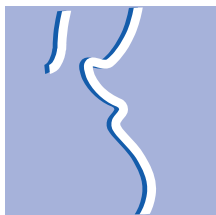


*Safe
Motherhood
A Review*



Executive Summary

The Safe Motherhood Initiative 1987–2005



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Introduction

[M]aternal health rarely gets the priority or attention that it deserves. Partly that's because the victims tend to be faceless, illiterate women who carry little weight in their own families, let alone on the national or world agenda.

– Nicholas D. Kristof, *New York Times*, March 20, 2004

Every minute of every day, one woman dies somewhere in the world from complications of pregnancy and childbirth. These deaths – more than half a million women each year – occur overwhelmingly in developing countries, where pregnancy complications are among the greatest killers of women of reproductive age.¹ This report surveys the principal global effort to address the problem and its causes: the Safe Motherhood Initiative.

What this report contains

The year 2007 will mark 20 years since the launch of the Safe Motherhood Initiative (SMI). The initiative is an international effort to raise awareness of the scope and dimensions of maternal mortality and to galvanize commitment among governments, donors, United Nations (UN) agencies, and other relevant stakeholders to take steps to address this public health tragedy. The anniversary provides a timely opportunity to take stock of how safe motherhood has fared within the health and development agenda and to assess the initiative's achievements and shortfalls.

In 1987, when health experts, development professionals, and policymakers gathered in Nairobi to inaugurate the

global initiative, maternal mortality was not a major national or international priority. In fact, it was often the overlooked component of maternal-child health (MCH) programs, as noted by Maine and Rosenfield in their seminal 1985 article, “Where is the M in MCH?”² At the Nairobi meeting, a group of international agencies launched a global movement, the Safe Motherhood Initiative, whose aim was to reduce the burden of maternal death and ill health in developing countries. Later that year, the Safe Motherhood Inter-Agency Group³ was established to realize the initiative’s goals. As a group and as individual organizations these agencies have raised international awareness about safe motherhood, set goals and programmatic priorities for the global initiative, stimulated research, mobilized resources, and shared information to make pregnancy and childbirth safer.

This report reviews progress in the safe motherhood field since 1987 and examines the challenges and opportunities that lie ahead. Designed for an audience of generalists and policymakers, the summary version provides an overview of how the field has changed in the following areas: international advocacy and commitment, country-level progress, and technical knowledge and interventions. The full version of the report, geared for technical experts and program managers, examines these issues in greater depth and presents data and evidence from document research, as well as from interviews with development and donor agency representatives and national decisionmakers.

The situation

Of all the health data monitored by the World Health Organization (WHO), maternal mortality shows the greatest disparity between poor and rich countries. In the poorest lands, a woman’s lifetime risk of dying during pregnancy

or childbirth is much higher than in the wealthiest. For example, one in every 12 women will die this way in east Africa, compared to 1 in 4,000 in northern Europe. Even within countries, poor, uneducated, and rural women suffer in greater proportion than their educated, wealthy, and urban counterparts. In Kenya, just over 23 percent of women in the poorest fifth of the population have access to skilled care during childbirth, while almost 78 percent of women in the wealthiest fifth are attended by a doctor or a nurse/midwife.⁴ Urban–rural differences can also be stark: in Peru, over 80 percent of urban women have a skilled provider attend their deliveries, while less than 20 percent of rural women receive such care.⁵

Pregnancy can also bring other disabilities and illnesses. According to the 2005 World Health Report, 20 million women a year experience maternal disability, which can range from fever and depression to debilitating conditions like obstetric fistula* or uterine prolapse.** The exact magnitude and scope of this suffering is unclear because of underreporting, poor recordkeeping systems, and problems of definition and classification.

Why invest in maternal health?

Research indicates that investments in curing these ills and making motherhood safer have a multiplier effect. That means they benefit not only the woman but also the health of newborns and children and the well-being of entire households, societies, and nations.

* Obstetric fistula refers to holes in the birth canal caused by prolonged or obstructed labor. Consequences include: vaginal incontinence, pelvic and/or urinary infections, pain, infertility, and early death. The social repercussions are often severe, resulting in abandonment and ostracism.

** Uterine prolapse is the falling or sliding of the uterus from its normal position in the pelvic cavity into the vaginal canal.

- Investing in maternal health saves individual women's lives and safeguards their well-being. For the half million women who die each year, and the millions more who suffer from short- and long-term disabilities, such life-saving investments are an urgent health and moral imperative. *And we know what to do.* Proven, cost-effective interventions to reduce maternal deaths exist. The challenge is to direct the needed funds effectively to ensure that services reach those most in need.
- The health of newborns is closely linked to the health of their mothers. About 30 to 40 percent of neonatal and infant deaths result from poor maternal health and inadequate care during pregnancy, delivery, and the critical immediate postpartum period. Data suggest that a mother's death also harms the overall well-being of her surviving children: in Bangladesh, the surviving children of a deceased mother are three to ten times more likely to die prematurely.⁶ In Tanzania, children who lost their mother during the previous year spent half as much time in school as other children. Where an adult male had died, the impact on children's health and survival was not significant.⁷
- A woman's death affects her family's well-being and that of society as a whole. Her family is less able to care for itself and forfeits any paid wages and all the unpaid labor she contributed to the household. Her death increases the chances her family will face poverty and malnutrition. Data show that the death of an adult woman lowers household consumption significantly in the poorest households for at least a year.⁸

- Investing in maternal health provides long-term benefits for the entire health delivery system. The improvements necessary for the provision of maternal health care also benefit many standard medical services. Developing adequate human resources and effective communications and referral mechanisms, and an efficient supply of equipment, drugs, and consumable goods like gloves and syringes, helps localities handle accidents, trauma, and other emergencies. In addition, pregnancy and childbirth are often the occasion for a woman's first contact with the health system: antenatal caregiving can be an opportunity to address other reproductive health concerns, such as family planning and sexually transmitted infections, or other conditions including tuberculosis, malaria, and HIV/AIDS.
- Safe motherhood investments are cost-effective. A 1993 World Bank World Development Report found them to be among the most cost-effective strategies for low-income countries. In 2005, researchers confirmed the finding: they assessed the cost-benefit value of community-based newborn care, antenatal care, and skilled care during childbirth and found them all to be highly cost-effective.⁹
- Safe motherhood is fundamentally a matter of human rights. All women are entitled to good health and high-quality health services. Maternal deaths are linked to women's low status in society and to their lack of decisionmaking ability and economic power. In order for women to be able to enjoy safe pregnancy and motherhood, they must have the same opportunities for health, education, and employment as their male counterparts.

Positive trends and achievements

Since the mid-1980s, safe motherhood has achieved greater prominence on the international agenda, gaining substantially increased visibility, resources, and attention. In 1985, virtually no donor, international agency, or non-governmental agency (NGO) specifically prioritized safe motherhood or maternal health. Many agencies and organizations now have programs dedicated to maternal health, donors have specifically prioritized safe motherhood in their funding, WHO and other UN agencies have specific programs on this issue, governments have developed national strategies and programs to reduce maternal mortality, and there is substantially greater knowledge and awareness of the problem and how to address it. Progress has been achieved on a number of key indicators, including the proportion of pregnant women receiving antenatal care and the proportion of births attended by a skilled birth attendant:

- Since 1990, the proportion of women receiving antenatal care in developing countries has increased by 20 percent, and more than 50 percent of women receive at least the four recommended antenatal visits.¹⁰
- Between 1990 and 2003, the presence of a skilled attendant at delivery increased significantly, from 41 to 57 percent in the developing world as a whole.¹¹

Safe motherhood in the international context

The past 20 years have witnessed dramatic shifts in the ways maternal health is framed and viewed at the global level. Within international agreements and treaties, the goal of safe motherhood now has major attention and

prominence as a critical element of reproductive health and a key development priority. The call for reducing maternal mortality reverberated in all the major international conferences of the 1990s. In the Millennium Development Goals (MDGs), it was defined as essential for poverty reduction and development. Two key global health agreements (the Programme of Action of the International Conference on Population and Development, or ICPD Programme of Action, of 1994, and the 2000 Millennium Declaration) in particular propelled safe motherhood onto the international stage.

The ICPD Programme of Action represented a paradigm shift in approaches to population, women's rights, and sexual and reproductive health. Before that gathering, most leaders in the population community were concerned primarily with achieving abstract demographic targets rather than meeting individuals' needs for reproductive health services and information. The ICPD Programme of Action was a watershed for safe motherhood: for the first time, a UN document defined maternal health as a core component of reproductive health. It set out a time-bound and measurable goal: to reduce maternal deaths worldwide by 75 percent by the year 2015.¹² Maternal health was situated within the context of a comprehensive, rights-based approach to reproductive health.

Since then, the commitment has been reaffirmed by several major global agreements, including the Platform for Action of the Fourth World Conference on Women, the outcome documents from the UN General Assembly Special Session on HIV/AIDS, the UN General Assembly Special Session on Children, and the Millennium Declaration.

In 2000, at the UN Millennium General Assembly in New York, 189 countries adopted specific international development goals with the aim of reducing poverty and promoting human development. Building upon the agreements and commitments made at the conferences of the 1990s, the MDGs offered a blueprint for reducing poverty and hunger as well as for addressing poor health, gender inequality, lack of education, lack of access to clean water, and environmental degradation. Echoing the ICPD Programme of Action, Goal 5 calls for an improvement in maternal health and a reduction in maternal mortality by 75 percent by 2015 from 1990 levels.

The identification of maternal health as one of the eight MDGs establishes it as central to poverty reduction and overall development. Its inclusion has brought greater international attention to maternal mortality and provided a mechanism for monitoring progress on maternal health: improving access to a skilled attendant at delivery (the key indicator for measuring progress for Goal 5). With the MDGs now widely accepted as the framework for assessing progress on overall health and development at the national and international levels, safe motherhood can figure more prominently in country programs and in development agencies' priorities. The question is—will it?

Knowing what works to reduce maternal mortality

Limited progress in reducing maternal mortality over the past two decades has in large part been attributed to three factors: inadequate investment in effective strategies, the lack of clear technical priorities for safe motherhood and the subsequent implementation of poorly-focused and ineffective interventions. When the initiative was launched

in 1987, insufficient information and research existed on the strategies that could have a major impact on maternal mortality levels.

While the 1987 Safe Motherhood Conference recommended a focus on what is now called skilled care during childbirth and essential obstetric care, it also called for two specific interventions that were more widely embraced by donors and governments: risk screening during antenatal care, and training of traditional birth attendants. They were favored in part because they were perceived as consistent with a focus on primary health care.¹³ Some safe motherhood plans also took a broad social approach to reducing maternal mortality, giving equal priority to strategies to raise women's status, educate girls and women, and improve family planning services. As a result, many programs lacked focus, clear ownership and responsibility were often lacking within government agencies, and the plan was perceived as too expensive for full implementation.¹⁴

In spite of this initial lack of clarity, operations research over the past 18 years has generally consolidated the knowledge base for safe motherhood. The clinical interventions needed to prevent and/or treat the vast majority of obstetric complications are known and accepted as simple and cost-effective. A broad agreement exists that good-quality maternal health services need to include skilled care for both routine and complicated cases, including emergency obstetric services for life-threatening complications, a functioning referral system to ensure timely access to appropriate care, and outreach to the community. The remaining challenge is to develop and evaluate ways to make this approach work in low-resource settings.

Since the Initiative was launched, a notable shift within the safe motherhood community has reframed maternal health from a “disease-specific” approach focusing on “quick fix” interventions to improving the broader health system that delivers maternity care. The 2005 report of the UN Millennium Project Task Force on Child Health and Maternal Health calls for strengthening the overall health system, particularly at the district level, as the best way to achieve dramatic and sustainable progress in maternal health. A well-functioning health system can ensure equitable and efficient delivery of safe motherhood information and services to the entire population, reaching them at home, in the community, and in health facilities at both primary and referral levels.

At the program level, this implies multiple, mutually supportive strategies to change whole systems (e.g., human resources, education and training, supplies and logistics, transportation and communication, etc.). It requires addressing both aspects of the equation: the supply side, such as availability of drugs, supplies, equipment, and adequately trained personnel, and the demand side, such as behaviors in the community about care-seeking during pregnancy and childbirth.

Progress at the country level: Key strategies

At the country level, progress in support of safe motherhood has been mixed. In some countries (Malaysia, Sri Lanka, Bolivia, Egypt, Honduras) concerted efforts on the policy, program, and budgetary fronts resulted in improved access and availability of maternal health services and a reduction in maternal mortality levels. In other countries investment has increased only minimally or even declined, and maternal mortality ratios have either stagnated or, in some settings, even increased.¹⁵

What needs to be in place at the country level in order for pregnancy and childbirth to be safe for all women? Analyses of successful and less successful case studies provide lessons and guidance. Key strategies include:¹⁶

- **Mobilizing political commitment at the highest level**

Indonesia's skilled attendance rates rose in part because it received consistent, high-level political support from the president's office in its efforts to improve maternal health by training and mobilizing community-based midwives. In 1989, the then-president issued a decree launching the Indonesian Safe Motherhood Initiative, which aimed to increase the proportion of births attended by health personnel. The Ministry of Health issued a new policy to accelerate the reduction of maternal mortality and to train and deploy a large number of community midwives to provide village-based MCH services. In 1996, the president launched the Mother-Friendly Movement, which worked to mobilize communities and providers to address the three delays in obstetric and neonatal emergencies (delay in the household decision to seek care, delay in reaching health facilities, and delay in delivery of care at health facilities).

Some countries have seen increasing political commitment at the national level to safe motherhood through the promulgation of national policies, but this has not always been translated into adequate programs and financing. A case study of Lao People's Democratic Republic in the full version of this report illustrates a situation where program activities have been implemented as vertical programs funded by different international agencies in specific areas of the country, and not on a national scale.

- **Improving access to both skilled care for normal deliveries and emergency services to handle life-threatening complications**

Beginning in the 1950s, Sri Lanka established a wide network of primary health care centers linked with higher-level facilities that provided specialized obstetric services. Community health facilities were staffed with skilled birth attendants able to refer complicated cases to well-equipped tertiary level health institutions through a communications and transport system.

- **Removing financial barriers to care**

Bolivia's national insurance fund was established in 1996 with the aim of minimizing economic barriers that prevent women from using public maternal health services. The insurance fund provided free coverage for noncomplicated antenatal, delivery, and postpartum care, as well as for C-sections and other emergency procedures. The fund led to increased use of antenatal and delivery services, though it appears to have benefited primarily women living under better economic circumstances.

- **Improving the quality of maternal health services through making providers more accountable and using effective monitoring systems**

In the past four decades, Malaysia has developed and refined a system for investigating the causes of maternal deaths. This now provides a mechanism to assess the quality of maternal health care, identify weaknesses and reasons for substandard care, and recommend improvements.

Challenges and opportunities

Despite the widespread global commitment to reducing maternal mortality and the strides that some countries have made, women in the developing world are still at extremely high risk of dying or being injured from pregnancy-related causes. In some places, the lifetime risk of death is one in eight. Several positive trends and achievements are apparent, but overall the Safe Motherhood Initiative has fallen short of the goal it set almost 20 years ago: to reduce maternal mortality by 50 percent by the year 2000.

What went wrong? A number of challenges at the global and national levels have hampered progress toward the goal of safe motherhood. These include:

- **The human resource crisis:** Experts agree that the backbone of maternal health care is the skilled birth attendant: a midwife, nurse, or doctor able to handle normal cases and manage complications. In many countries, the fostering of midwifery personnel has long been neglected, resulting in insufficient numbers or outdated skills that prevent competent care. According to the 2005 World Health Report, *Make Every Mother and Child Count*, the human resource crisis is a pressing challenge for scaling up maternal and child health services. Migration (the “brain drain” of trained people from developing to developed countries), HIV/AIDS, and human resource policies that ignore or worsen the situation have contributed to severe shortages and inequities in the distribution of health workers. Conditions are particularly dire in rural areas. In addition to lacking the necessary skills to do their jobs effectively, rural health professionals face difficult living and working conditions, including inadequate pay, poor-quality facilities, supply shortages, lack of supporting policies and clinical norms, and health and security risks.

Over the next ten years, an estimated 334,000 additional midwives will need to be trained, and the skills of an additional 140,000 health providers will need to be upgraded in order to meet the goal of universal access to high-quality maternal and child health services.¹⁷ Innovative and sustainable strategies are necessary. Critical are increased investment in the health sector and strengthening the health system to provide high-quality, equitable care.

- **Financial investments for health:** In many low-resource countries, government spending for health has not been adequate for sustained improvements in maternal health. For example, from 1990 to 2002, total health expenditure in many sub-Saharan African countries decreased or stagnated.¹⁸ A further complication is the difficulty of determining the exact amount allocated to safe motherhood at the national level. Often this figure is buried, absorbed within broader categories such as reproductive health or population policy. Some general categories like commodities or personnel may include sums relevant to maternal health. Recent trends toward decentralization and “basket” funding also make definitive labeling impossible. These factors make it difficult to assess whether funding is sufficient to meet stated policy goals.

Between 1990 and 2002, external donor assistance for health increased from US\$3.2 billion to US\$6.3 billion, and the proportion of funds for population/reproductive health rose by 9 percent (adjusting for inflation). The latter increase was mainly in response to the HIV/AIDS crisis; within reproductive health, funds for family planning and maternal health have decreased or stayed the same. While overall funding for health is up, donor assistance continues to fall behind commitments made at the global conferences

of the 1990s.¹⁹ Both national governments and the donor community need to take immediate steps to increase their investment in health broadly, and safe motherhood specifically, in order to meet the MDG goal of improving maternal health by 75 percent by 2015.

- **Strengthening the health system:** A well-functioning and efficient health system supports the delivery of high-quality and equitable health care. In many developing countries, health systems are weak, fragmented, and unable to provide basic, life-saving services. In some contexts, the health system is also inherently inequitable, delivering good-quality care to certain segments of the population (e.g., urban or wealthy groups) and neglecting others (the poor and disadvantaged). For maternal health, only a well-functioning health system can ensure a continuum of care, from pregnancy to birth and into the postnatal period, and from the primary health facility to referral-level care.²⁰

Strengthened and possibly reorganized health systems are critical to ensuring that all women receive adequate, competent care during pregnancy and childbirth. This involves creating a range of infrastructure and mutually supportive systems and policies that affect human resources, education and training, supplies and logistics, and transportation and communication. In the past, strategies have focused on separate, segmented components of safe motherhood, rather than taking a comprehensive approach. While the separate components were relatively easier to design and implement, they were not highly effective in addressing maternal mortality.

Conclusion

The goal of improving maternal health by 2015 will not be met unless immediate and dramatic action is taken. In discussions with a range of national decisionmakers and colleague agencies, the following recommendations and opportunities for action emerged:

- The most critical requirement for realizing MDG and ICPD Programme of Action goals in maternal health is for donors and governments to increase their financial commitment to maternal health specifically, and to the health sector more generally. Several representatives also reiterated the importance of ensuring that available funds are used efficiently.
- Increased funds should be invested in strengthening the existing health system. Donors need to broaden their funding scope so as to move from a disease-based approach to one focused on systemic improvements in delivery of services. For maternal health in particular, the continuum of care from the entire health system needs to be addressed, from the community level to referral care.
- Greater advocacy is needed for safe motherhood at the global and national levels. What has been missing from previous advocacy campaigns is a single, unified message supported by the safe motherhood world community. Safe motherhood advocates have tended to lobby for individual or separate components (e.g., emergency obstetric care, skilled care during childbirth) rather than for maternal health as a whole.

- The various financing mechanisms in development need to be better understood. National funding strategies either have already adopted or are in the process of adopting a basket approach, in the form of Sector-Wide Approaches (SWAps), Poverty Reduction Strategy Papers (PRSPs), or other financing mechanisms. Only through engagement with finance and economics experts will safe motherhood be ensured a piece of the global development funding pie.
- Health and gender equity need to be addressed within both overall development strategies and those directed specifically at maternal health. Long-neglected issues within safe motherhood, such as unsafe abortion and the needs of pregnant adolescents (married as well as unmarried), should be dealt with in a scientific and unbiased manner.

In order to accelerate progress toward achieving the MDGs, a new global health partnership was launched in September 2005. The Partnership for Maternal, Newborn and Child Health (PMNCH) aims to harmonize and intensify actions at country, regional and global levels in support of the MDGs for maternal and child health (Goals 4 and 5). By bringing together maternal, newborn, and child health, the partnership has the potential to develop a single set of messages accessible to a wide and diverse audience, provide a consistent and sustained approach to the mobilization of both financial and technical resources as well as political will and commitment, and build effective links to other initiatives. Achieving these aims will be critical to ensuring that maternal health receives the attention and resources that will be essential if the lives of thousands of women are to be saved.

Endnotes

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- 11 State of World Population 2005 Report, *The Promise of Equality: Gender Equity, Reproductive Health and the Millennium Development Goals*, UNFPA. At the regional level, the most marked improvements took place in South-Eastern Asia (from 34 to 64 percent) and Northern Africa (from 41 to 76 percent). In sub-Saharan Africa and Western Asia, the indicator increased by only 1 percentage point between 1990 and 2003.
- 12 While the 1990 World Summit for Children "Plan of Action for Implementing the World Declaration on the Survival, Protection and Development of Children in the 1990s" included a goal to reduce maternal mortality by 50 percent by 2000, it did so in the context of a larger set of quantitative goals focused primarily on child and infant health and well-being. The ICPD Programme of Action placed maternal health in the reproductive health context; in addition, at the ICPD, the international community pledged financial and other resources to realize this promise.
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- 14 *The Safe Motherhood Action Agenda: Priorities for the Next Decade.* Report on the Safe Motherhood Technical Consultation, 18–23 October 1997, Colombo, Sri Lanka. New York: Family Care International, 1988.
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For further information and additional copies, please contact: publications@fcimail.org



588 Broadway, Suite 503 New York, NY 10012 USA

Tel +1.212.941.5300 **Fax** +1.212.941.5563

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