level of support offered by each entity?

Program Components

- Do all health centers have trained staff in place who can provide basic comprehensive obstetric care as well as family planning services?
- Does health center staff have transport to quickly move a woman with obstructed labor, or other emergencies requiring surgery, to a district hospital?
- Do all first referral facilities (district hospitals) have trained staff who can manage obstetric emergencies?
- Do the health centers and hospitals have adequate supplies and equipment to allow providers to give quality care for pregnancy and childbirth?
- Is 24-hour care provided at health centers and district hospitals?

Research and Evaluation

- Is there an established process for the evaluation of maternal health programs?
- Are evaluation results incorporated into the policy process?
- Are special studies undertaken, as needed, to improve the program?

Maternal Health Handout II.2.4

Additional Readings for Assessing the Maternal Health Policy Environment

Berer, M. and T.K. S. Ravindran (eds). 2000. *Safe Motherhood Initiatives: Critical Issues*. Published by Blackwell Science Ltd. for Reproductive Health Matters.

Koblinsky, Marge, Katie McLaurin, Pauline Russell-Brown, and Pamina Gorbach. 1995. "Indicators for Reproductive Health Program Evaluation: Final Report of the Subcommittee on Safe Pregnancy." The EVALUATION Project.

Maine, Deborah, Murat Z. Akalin, Victoria M. Ward, and Angela Kamara. 1997. *The Design and Evaluation of Maternal Health Programs*. New York: Columbia University, Center for Population and Family Health.

Maine, Deborah. 1991. *Safe Motherhood Programs: Options and Issues*. New York: Columbia University, Center for Population and Family Health.

Policy Project. 2002. *What Works: A Policy and Program Guide to the Evidence on Family Planning, Safe Motherhood and STI/HIV/AIDS Interventions, Module 1: Safe Motherhood*. Washington, D.C.: The Futures Group International.

Regional Technical Assistance 5825, Strengthening Safe Motherhood Programs Final Report. 2002. Prepared for the Asian Development Bank by The Futures Group International.

UNICEF, WHO, AND UNFPA. 1997. *Guidelines for Monitoring the Availability and Use of Obstetric Services*. New York: UNICEF.

Women of the World Series: Laws and Policies Affecting Their Reproductive Lives.

Available for: East and Central Europe, Latin American and Caribbean, and Francophone Africa, Anglophone Africa. Edited by The Center for Reproductive Rights (formerly known as The Center for Reproductive Law and Policy).

World Health Organization. 1997. "Coverage of Maternal Care: A Listing of Available Information, Fourth Edition." Geneva: WHO.

Prioritizing Policy Issues: Making the Best Matches

Supplemental Background Notes

The trainer need not make any modifications to the exercises in this unit, except to refer to the examples of maternal health policy issues previously discussed.

Modifications to Activities

ACTIVITY 1

Introduction

- Proceed as instructed in the manual.

ACTIVITY 2

Prioritizing Reproductive Health Issues

- Proceed as instructed in the manual.

ACTIVITY 3

Matching Issues and Opportunities

- Proceed as instructed in the manual.

THE ADVOCACY STRATEGY: MOBILIZING FOR ACTION

“Maternal and child health is at the root of the vicious cycle of poverty that restrains our communities from realizing their potential. We must never forget that women are the backbones of our communities and that our children are our future.”

Fred Sai,
President of the Ghana Institute of Arts and Sciences

Supplemental Introductory Material

A challenge facing any network is “to mobilize and sustain the energy and commitment necessary to make safe motherhood a top priority and ensure that the necessary resources are dedicated to this effort” (WRA, 2000). In addition, an artful advocacy campaign that is well thought out and compelling will have a much bigger impact than fragmented, uncoordinated efforts.

What Is Advocacy?

Supplemental Background Notes

Within the maternal health arena, advocacy networks might choose to focus on national-level efforts, such as development of a national safe motherhood policy, or community-based efforts, such as creation of an emergency transport mechanism in a rural village.

In India, the White Ribbon Alliance’s advocacy activities included art contests, micro-loan funds for women, seminar camps, rallies, and films focusing on safe motherhood to coincide with the International Women’s Day. Television spots on safe motherhood, supported by UNFPA, were aired. More than 200 representatives of the press attended a media conference. A panel of representatives from the MOH, WHO, UNICEF, UNFPA, the Federation of Ob-Gyns, and others presented information on key actions to achieve safe motherhood.

Modifications to Activities

What Is Advocacy?

- Invite an expert speaker who has knowledge of maternal health issues to present information on advocacy efforts in the given country. This person could be a community member, midwife, or other practitioner, or member of an NGO working in maternal health. You could also invite an activist with experience lobbying the government on maternal health issues. Make sure the speaker you invite is familiar with maternal health advocacy and clearly describes what makes advocating for maternal health different from advocating for other reproductive health issues.

The Adolescent Project (TAP) in Nigeria integrated White Ribbon Alliance activities into a campaign to raise awareness, change current policy on adolescent reproductive health, ensure adolescent sensitive legislation, and, in the long run, reduce maternal and infant mortality. The campaign, “Childbearing is a gift: dying is not the price,” organized a float parade with the theme of safe motherhood. The governor was decorated with the white ribbon on International Women’s Day, and community members wore traditional green scarves to symbolize safe motherhood. Members visited the island of Bonny where his Royal Highness, The King of Bonny, pledged his support and stated, “Everything done in Bonny is always a success and this campaign will also be a success.”

Defining Advocacy

- Proceed as instructed in the manual.

Steps in the Advocacy Process

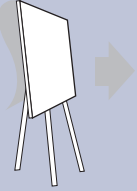
- Proceed as instructed in the manual.

ACTIVITY 1

ACTIVITY 2

ACTIVITY 3

ACTIVITY 4



Advocacy and Related Concepts

- Proceed as instructed in the manual. Give one maternal health-specific example of the difference between maternal health advocacy and the other concepts presented (IEC, PR, Community Mobilization).

Issues, Goals, and Objectives: Building the Foundation

Supplemental Background Notes

This unit should be approached with special attention to the concerns of pregnant women and their families in determining long-term goals versus short-term objectives. Consider the national, subnational, and community-level policy environment for maternal health.

Modifications to Activities

Key FP/RH Issues

- Proceed as instructed in the manual, replacing the definition of reproductive health with the six pillars of safe motherhood.

Developing an Advocacy Goal

- Proceed as instructed in the manual, drawing on the maternal health-specific examples listed below of the difference between an issue, goal, and objective.

Example 1:

Advocacy Issue: Prevention of malaria during pregnancy.

Advocacy Goal: Sulfadoxine-pyrimethamine (SP) available to all pregnant women seeking antenatal care and delivery services at public hospitals.

Advocacy Objective: By 2005, secure funding from the Ministry of Health to implement a demonstration site to determine how best to offer this treatment to pregnant women.

Example 2:

Advocacy Issue: Lack of trained/licensed midwives in the province.

Advocacy Goal: One trained/licensed midwife for each village in the province.

Advocacy Objective: Within 12 months, the Provincial Department of Health will appoint at least one midwifery teacher in each of the public midwifery schools.

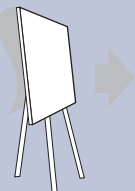
Setting Advocacy Objectives

- Proceed as instructed in the manual.
- Maternal Health Handout III.2.1: The “Six Pillars” of Safe Motherhood
- Maternal Health Handout III.2.2: Developing an Advocacy Goal and Objective

ACTIVITY 1



ACTIVITY 2



ACTIVITY 3

ADDITIONAL HANDOUTS

Maternal Health Handout III.2.1

The “Six Pillars” of Safe Motherhood

The basic principles of safe motherhood are neither new nor controversial. They are considered the “six pillars” of safe motherhood:

1. **Family Planning**-to ensure that individuals and couples have the information and services to plan the timing, number, and spacing of pregnancies.
2. **Antenatal Care**-to provide vitamin supplements, vaccinations, and screen for risk factors in order to prevent complications where possible, and to ensure that complications of pregnancy are detected early and treated appropriately.
3. **Obstetric Care**-to ensure that all birth attendants have the knowledge, skills, and equipment to perform a clean and safe delivery, and to ensure that emergency care for high-risk pregnancies and complications is made available to all women who need it.
4. **Postnatal Care**-to ensure that postpartum care is provided to mother and baby, including lactation assistance, provision of family planning services, and managing danger signs.
5. **Postabortion Care**-to prevent complications where possible and ensure that complications of abortion are detected early and treated appropriately; to refer other reproductive health problems; and to provide family planning methods as needed.
6. **STD/HIV/AIDS Control**-to screen, prevent, and manage transmission to baby; to assess risk for future infection; to provide voluntary counseling and testing; to encourage prevention; and where appropriate to expand services to address mother to child transmission.



Maternal Health Handout III.2.2

Developing an Advocacy Goal and Objective

Example 1:

Advocacy Issue: Prevention of malaria during pregnancy.

Advocacy Goal: Sulfadoxine-pyrimethamine (SP) available to all pregnant women seeking ANC and delivery services at public hospitals.

Advocacy Objective: By 2005, secure funding from the Ministry of Health to implement a demonstration site to determine how best to offer this treatment to pregnant women.

Example 2:

Advocacy Issue: Lack of trained/licensed midwives in the province.

Advocacy Goal: One trained/licensed midwife for each village in the province.

Advocacy Objective: Within 12 months, the Provincial Department of Health will appoint at least one midwifery teacher in each of the public midwifery schools.

Target Audiences: Identifying Support and Opposition

Supplemental Background Notes

Be sure to note the kinds of audiences that may be targets of maternal health advocacy efforts. These include women's rights groups, child welfare activists, husbands, mothers-in-law, and health care providers.

Modifications to Activities

Identifying Support and Opposition

For the Introduction:

- Discuss the types of opposition one might expect to maternal health efforts and the reasons for such opposition.

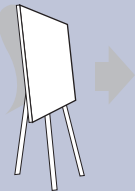
For Power Mapping, substitute this maternal health-specific advocacy objective and target audience:

- **Advocacy Objective.** Within the next two years, the Ministry of Health will develop operational blood banks in three district hospitals.
- **Target Audiences.** Ministry of Health officials, policy champions, medical associations and related institutions, private sector business associations, women's groups, child welfare groups, and so forth. Those opposed to this program might include public health officials who feel the program might take away existing resources. Encourage participants to think of other specific examples.

Analyzing the Target Audience

- Proceed as instructed in the manual.

ACTIVITY 1



ACTIVITY 2

Messages: Informing, Persuading, and Moving to Action

Supplementary Background Notes

The tools for developing effective advocacy messages apply equally to maternal health as other topic areas.

Modifications to Activities

ACTIVITY 1

Techniques of Persuasion

- Modify this exercise to include examples of controversial maternal health-related statements. For example:
 - Postabortion care services should be widely available to women even when a physician is not present.
 - Community health workers should be required to, and legally supported in, treating complications during pregnancy, including the use of medications.

ACTIVITY 2

Advocacy Communication

- Proceed as instructed in the manual, keeping the focus on maternal health advocacy.

ACTIVITY 3

Elements and Characteristics of a Message

- Proceed as instructed in the manual, keeping the focus on maternal health advocacy.

ACTIVITY 4

Developing Advocacy Messages

- Proceed as instructed in the manual, keeping the focus on maternal health advocacy.

ACTIVITY 5

Delivering Advocacy Messages

- Modify the one-minute advocacy message as follows:
 - **Statement.** Maternal death is a serious threat to our country's economic well-being, and it is creating a huge burden on individual families and communities. We can no longer afford to avoid dealing with this issue at the national level.
 - **Evidence.** A mother's death has profound consequences on her family. In some countries, if the mother dies, the risk of death for her children under age five can increase by as much as 50 percent. In addition, because these women are stricken during their most productive years, their deaths have profound impact on society and on the economies of their nations. The World Bank and WHO have estimated the burden of disability and death with DALYs (see

explanation in Section E of the Overview). The analysis shows that the complications of pregnancy and childbirth are one of the greatest threats to women's lives and health in less developed countries (Ransom, 1998).

- **Example:** Since the loss of his wife during the birth of their last child, Jacob, father of four, often has to leave his village to find work. His children are often left with extended family members, but they are not always able to take the children in because their financial resources are already stretched. Jacob's eldest daughter is unable to continue her education because she must spend her time caring for younger siblings. Often, they do not have enough food to eat, and Jacob's eldest son may also need to leave school to seek manual labor outside the village with his father in order to provide basic necessities for his brothers and sisters. This scenario is typical of families that lose their mother.
- Use the following maternal health-specific role plays:

Sample Role-Play Scenarios

Scenario 1

Your NGO network seeks to increase awareness about the importance of a woman delivering with a skilled attendant. You discover that some members of the provincial health commission for your area are considering a line item in the budget to transport women in labor to a district hospital. Unfortunately, they do not have the full support of other commission members to ensure the budget will be approved. You and other network members are able to secure a meeting with the undecided and opposed commissioners. Prepare a 10-minute role-play of your meeting with the commissioners to try and persuade them to allow this line item to remain in the budget.

Scenario 2

Your network provides training for auxiliary health care workers to recognize obstetric emergencies. Your group learns that new guidelines for health care workers to manage complications in pregnancy and childbirth are being considered, but midwives and auxiliary nurses have not been consulted in the implementation plans for these new guidelines. You have been invited to an advisory group meeting to present your network's activities. Therefore, you have an opportunity to show policymakers and community members how midwives and auxiliary nurses are critical in the reduction of maternal mortality. Prepare a 10-minute role-play of your presentation at the meeting and ask other participants to provide both support and opposition to your issue.

Scenario 3

Your network provides a range of antenatal services for women in your community, including nutritional supplements and counseling. Each year, you receive funds from the Ministry of Health, and you have used these funds to support all of the activities in your program. You have recently begun to provide postabortion care services; however, women who come to you in need are being punished for having an illegal abortion before arriving. You have made an appointment to speak with the Ministry of Health official who approves your grant, anticipating that he will be pressured to cut your funding because of negative publicity. Prepare a 10-minute role-play of your meeting with him/her in which you attempt to persuade him to continue funding your program.

Scenario 4

The Ministry of Health is facing serious budget cuts and can only pay its clinicians for eight hours of work a day, which is leaving many facilities without skilled caregivers, particularly at night. You notice that most health care providers in your facility are choosing to do their eight-hour shifts between 9 a.m. and 5 p.m., times at which the clinic is usually overstaffed. You have managed to meet with a senior official at the ministry to discuss this issue. Prepare a 10-minute role-play in which you attempt to convince the official to regulate working hours so that there are always skilled attendants at the clinic.

- Maternal Health Handout III.4.1: Sample Role-Play Scenarios

ADDITIONAL HANDOUT

Maternal Health Handout III.4.1

Sample Role-Play Scenarios

Scenario 1

Your NGO network seeks to increase awareness about the importance of a woman delivering with a skilled attendant. You discover that some members of the provincial health commission for your area are considering a line item in the budget to transport women in labor to a district hospital. Unfortunately, they do not have the full support of other commission members to ensure the budget will be approved. You and other network members are able to secure a meeting with the undecided and opposed commissioners. Prepare a 10-minute role-play of your meeting with the commissioners to try and persuade them to allow this line item to remain in the budget.

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Data Collection: Bridging the Gap Between Communities and Policymakers

Supplemental Background Notes

Data collection is particularly complex for maternal health advocates, because collecting data on maternal morbidity and death is so difficult. National registration systems are often inadequate to provide accurate estimates of maternal mortality. Additionally, morbidities are difficult to define and measure.

Traditionally, information on maternal mortality has been collected in hospital-based studies. In rare circumstances, population surveillance systems have reported on maternal deaths. Generally, serious under-reporting of maternal deaths is due in part to the misclassification of deaths. Advocates must always supplement quantitative studies with qualitative data

and case studies to show policymakers the true magnitude of maternal mortality in a given setting. Qualitative data are also useful in settings where advocates are accused of exaggerating prevalence figures.

“I have seen mothers who are suffering from eclampsia and the doctors just do not have the resources to treat their condition. Since the government is ashamed that we no longer have the resources we used to have, doctors are often fined when a mother dies in childbirth. Since doctors are so poorly paid now, we do not have the money to pay these fines. If a doctor has to choose between caring for his or her family or paying the fine, the doctor may send the dying mother home so her death is not recorded and the fine will not be imposed.”

-Anonymous doctor, Uzbekistan

When we were outside of the ward a nurse came in and told other moms: “You’d better wash your hands with chlorine and never let [Natasha] approach your babies. She has AIDS and her baby is infected. Be careful, for you can pick it up from her.”

-Odessa, Ukraine

From the book, *“Here and Now”: People Living with HIV/AIDS Telling about Themselves*, by “Faith, Hope, and Love” NGO, UNAIDS, and UNDP, 2000.

Modifications to Activities

Introduction

- Emphasize the specific challenges of data collection for maternal health programs and policies, as outlined in the supplemental background notes.
- Describe the Safe Motherhood Model (see Maternal Health Handout III.5.1: Data and Information Resources).
- Incorporate the maternal death audit or verbal autopsy into the introduction (see Maternal Health Handout III.5.6: Measuring Maternal Mortality).

ACTIVITY 1

ACTIVITY 2

- Draw on the quotes from the anonymous doctor in Uzbekistan and the Ukrainian health care worker.

Research Scenarios

- Scenario 2 already uses a topic directly related to maternal health. Other scenarios include:

Data Collection Scenario 1

Your network has decided to focus on educating the community about danger signs during pregnancy and childbirth and the implementation of a birth and complications readiness plan. Members will use advocacy messages to convince household decision makers to take action to support this initiative. A survey of households in a representative community reveals that mothers-in-law and husbands are the main decision makers in the family and that they do not see the need to have a birth plan. In addition, you find out that a woman cannot be seen in clinics unless her husband or another elder male accompanies her.

Question: What implications do these data have for your advocacy strategy and the message you will deliver to household decision makers?

Data Collection Scenario 2

The Ministry of Health funds a surveillance survey in five hospital-based maternity wards. In your review of the findings, one of the hospitals showed an increase in maternal deaths compared with the prior two years. Hospital officials report that the sudden increase was due to more women from rural areas coming to the hospital to deliver, whereas in prior years these women would have delivered in their villages. However, rural women coming from the villages were often arriving with serious complications that at times were too late to manage.

Questions: How would your advocacy network use this information in setting priorities for an advocacy strategy? If your advocacy strategy is in place, how might this information modify your plans?

Data Collection Scenario 3

Through informal interviews in a rural community, you find out that husbands are not encouraging their pregnant wives to deliver at the hospital because the cost of supplies is too high. The community was encouraged to develop a system with which to collect community funds so that at least women with complications could pay for the care they needed at local hospitals. Some men in the community, especially those whose wives were past their reproductive years or who were practicing family planning, were against contributing to the pool because their wives would never use these resources.

Questions: What data will you use to show that the entire community benefits from allowing its pregnant women to have access to such resources? How will you present your information in such a way that will promote solutions?

ACTIVITY 3

ACTIVITY 4

ACTIVITY 5

ACTIVITY 6

ACTIVITY 7

ADDITIONAL HANDOUTS

Data Collection Scenario 4

Currently, there is a shortage of OB-GYNS at the major referral hospital in your district. Your network knows that there are many capable midwives that can be trained to manually remove the placenta after delivery or perform emergency vacuum extractions. The Ministry of Health needs to be convinced that these midwives can be trained to handle the cases needing such services at the referral hospital.

Questions: What data do the network need to convince the ministry this solution to the shortage is a viable one? How could it obtain the data?

Data Collection Techniques

- Make sure participants are aware of the specific quantitative and qualitative data resources available to them. In the area of maternal health, there are many sources available on the Internet. These resources are detailed in Handouts III.5.1: Data and Information Resources and III.5.2: Maternal Health Internet Resource List.

Baseline Assessment

- The exercise is equally valid for evaluating maternal health programs. Participants can see from the example described in the associated handout how baseline techniques are applied to maternal health programs for program design purposes.

Interviews

- The exercise applies equally to interviewing for maternal health programs. Substitute the Interview Topic Guide (Maternal Health Handout III.5.4: Interview Topic Guide) in this supplement.

Focus Group Discussion

- Proceed as instructed in the manual.

Secondary Data Analysis

- Divide participants into three groups.
 - Group 1: Current Use and Fertility
 - Group 2: Antenatal Care
 - Group 3: Skilled Attendance at Birth
- Distribute the appropriate data set to each group. For Group 1, use the data set provided in the original manual. For Groups 2 and 3, use the data sets included as Maternal Health Handout III.5.5: Secondary Data Analysis.

- Maternal Health Handout III.5.1: Data and Information Resources
- Maternal Health Handout III.5.2: Maternal Health Internet Resource List
- Maternal Health Handout III.5.3: Data Collection Scenarios
- Maternal Health Handout III.5.4: Interview Topic Guide
- Maternal Health Handout III.5.5: Secondary Data Analysis
- Maternal Health Handout III.5.6: Measuring Maternal Mortality
- Maternal Health Handout III.5.7: The Four Delays Model

Data and Information Resources

Data Sources

To speak to policymakers about the importance of reducing maternal mortality, advocates can rely on information and data produced with various computer models and composite indices.

Safe Motherhood Model. The POLICY Project has developed the Safe Motherhood Model, a statistical model to represent the relationships between a national maternal health program and the resulting maternal mortality ratio and number of maternal deaths. Data show that the stronger the national program, the lower the ratio and the fewer the deaths. The model [Excel version] was approved for application in October 2001. The first field applications took place in Ethiopia, Guatemala, and Uganda. The model is well suited to multisectoral policy dialogue on interventions that can reduce maternal mortality.

Maternal and Neonatal Program Effort Index. The Maternal and Neonatal Program Effort Index (MNPI) is a tool that reproductive health care advocates, providers, and program planners can use to assess maternal health program features and can create a baseline to track progress over time. The index rates program inputs and services, political and popular support, and assesses the magnitude of efforts devoted to the reduction of maternal mortality and morbidity and closely related neonatal items. Results from the 1999 MNPI application are available for 49 countries. The MNPI was re-administered in 2002 in 57 countries.

REDUCE Model. The REDUCE Model, a computer model developed by the SARA Project, may be used by advocates and policymakers to project the consequences of maternal mortality and morbidity at the country level. This model projects the socioeconomic impacts of maternal death and disability.

Information Resources

Many maternal health advocates use the Internet as a source of information. Some key websites include the following:

- The Safe Motherhood Initiative has a variety of media and materials, including fact sheets. <http://www.safemotherhood.org>
- The Maternal and Newborn Health, Department of Reproductive Health and Research, World Health Organization, contains several tools for making motherhood safer and provides a link to World Health Organization publications on this topic. <http://www.who.int/reproductive-health/MNBH/index.htm>

- Maternal and Neonatal Health Program is USAID's flagship program to reduce maternal and neonatal deaths. The site includes materials and links to other resources related to maternal health.
<http://www.mnh.jhpiego.org>
- The Reproductive Health Outlook (RHO) website provides up-to-date summaries of research findings, program experience, and clinical guidelines related to key reproductive health topics, including safe motherhood, as well as analyses of policy and program implications.
http://www.rho.org/html/safe_motherhood.htm#
- The United Nation's Population Fund's (UNFPA's) website provides up-to-date statistics, fact sheets, publications, links, a glossary, and donor information relevant to making pregnancy safer for women around the world. <http://www.unfpa.org/mothers/index.htm>

Maternal Health Internet Resource List

Development, Education, Population, and Public Health

- [Academy for Educational Development \(AED\) www.aed.org](http://www.aed.org)
- [Africare www.africare.org](http://www.africare.org)
- [American Public Health Association \(APHA\) www.apha.org](http://www.apha.org)
- [Amigos de las Americas www.amigoslink.org](http://www.amigoslink.org)
- [Centers for Disease Control and Prevention \(CDC\) www.cdc.gov](http://www.cdc.gov)
- [Centre for Development and Population Activities \(CEDPA\) www.cedpa.org](http://www.cedpa.org)
- [Department for International Development \(DFID\) www.dfid.gov.uk](http://www.dfid.gov.uk)
- [Futures Group www.futuresgroup.com](http://www.futuresgroup.com)
- [JHPIEGO www.jhpiego.org](http://www.jhpiego.org)
- [Johns Hopkins University Center for Communication Programs \(JHUCCP\) www.jhuccp.org](http://www.jhuccp.org)
- [John Snow, Inc. \(JSI\) www.jsi.com](http://www.jsi.com)
- [Management Sciences for Health www.msh.org](http://www.msh.org)
- [Media/Materials Clearinghouse \(JHU/CCP\) www.jhuccp.org/mmc](http://www.jhuccp.org/mmc)
- [National Center for Education in Maternal & Child Health \(NCEMCH\) www.ncemch.org](http://www.ncemch.org)
- [National Institutes of Health \(NIH\) www.nih.gov](http://www.nih.gov)
- [Population Action International \(PAI\) www.populationaction.org](http://www.populationaction.org)
- [Population Communications International \(PCI\) www.population.org](http://www.population.org)
- [Population Reference Bureau \(PRB\) www.prb.org](http://www.prb.org)
- [Population Services International \(PSI\) www.psiwash.org](http://www.psiwash.org)
- [PLANET www.planetwire.org](http://www.planetwire.org)
- [Tools for Life \(JHUCCP\) www.jhuccp.org/tools](http://www.jhuccp.org/tools)
- [United Nations Population Fund \(UNFPA\) www.unfpa.org](http://www.unfpa.org)

Global Development, Humanitarian Relief, and Donor Organizations and Foundations

- [American Red Cross www.redcross.org](http://www.redcross.org)
- [American Refugee Committee www.archq.org](http://www.archq.org)
- [CARE www.care.org](http://www.care.org)
- [Catholic Relief Services \(CRS\) www.catholicrelief.org](http://www.catholicrelief.org)
- [InterAction www.interaction.org](http://www.interaction.org)
- [MAP International www.map.org](http://www.map.org)
- [Outreach International www.outreachinternational.org](http://www.outreachinternational.org)
- [Oxfam America www.oxfamamerica.org](http://www.oxfamamerica.org)
- [United Nations \(UN\) www.un.org](http://www.un.org)
- [United Nations Children's Fund \(UNICEF\) www.unicef.org](http://www.unicef.org)
- [USAID: Global Health www.usaid.gov/pop_health](http://www.usaid.gov/pop_health)
- [World Health Organization \(WHO\) www.who.int/home-page](http://www.who.int/home-page)

Health Policy

- [The Center for Reproductive Rights \(formerly The Center for Reproductive Law and Policy\) www.crlp.org](http://www.crlp.org)
- [Institute for Child Health Policy \(ICHP\) www.ichp.edu](http://www.ichp.edu)
- [IPAS: Initiatives in Reproductive Health Policy www.ipas.org](http://www.ipas.org)
- [Eldis: Health Policy www.eldis.org/health](http://www.eldis.org/health)
- [Maternal & Child Health Policy Research Center www.mchpolicy.org](http://www.mchpolicy.org)

Health Statistics, Databases, and Research

- [Churchill Livingstone www.elsevier-international.com/cl](http://www.elsevier-international.com/cl)
- [Cochrane Collaboration www.cochrane.de](http://www.cochrane.de)
- [Data from Developing Countries www.biko.sscnet.ucla.edu/dev_data/data.htm](http://www.biko.sscnet.ucla.edu/dev_data/data.htm)
- [Demographic and Health Surveys \(DHS\) www.measuredhs.com](http://www.measuredhs.com)
- [Eldis: The Gateway to Development Information www.eldis.org](http://www.eldis.org)
- [Elsevier Science www.elsevier.com](http://www.elsevier.com)
- [Harvard School of Public Health Global Maternal & Child Health Links www.hsph.harvard.edu/Academics/mch/home/resources/links/links.html](http://www.hsph.harvard.edu/Academics/mch/home/resources/links/links.html)
- [Healthlink www.healthlink.org.uk](http://www.healthlink.org.uk)
- [Infonation www.un.org/Pubs/CyberSchoolBus/infonation/e_infonation.htm](http://www.un.org/Pubs/CyberSchoolBus/infonation/e_infonation.htm)
- [The Library of Congress Online Catalog www.catalog.loc.gov](http://www.catalog.loc.gov)
- [PubMed www.ncbi.nlm.nih.gov](http://www.ncbi.nlm.nih.gov)
- [National Maternal and Child Health Clearinghouse \(NMCHC\) www.ask.hrsa.gov/MCH.cfm](http://www.ask.hrsa.gov/MCH.cfm)
- [OBGYN.net Image Library www.obgyn.net/image_library/image_library.asp](http://www.obgyn.net/image_library/image_library.asp)
- [Popline www.jhuccp.org/popline](http://www.jhuccp.org/popline)
- [PopNet www.popnet.org](http://www.popnet.org)
- [Population, Health & Nutrition Information Project www.phnip.com](http://www.phnip.com)
- [Population Reference Bureau www.prb.org](http://www.prb.org)
- [U.S. Census International Database www.census.gov/ipc/www/idbnew.html](http://www.census.gov/ipc/www/idbnew.html)
- [Virtual Health Library www.dse.de/zg/lernbibl/lernbib.htm](http://www.dse.de/zg/lernbibl/lernbib.htm)
- [World Health Organization Statistical Information System www.who.int/whosis](http://www.who.int/whosis)

Maternal Health

- [Childbirth.org www.childbirth.org](http://www.childbirth.org)
- [Maternal and Child Health Bureau \(MCHB\) www.mchb.hrsa.gov](http://www.mchb.hrsa.gov)
- [The Maternal and Neonatal Health \(MNH\) Program www.mnh.jhpiego.org](http://www.mnh.jhpiego.org)
- [MotherCare www.jsi.com/intl/mothercare](http://www.jsi.com/intl/mothercare)
- [OBGYN.net www.obgyn.net/pb/pb.asp](http://www.obgyn.net/pb/pb.asp)
- [Safe Motherhood www.safemotherhood.org](http://www.safemotherhood.org)
- [USAID Nutrition and Maternal Health www.usaid.gov/pop_health/nmh/nmhhome.htm](http://www.usaid.gov/pop_health/nmh/nmhhome.htm)
- [White Ribbon Alliance for Safe Motherhood www.whiteribbonalliance.org](http://www.whiteribbonalliance.org)

Ministries of Health, Professional and Medical Organizations

- African Medical and Research Foundation (AMREF) www.amref.org
- American College of Nurse-Midwives (ACNM) www.midwife.org
- SatelLife www.healthnet.org
- International Confederation of Midwives www.internationalmidwives.org
- Links to Midwifery Associations
hometown.aol.com/Midgewife/linksmidwifery.html
- Ministries of Health World Wide www.who.int/emc/surveill/mohglobal.html

Neonatal Health

- Child Health Research Project www.childhealthresearch.org
- Save the Children www.savethechildren.org
- Saving Newborn Lives Initiative
www.savethechildren.org/mothers/learn/newborn.htm

Nutrition

- Africa Nutrition Database Initiative www.africanutrition.net
- Helen Keller International (HKI) www.hki.org
- The Linkages Project www.linkagesproject.org
- Opportunities for Micronutrient Interventions (OMNI)
www.jsi.com/intl/omni/home

Reproductive Health

- The Alan Guttmacher Institute www.agi-usa.org
- Family Care International (FCI) www.familycareintl.org
- Family Health International (FHI) www.fhi.org
- INTRAH www.intrah.org
- Pathfinder International www.pathfind.org
- The POLICY Project www.policyproject.com
- Reproductive Health Outlook (RHO) www.rho.org
- ReproLine® www.reproline.jhu.edu

Women/Women's Health

- Feminist Majority Foundation (FMF) www.feminist.org
- International Center for Research on Women (ICRW) www.icrw.org
- International Women's Health Coalition (IWHC) www.iwhc.org
- WomanKind Worldwide www.womankind.org.uk
- Women's Issues - 3rd World women3rdworld.miningco.com
- WomenWatch www.un.org/womenwatch

Maternal Health Handout III.5.3

Data Collection Scenarios

Data Collection Scenario 1

Your network has decided to focus on educating the community about danger signs during pregnancy and childbirth and the implementation of a birth and complications readiness plan. Members will use advocacy messages to convince household decision makers to take action to support this initiative. A survey of households in a representative community reveals that mothers-in-law and husbands are the main decision makers in the family and that they do not see the need to have a birth plan. In addition, you find out that a woman cannot be seen in clinics unless her husband or another elder male accompanies her.

Question: What implications do these data have for your advocacy strategy and the message you will deliver to household decision makers?

Data Collection Scenario 2

The Ministry of Health funds a surveillance survey in five hospital-based maternity wards. In your review of the findings, one of the hospitals showed an increase in maternal deaths compared with the prior two years. Hospital officials report that the sudden increase was due to more women from rural areas coming to the hospital to deliver, whereas in prior years these women would have delivered in their villages. However, rural women coming from the villages were often arriving with serious complications that at times were too late to manage.

Questions: How would your advocacy network use this information in setting priorities for an advocacy strategy? If your advocacy strategy is in place, how might this information modify your plans?

Data Collection Scenario 3

Through informal interviews in a rural community, you find out that husbands are not encouraging their pregnant wives to deliver at the hospital because the cost of supplies is too high. The community was encouraged to develop a system with which to collect community funds so that at least women with complications could pay for the care they needed at local hospitals. Some men in the community, especially those whose wives were past their reproductive years or who were practicing family planning, were against contributing to the pool because their wives would never use these resources.

Questions: What data will you use to show that the entire community benefits from allowing its pregnant women to have access to such resources? How will you present your information in such a way that will promote solutions?

Data Collection Scenario 4

Currently, there is a shortage of OB-GYNS at the major referral hospital in your district. Your network knows that there are many capable midwives that can be trained to manually remove placenta after delivery or perform emergency vacuum extractions. The Ministry of Health needs to be convinced that these midwives can be trained to handle the cases needing such services at the referral hospital.

Questions: What data do the network need to convince the ministry this solution to the shortage is a viable one? How could it obtain the data?

Maternal Health Handout III.5.4

Interview Topic Guide

Purpose of research: To learn what community members think about having a healthcare worker educate the community about danger signs during pregnancy and childbirth.

I. Introduction

- A. Explain who you are and the purpose of your research.
- B. Explain the procedure (e.g., I would like to ask you some questions; I would like about 15 minutes of your time).
- C. Emphasize that there are no right or wrong answers to the questions you will ask.
- D. Ask the respondent's name and how many children he/she has and their ages.

II. Rapport Building (Opening conversation to set a comfortable tone) Ask the respondent something general and appropriate about his/her family, children, work, or community (e.g., how old are her children).

III. In-Depth Discussion (Sequence the questions by moving from questions that seek factual information to questions that require the respondent's opinion.)

- A. Sample questions:
 - 1. What do they know about the danger signs associated with pregnancy and childbirth?
 - 2. Has anyone educated the community before about danger signs during pregnancy and childbirth?
 - 3. Would they like a health care worker to come talk to them about the danger signs?
 - 4. Do they think that knowing about the danger signs would help the community seek care if these signs were to present themselves?
- B. Be prepared to follow up with probing questions to clarify or explore further.

IV. Closure

- A. Briefly summarize what you have heard and ask for the respondent's final reaction (e.g., is there anything that we did not discuss that you would like to add?).
- B. Thank the respondent for his/her time.

V. Review and Organize Interview Notes

Secondary Data Analysis

Group 2: Antenatal Care-Table A

Number of antenatal care visits and stage of pregnancy
Percent distribution of live births in the past five years by number of antenatal care visits
and by stage of pregnancy at time of the first visit.
(Data from Tanzania Demographic and Health Surveys (TDHS))

Number and timing of antenatal care visits	TDHS 1991-1992	TDHS 1996	TDHS 1999*
Number of visits			
None	3.6	2.1	2.4
1	1.1	1.5	2.9
2-3	23.5	22.5	23.1
4+	69.5	69.5	69.9
Don't know/missing	2.4	4.4	1.6
Total	100%	100%	100%
Median**	5.0	3.9	4.1
Number of months pregnant at first visit			
No antenatal care	3.6	2.1	2.4
<6 months	60.1	60.5	61.4
6-7 months	34.0	34.7	32.0
8+ months	1.7	1.7	2.9
Don't know/missing	0.5	1.0	1.2
Total	100%	100%	100%
Median	5.6	5.6	5.5
Number of births	8,032	6,916	2,183

*Refers to most recent birth only

** For those with antenatal care

Group 2: Antenatal Care-Table B
Antenatal Care Content

Among women who have had births in the five years preceding the survey, percentage of the most recent births for which specific antenatal care was received, by content of antenatal care, and selected background characteristics.

Background	Informed of pregnancy complications	Has a card with immunizations	Give/bought iron tablets	Given/bought anti-malarials	Number of births
Mother's age at birth					
<20	33.2	39.3	45.4	23.0	368
20-34	43.0	40.7	45.4	34.7	1,486
35+	42.2	33.2	38.8	32.5	329
Birth order					
1	37.6	38.2	45.9	33.2	498
2-3	42.2	43.4	47.0	30.0	719
4-5	44.0	41.4	44.1	35.9	479
6+	41.1	32.6	39.5	31.7	487
Residence					
Urban	52.6	37.0	49.8	41.9	502
Rural	37.9	40.0	42.8	29.6	1,681
Mother's education					
No education	28.9	33.8	36.8	26.7	581
Primary incomplete	41.2	38.6	43.6	27.5	370
Primary complete	46.2	42.5	86.3	47.5	1,143
Secondary+	58.6	37.2	86.5	58.6	89
Total	41.3	39.3	44.4	32.4	2,183

Group 3: Skilled Attendance at Birth-Table A
Place of Delivery

Percent distribution of births in the five years preceding the survey by place of delivery, according to selected background characteristics.

Background	Health facility	Home	Don't know/missing	Total (%)	Number of births
Mother's age at birth					
<20	54.0	46.0	0.0	100	575
20-34	43.9	55.8	0.3	100	2,286
35+	27.1	72.6	0.2	100	422
Birth order					
1	59.9	40.0	0.0	100	769
2-3	46.6	53.3	0.1	100	1,100
4-5	38.3	61.2	0.5	100	715
6+	25.8	73.7	0.5	100	698
Residence					
Urban	82.8	17.2	0.1	100	614
Rural	34.5	65.3	0.3	100	2,668
Mother's education					
No education	24.4	75.2	0.4	100	907
Primary incomplete	44.2	55.7	0.1	100	548
Primary complete	51.0	48.7	0.2	100	1,711
Secondary+	78.8	21.2	0.0	100	116
Total	43.5	56.3	0.2	100	3,282

Group 3: Skilled Attendance at Birth-Table B
Assistance During Delivery

Percent distribution in the five years preceding the survey by type of assistance during delivery, according to selected backgrounds.

Background	Doctor	Nurse/ Midwife	Rural medical aide	MCH aide	Village health worker	Trained birth attendant	Traditional birth attendant	Relative/ Other	No one	Don't know/ Missing	Total (%)	Number of Births
Mother's age at birth												
<20	9.8	33.2	4.8	5.4	3.0	8.1	5.7	27.6	2.5	0.0	100	575
20-34	7.0	29.5	2.3	5.6	1.6	11.3	7.3	28.1	6.9	0.3	100	2,286
35+	6.5	16.0	2.0	3.1	1.3	12.6	5.6	39.2	13.8	0.0	100	422
Birth order												
1	11.5	38.5	5.2	3.9	2.4	7.3	6.8	23.0	0.8	0.4	100	769
2-3	7.5	31.4	2.2	6.3	1.6	12.0	6.1	27.9	4.8	0.1	100	1,100
4-5	6.6	25.1	0.8	6.0	2.0	12.4	7.0	30.9	8.8	0.5	100	715
6+	3.7	16.1	2.6	4.3	1.3	11.4	7.5	37.5	15.5	0.1	100	698
Residence												
Urban	16.6	60.1	3.5	3.1	0.7	6.1	2.4	6.0	1.1	0.4	100	614
Rural	5.3	21.1	2.5	5.8	2.1	12.0	7.8	34.8	8.4	0.2	100	2,668
Mother's education												
No education	5.3	14.1	2.0	4.0	1.4	7.7	8.2	46.5	10.4	0.3	100	907
Primary incomplete	5.1	28.7	3.0	6.4	1.9	10.8	5.1	30.6	8.1	0.1	100	548
Primary complete	8.4	33.8	3.1	5.9	2.1	12.9	6.4	21.6	5.3	0.0	100	1,711
Secondary+	20.0	59.6	0.9	0.9	0.0	5.4	8.9	4.1	0.1	0.1	100	116
Total	7.4	28.4	2.7	5.3	1.8	10.9	6.8	29.4	7.0	0.2	100	3,282

Maternal Health Handout III.5.6

Measuring Maternal Mortality

The Tenth International Classification of Diseases (ICD-10) defines a maternal death as “the death of a woman while pregnant or within 42 days of the termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.” Maternal deaths are often misclassified and underreported; therefore, it is difficult to obtain an accurate assessment of the true level of maternal mortality in a given setting. The following table describes various methods of measuring maternal mortality.

Method	Description
<i>Household Survey*</i>	Household surveys using direct estimation require very large sample sizes to provide reliable and representative results. Confidence intervals are wide and resulting indicators can be imprecise.
<i>Vital Registration*</i>	Data on births and deaths in developed countries are collected through vital registration and medical certification of causes of death. Vital registration systems in developing countries are often incomplete.
<i>Population Census Data**</i>	The national population census is a feasible and promising approach for measuring maternal mortality.*
<i>Sisterhood Method*</i>	This is an indirect survey method involving asking women of reproductive age a series of questions about the survival of all their adult sisters. This questionnaire is usually added to an existing household survey making the method cost-effective. Estimates generated by the sisterhood method generally apply to a period 10-12 years prior to the study. A more recent derivation used in Demographic and Health Surveys (DHS) can produce an estimate that applies to a more recent period, but requires a larger sample size.
<i>Reproductive Age Mortality Surveys (RAMOS)*</i>	These surveys are in-depth reviews of deaths among all women of reproductive age. The results yield data on the maternal mortality ratio, causes of death, high-risk groups, and avoidable factors. They are complex and costly to conduct. Only 10 developing countries have used RAMOS to date.
<i>WHO/UNICEF Estimates*</i>	This method was used to estimate maternal mortality for the year 1990. The method involves adjusting existing estimates to account for underreporting or misclassification and using a model to generate an estimated figure for places without existing estimates. The model relies on fertility rates and proportion of births that are assisted by skilled personnel.

Method	Description
<i>Verbal Autopsy*</i>	The tool is a structured questionnaire administered to family members of mothers or infants who have died. Questions are asked to review the circumstances surrounding the death of a woman of reproductive age or the death of a child in the peri/neonatal period determine the cause of death as well as on other variables such as socioeconomic status, number of previous births, education-level nutritional status, and the process of care seeking and decision making before death.
<i>Maternal Death Audit***</i>	A maternal death audit consists of regular meetings of midwives, staff from health centers, health administrators, and hospital physicians to discuss maternal and perinatal deaths. Community involvement is invited if considered desirable. The background of a designated number of cases and chronology of events leading to the death are presented. Participants then review and discuss case management in order to improve future outcomes.

Notes:

*WHO. 1998. "Measure Progress." In *World Health Day: Safe Motherhood 7 April 1998 Information Kit*.

**Stanton, C., J. Hobcroft, K. Hill, N. Kodjogbé, W.T. Mapeta, F. Munene, M. Naghavi, V. Rabeza, B. Sisouphanthong, and O. Campbell. 2001. "Every Death Counts: Measurement of Maternal Mortality via a Census." In *Bulletin of the World Health Organization* 79(7): 657-664.

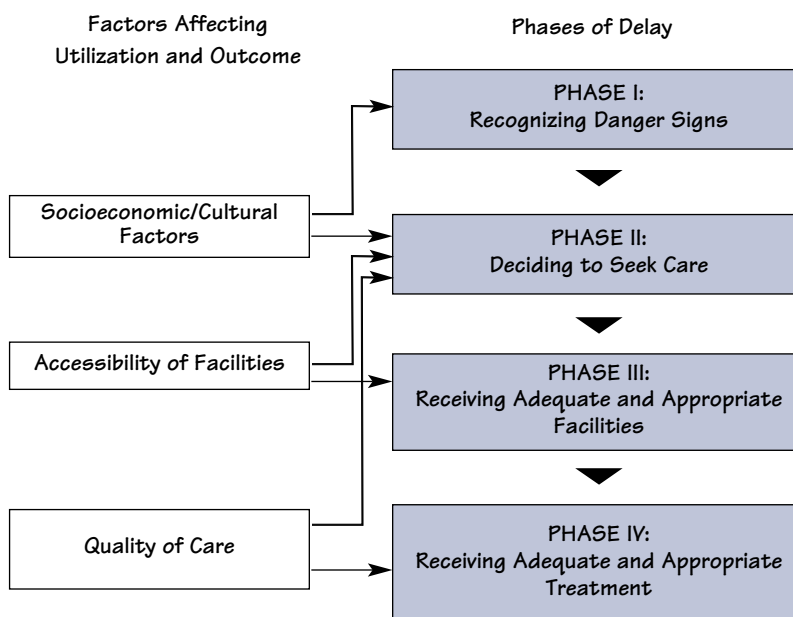
***Supratikto, G., M. Wirth, E. Achadi, S. Cohen, and C. Ronsmans. 2002. "A District-based Audit of the Causes and Circumstances of Maternal Deaths in South Kalimantan, Indonesia." In *Bulletin of the World Health Organization* 80(3): 228-235.

Maternal Health Handout III.5.7

The Four Delays Model

Prevention and timely treatment of complications can effectively reduce maternal morbidities and mortalities. Maine et al. (1997) developed the “Three Delays Model,” which groups delay-related barriers to obtaining emergency obstetric services into three major categories. This model can be instructive in assessing and evaluating the most urgent barriers to adequately responding to emergency obstetric complications in a particular setting. These three delays are: 1) delay in seeking care, 2) delay in reaching a treatment facility, and 3) delay in receiving adequate treatment at a facility. Ransom and Yinger (2002) expand on this model by dividing the first delay into two: 1) delay in recognizing danger signs, and 2) delay in seeking care.

- The **delay in recognizing danger signs** is influenced by recognizing that there is a problem (life threatening complication).
- The **delay in deciding to seek care** is influenced by knowing where to go for help and having the ability to do so.
- The **delay in reaching a medical facility** is influenced by the accessibility of the health facility, availability of services within the health facility, transportation, and associated costs.
- The **delay in receiving treatment** is influenced by the condition of the facility; sufficient staff, drugs, and supplies; and management of the facility.



Sources: Maine, D., M.Z. Akalin, V.M. Ward, and A. Kamara. 1997. *The Design and Evaluation of Maternal Mortality Programs*. New York: Columbia University, Centre for Population and Family Health, School of Public Health. Ransom, E. and N. Yinger. 2002. “Making Motherhood Safer: Overcoming Obstacles on the Pathway to Care.” MEASURE Communication Policy Brief. Washington, D.C.: Population Reference Bureau.

Fundraising: Mobilizing Resources

Supplemental Background Notes

Mobilizing resources requires the same skills regardless of the goal of the network.

Modifications to Activities

Introduction

- Proceed as instructed in the manual. Techniques apply equally to fundraising for maternal health advocacy.

Current Status of Support

- Remind participants that maternal health usually attracts a diverse group of donors, although the range of donors may be somewhat narrower than for reproductive health issues more broadly, including HIV/AIDS. The issue is framed in so many ways—as a human right, a women’s empowerment issue, a reproductive health issue, a family planning issue, and a child health issue, to name a few—so advocates have a variety of options, depending on how they frame the issue.

Developing a Fundraising Strategy

- Proceed as instructed in the manual. Think through some of the circumstances under which it may be inappropriate to accept funding from certain sources to support advocacy activities. Advocacy networks should seek sources from organizations that are the least likely to give money with “strings” attached. Participants should stay focused on developing a fundraising activity to support the network’s advocacy goals, not their own organization’s agenda.
- Maternal Health Handout III.6.1: International Donors in Maternal Health

ACTIVITY 1

ACTIVITY 2

ACTIVITY 3

ADDITIONAL
HANDOUT

International Donors in Maternal Health

Bilateral and Multilateral Donors

- Australian Agency for International Development (AusAID)
- Belgian Administration for Development Cooperation (BADC)
- BMZ (German)
- Canadian International Development Agency (CIDA)
- Danida (Danish)
- Department for International Development (UK)
- Directorate-General for Development Cooperation (Netherlands)
- European Commission (EC)
- Finnida (Finnish)
- NORAD (Norwegian)
- Swedish International Development Cooperation Agency (Sida)
- Swiss Agency for Development and Cooperation (SDC)
- United Nations Population Fund (UNFPA)
- United Nations High Commission for Refugees (UNHCR)
- United Nations Children's Fund (UNICEF)
- U.S. Agency for International Development (USAID)
- World Bank
- World Health Organization (WHO)

Private Foundations

- Aga Khan Foundation
- Conservation, Food and Health Foundation
- Ford Foundation
- Bill and Melinda Gates Foundation
- William and Flora Hewlett Foundation
- W.K. Kellogg Foundation
- John D. and Catherine T. MacArthur Foundation
- Misereor
- David and Lucile Packard Foundation
- Public Welfare Foundation
- Rockefeller Foundation
- Wallace Global Fund

Implementation: Developing an Action Plan

Supplemental Background Notes

Developing an action plan requires the same skills regardless of the goal of the network.

Modifications to Activities

Introduction

- Proceed as instructed in the manual.

Reviewing the Advocacy Process

- Proceed as instructed in the manual.

Developing the Implementation Plan

- Proceed as instructed in the manual. See Maternal Health Handout III.7.1: Sample Advocacy Implementation Plan.

- Maternal Health Handout III.7.1: Sample Advocacy Implementation Plan

ACTIVITY 1

ACTIVITY 2

ACTIVITY 3

ADDITIONAL
HANDOUT

Sample Advocacy Implementation Plan

Maternal Health Handout III.7.1

Advocacy Objective: By 2005, the Ministry of Health will develop emergency protocols for treating obstetric complications.			
Activity	Needed Resources	Responsible Person(s)	Time Frame
Contact Advocacy Network Organizations to discuss advocacy objective and presentation to MOH	Contact information for the Advocacy Network Representatives	Advocacy Network Chairperson	1 week (due November 15)
Schedule an appointment with appropriate MOH officials	Contact information for the MOH officials, preferably the maternal and child health department	Advocacy Network Chairperson	1 week (due November 23)
Create fact sheets for decision makers, which include: <ul style="list-style-type: none"> Country maternal mortality ratio and statistics on skilled attendants at delivery How standards and protocols improve quality of care Testimony of a healthcare provider to discuss how protocols and drills have improved clinicians' ability to provide quality care 	<ul style="list-style-type: none"> Research materials (articles, books, journals, internet) Data Testimony Format for information Paper Printer 	Advocacy Network's Research and Monitoring Team Advocacy Network's Communication Team	4 weeks (due December 28)
Attend meeting with appropriate MOH officials to present argument, assure support and identify next steps	Persuasive Presenter Fact sheets Information on Network activities, contacts, etc.	Advocacy Network's Chairperson, Communication Team Leader, and Research Team Leader	4 weeks (due January 26)

Monitoring and Evaluation

Supplemental Background Notes

The guidelines included in this supplement are equally applicable to advocacy on maternal health issues.

Modifications to Activities

ACTIVITY 1

Introduction to Monitoring and Evaluation

- Proceed as instructed in the manual.

ACTIVITY 2

Developing a Monitoring and Evaluation Framework

- Proceed as instructed in the manual. Discuss evaluating the success of advocacy and policy efforts, including what the difficulties are.

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