

What are the main functions of the World Health Organization?

Written by Jacqueline Hope

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JACQUELINE HOPE, NOV 8 2010

The World Health Organization (WHO) is the body of the United Nations (UN) responsible for directing and coordinating health. As such WHO has come to play a vital role as an actor in the field of international public health and international public health policy. Since its inception in 1947 WHO has been at the forefront of many breakthroughs in the field including, most notably, what has come to be described as one of the greatest humanitarian achievements of the 20th century, the elimination of Smallpox in 1979. However WHO's inability to control the spread of HIV/AIDS, particularly in Africa has cast doubt on its effectiveness. Though much of the media attention given to WHO concentrates on its role in controlling and ultimately eliminating infectious disease, WHO's mandate is far broader. The details of WHO's mandate will be examined in detail throughout this paper but put simply this mandate is to ensure the attainment of the highest possible level of all forms of health by all human beings. This paper will focus on the area of maternal health. Maternal health is an important indicator, alongside life expectancy, of development. This is reflected by the inclusion of maternal health in the Millennium Development Goals (MDGs) however the area of maternal health is often ignored by international relations (IR) scholars who tend to focus analysis of WHO on its role in dealing with infectious disease. This focus on infectious disease by IR scholars is understandable in light of globalization. Due to globalization and the related transport revolution of the 20th century it is now possible for infectious diseases to spread around the globe in a matter of days. The threat of infectious disease brings with it a number of traditional, hard security issues that put bluntly other health issues do not. However in light of the development of the human security paradigm from the late 1990s onwards it is now becoming increasingly apparent that IR scholars will need to expand their examination of the ways in which WHO functions beyond the realm of infectious disease.

This paper will examine the ways in which WHO functions in relation to maternal health. It will do this by first examining the history, structure and functions of WHO and the role that the MDGs have come to play in influencing WHO's operations. The paper will then focus on maternal health as a concept before detailing what role WHO plays in the field of maternal health at an international, regional and national level. The final section of the paper will critique WHO's functioning in the area of maternal health with a focus on WHO's operations at the international level. The paper will conclude by asking if it is fair or even possible to pass judgement on the functioning of an organization as complex and multifaceted as WHO by focusing on only one, narrow section of its overall mandate.

The History, Functions and Structures of the World Health Organization

In order to understand how WHO functions when dealing with the area of maternal health it is first necessary to understand something of the history, functions and structures of WHO. These three areas are closely interrelated. It is important to examine all three in order to paint a complete picture of WHO's functioning in relation to maternal Health.

The constitution of the World Health Organization entered into force on the 7th April 1948; however the idea of an international (or at least transnational) approach to dealing with matters of health had existed since the middle of the 19th century with efforts centred on combating infectious disease[1]. As the 20th century progressed, the focus of international health policy broadened[2].

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The constitution of WHO indicates that, by the middle of the 20th century nations were willing to cooperate in a broad range of health-related policy matters. Chapter II, Article 2 of WHO's constitution lists the twenty-two functions of WHO[3]. In addition to a continuing focus on infectious disease there are also functions that specifically deal with areas including research, assistance to government and addressing non-infectious disease that had previously been given little attention on the international health policy stage.

The constitution of the World Health Organization also addresses its structures. These structures are complex, with three levels of organization at an international level, the World Health Assembly (WHA), comprising representatives of every WHO member state[4], The Executive board, which comprises members elected by the WHA[5] and The Secretariat[6] comprised of WHO's Director-General and technical and administrative staff[7]. The constitution also specifies provisions to create regional organizations[8] and "committees considered desirable to serve any purpose within the competence of the organization[9]".

The focus of WHO's work has shifted over time. This is not surprising, considering the broad scope of WHO's mandate that the organization tends to focus its work around only some of its functions at any given time. The organization's *Eleventh General Programme of Work 2006-2015* details the six core functions it is focusing on between 2006 and 2015[10]. These functions are:

1. Providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
2. Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
3. setting norms and standards and promoting and monitoring their implementation;
4. Articulating ethical and evidence-based policy options;
5. Providing technical support, catalysing change, and building sustainable institutional capacity;
6. Monitoring the health situation and addressing health trends[11].

This set of functions, according to WHO are based on an analysis of WHO's comparative advantage as an actor in the international system[12]. This advantage WHO believes, lies in the organization's "neutral status and near universal membership, its impartiality and its strong convening power[13]." This set of functions and WHO's claims about its comparative advantage will be examined in greater detail later in this paper.

Two points become apparent from reading WHO's *Eleventh General Programme of Work 2006-2015*, the first is that WHO is acutely aware of the challenges it faces if it is to remain a relevant actor in international health[14] (a topic that will be returned to later in this paper) and second, the direction of WHO's work for this period is geared towards meeting the health related Millennium Development Goals. Both these points indicate that WHO is aware of the fact that it cannot function as an independent actor in the international system. Any action WHO takes must be informed by the actions of other actors in the international system and likewise WHO's actions impact upon the actions of other actors in the international system.

The Millennium Development Goals

Before examining WHO's role in maternal health it is important to understand how the Millennium Development Goals (MDGs) have come to play such a prominent role in shaping WHO's work. The MDGs came out of the United Nations Millennium Declaration which was endorsed by 189 countries in September 2000[15] and resolves to work towards combating poverty, ill health, discrimination and inequality, lack of education and environmental degradation[16].

The MDGs are eight specific goals that the 191 United Nations (UN) states have committed themselves to achieving by 2015. The MDGs are:

1. to eradicate extreme poverty and hunger;
2. to achieve universal primary education;

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3. to promote gender equality and empower women;
4. to reduce child mortality;
5. to improve maternal health;
6. to combat HIV/AIDS, malaria and other diseases;
7. to ensure environmental sustainability; and
8. to develop a global partnership for development[17].

These goals are interdependent[18], progress or lack thereof in achieving one goal will have effects on progress towards achieving the others. Likewise it is acknowledged that in order to achieve the MDGs all sections of the UN system will be required to work together and, more importantly, that the UN alone cannot achieve the MDGs. Achieving the MDGs will require the cooperation and action of UN member states and of other international, regional and local governmental and non-governmental organizations. WHO in particular accepts this to be the case; WHO's need to work closely with other UN bodies, states and other actors in the international system is a major theme of WHO's *Eleventh General Programme of Work 2006-2015*.

The MDGs are unique in that they have broad support across the international system. The constituent bodies of the UN and all 191 UN member states are committed to achieving the MDGs. Regional organizations including the European Union[19] and the Association of Southeast Asian Nations[20] (ASEAN) frame, to varying extents, their policies in a variety of areas around the achievement of the MDGs. Many major international charities such as the Red Cross[21] and OXFAM[22] are focusing their work, again to varying degrees, on achieving the MDGs. There are also many civil society organizations, operating at local, national, regional and international levels that are engaged with the MDGs[23]. Considering this broad support it is little wonder that WHO have chosen to focus so heavily on the achievement of the MDGs in the *Eleventh General Programme of Work 2006-2015*.

WHO and Maternal Health

Following the preceding discussion of WHO's functions and Millennium Development Goals it is now possible to examine how WHO functions in the area of maternal health. This discussion will be framed around WHO's contribution to achieving MDG 5 which concerns improving maternal health. It will first examine exactly what maternal health is, before looking at how WHO functions in relation to maternal health at the international, regional and national levels.

Defining Maternal Health

The World Health Organization defines maternal health as referring to "the health of women during pregnancy, childbirth and the postpartum period[24]." Maternal health is complex. There are a broad range of conditions, complications and circumstances that can negatively impact upon maternal health. Some of these are specific to pregnancy, childbirth and the postpartum period[25] (the period immediately following pregnancy or childbirth, defined as being 42 days in length by the International Statistical Classification of Diseases and Related Health Problems (ICD)[26]). Others are either pre-existing conditions or conditions that are contracted during pregnancy, childbirth and the postpartum period that are exacerbated or complicated by pregnancy, childbirth or the postpartum period[27]. Some conditions and complications are acute in nature and others chronic[28]. Conditions and complications can affect physical health, mental health or both[29]. Many conditions and complications are universal, affecting women worldwide[30]. Others are common in the developing world and almost unheard of in the developed world[31]. Certain conditions and complications of pregnancy are strongly associated with cultural practices[32]. The one fact that links all these conditions, complications and circumstances is that they are, almost without exception, preventable and/or treatable[33].

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WHO and Maternal Health: The International Picture

The goal of MDG 5 is to improve maternal health. This goal was translated into two targets to be achieved by 2015[34]. These two targets are:

1. to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio; and
2. to achieve by 2010, universal access to reproductive health[35].

The second of these targets is the major goal of the International Conference on Population and Development and was incorporated into the MDGs in 2005[36]. The first is one of the original MDG targets. Progress towards these goals is measured by a number of indicators. The indicators related to the first target are:

- a) the maternal mortality ratio; and
- b) the proportion of births attended by skilled health personnel[37].

The indicators related to the second target are:

- a) the contraceptive prevalence rate;
- b) the adolescent birth rate;
- c) antenatal care coverage; and
- d) the unmet need for family planning[38].

It is clear from examining these goals that WHO must address a number of challenges if it is to succeed in meeting these goals by 2015. These challenges are multifaceted. They relate not only to health but to culture[39], economics[40] and gender[41] amongst other factors.

At an international level WHO coordinates much of its policy related to maternal health through the Department of Making Pregnancy Safer (MPS). MPS was formed in 2005[42] and works "to strengthen WHO's role in providing technical, intellectual, and political leadership in the field of health and human rights[43]." The department aims to "strengthen WHO's capacity to support countries in their endeavour to improve maternal and newborn health[44]." MPS evolved out of WHO's Safe Motherhood Initiative[45] and focuses its work on 75 priority countries. These countries, located mostly in sub-Saharan Africa and south and central Asia[46] account for 97% of maternal mortality[47].

MPS primarily focuses on four key working areas:

1. strengthening national capacity by assessing the technical capacity of health systems and health policy within countries;
2. building partnerships with governments and other actors in order to build upon existing strategies for poverty reduction and cost-effective interventions;
3. monitoring progress towards achievement of the MDGs through global surveys and data analysis; and
4. advocacy, particularly mobilizing resources at national, regional and international levels in order to increase investment in maternal health, advocate continuum of care approaches in the area of maternal and newborn health and work towards achieving universal maternal health coverage and skilled care at all births[48].

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The most recent MPS annual report published in 2008 continues with these themes detailing achievements such as the development and enhancement of partnerships with other UN organizations, academic and professional organizations[49], capacity building workshops[50] and the development of major advocacy projects[51].

MPS also publishes recommendations for preventing, managing and treating a variety of common conditions and complications of pregnancy[52] and on what care should be provided as standard to all women before, during and after pregnancy, childbirth and the postpartum period[53].

Regional Strategies

With the exception of the Pan-American Health Organization (PAHO) (which serves as WHO's regional office for the Americas (AMRO)[54]) which includes maternal health in its general report on health in the region[55], each WHO regional office, the Regional Office for The Eastern Mediterranean (EMRO), the Regional Office for Africa (AFRO), the Regional Office for Europe (EURO), the Regional Office for South-East Asia (SEARO) and the Regional Office for the Western Pacific (WPRO) publishes reports dealing specifically with maternal health[56][57][58][59][60].

These reports all take on a similar form. All are focused on one or more of the MDG targets and all follow roughly the same structure. This structure looks at the current situation in each region, strategic directions for the region, and implementation frameworks. What becomes apparent from reading these reports is that all WHO regions face a number of similar difficulties in making progress in the area of maternal health. These difficulties mostly stem from deep and in many cases deepening inequalities within regions. Economic capacity of states and individuals, pre-existing health problems including infection and malnutrition, cultural values including gender discrimination and religion and political instability are some of the root causes of inequalities in the area of maternal health[61][62][63][64][65][66].

In addition to the common problems that all WHO regions face there are a number of issues that are specific to particular regions. These problems, like those which all WHO regions face are rooted in a complicated web of economic capacity, health, culture and politics. One well-known example of a maternal health issue that exists almost entirely at a regional level is obstetric fistula in Africa[67].

Each WHO regional office believes that if the maternal health situation is to improve they must work to overcome these difficulties at a regional level. For example EURO states that "a regional strategy for Making Pregnancy Safer (MPS) provides the opportunity to call attention to the maternal and perinatal ill-health situation in the region and creates a means to unite efforts to accelerate actions needed to improve maternal and perinatal health in the European region. This strategy was developed in response to requests from some of the 53 European Members States based on their needs[68]." Similarly AFRO states that its regional roadmap for improving maternal health "provides a framework for building strategic partnerships for increased investment in maternal and newborn health at institutional and programme levels. Consensus amongst the major stakeholders at African regional level to support countries over the next eleven years using this Road Map is a breakthrough in maternal and newborn mortality reduction efforts[69]."

It is clear to see that the regional level of WHO plays a significant role in improving maternal health and in achieving MDG 5 not only because WHO regional offices are equipped to deal with problems that are specific to particular regions but also because they play an important role in coordinating international policy. WHO regional offices are not merely concerned with issues that affect their own regions, they are also deeply involved with attempting to tailor regional solutions to global problems in the area of maternal health.

WHO and National Policy

WHO's major contribution to the health policy of individual nations is normative in nature. One of WHO's major functions, as discussed above, in the area of maternal health at an international level is to publish recommendations on how to care for women before during and after pregnancy, childbirth and the postpartum period and how to prevent, manage and treat many of the complications that can arise during this period.

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WHO produces a range of literature designed to fulfil this normative function. Some of it is technical in nature, designed largely as a teaching aid to those working in the field. An example of this type of literature is *Care in Normal Birth: a practical guide* which is a detailed and systematic guide to care providing information on such matters as diagnosing when labour has started, how to monitor the progress of labour, how to prevent prolonged labour etc[70]. Other literature is directed at policymakers. An example of this form of literature is *Standards for Maternal and Neonatal Care*. This document discusses standards for maternal and newborn care. Each standard is presented in a uniform manner[71] and details the evidence and rationale used in developing the standard[72]. WHO states that the purpose of this document is to help policymakers develop and implement policy at national, sub-national and facility levels for providing effective maternal and newborn health services and improve to the uptake of these services by communities[73]. Other documents are a combination of technical and policy considerations.

WHO's regional bodies also play a normative function in relation to national health policy. An example of this can be found in EURO's *Assessment Tool for the Quality of Hospital Care for Mothers and Newborn Babies* which is an exhaustive survey assessing everything from drug availability to foetal monitoring[74].

How effective is WHO in the area of maternal health?

The role WHO plays as an actor in maternal health is a complex one. Now that some insight as to how WHO functions in relation to maternal health has been gained it is possible to assess how effective it has been.

Assessing the effectiveness of WHO in the area of maternal health is not as easy as it may first appear. This is the case for a number of reasons. First is the question of exactly how to measure the effectiveness of WHO. Should WHO's effectiveness be measured against the MDGs, against the WHO constitution or against the functions outlined in *Eleventh General Programme of Work 2006-2015*? Second is the question of which level any assessment should focus on. Should assessment of WHO's effectiveness be focused on the international, regional or national levels or should any accurate assessment of WHO's functionality take in all three? Complicating the situation further is the fact that WHO itself admits that acquiring accurate data in relation to maternal morbidity and mortality is difficult[75], though the acquisition of data is improving[76] it is still the case that any judgment passed on WHO's effectiveness as an actor has the potential to be grossly inaccurate.

This paper will assess WHO's performance in relation to maternal health using two frameworks. These frameworks will both focus on WHO at an international level. The reason for this is simple, as a scholar of international relations the international level is the most relevant. One framework will focus on the MDGs and the other will focus on WHO's *Eleventh General Programme of Work 2006-2015* and the functions WHO has defined for itself in this report. These two approaches whilst by no means exhaustive serve to illustrate the difficulties in accurately assessing the performance of an organization as multidimensional as WHO.

WHO, Maternal Health and the Achievement of the MDGs

Assessing WHO's performance using the achievement of the MDG 5 targets discussed above as a benchmark does not paint a pretty picture. Put bluntly WHO will fail to achieve these targets. Data published in 2005 indicates that few low and middle income countries will achieve the 75 percent reduction in the maternal mortality ratio that the first target of MDG 5 demands[77]. Worse still, the African region has gone backwards with the maternal mortality ratio widening from 870 deaths per 100,000 live births in 1990 to 1,000 deaths per 100,000 live births in 2001[78]. However there is still cause for cautious optimism. Though, at a regional level, none of the regions have achieved the yearly percentage decline in the maternal mortality ratio required to achieve the 75 percent target, some, most notably East Asia are close to doing so[79]. Moreover the global maternal mortality ratio is slowly declining[80]. Another point of progress is the increase in number of births attended by a skilled assistant with the percentage of births attended worldwide increasing by 14 percent in the 16 year period from 1990 to 2006.

Data related to the second MDG target of achieving universal reproductive health and its indicators is far more difficult to come by which in itself suggests that it is unlikely that this target will be met. The available data indicates that some progress has been made particularly in the area of access to and use of contraception however this

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progress is patchy at both the international level and within states[81]. Progress in this area, especially within states is tightly linked to socio-economic status and other markers of development[82].

As noted above it is difficult, if not impossible to assess progress towards the achievement of any one of the eight MDGs in isolation. Progress or lack thereof in achieving any one of the eight goals has effects on progression towards achieving the others. This is especially true of MDG 5. Perhaps more than any of the other goals the achievement of MDG 5 will require progress towards achieving at least some of the targets and indicators of almost every other MDG. This is because the improvement of maternal health is so closely interlinked with other aspects of development. The eradication of extreme poverty and hunger will mean that women's bodies will be better able to tolerate the physiological stress that even uncomplicated pregnancy causes[83]. Improved education and gender equality will result in fewer pregnancies in the very young and fewer unwanted pregnancies among women of all ages[84]. Uncontrolled HIV/AIDS, Malaria and other infectious diseases are in large part responsible for the increasing maternity mortality ratios in Africa[85] as such it stands to reason that combating these diseases will result in a fall in the maternal mortality ratio in the region. It also stands to reason that the development of global partnerships for development will undoubtedly have positive consequences for maternal health.

WHO recognizes this. The World Health Report 2005 titled *Making Every Child and Mother Count* reflects this recognition. Several case studies featured in the report focus on the links between maternal health and other areas of development. One looks at the situation in Africa with a focus on Malawi[86], another links economic crisis and political instability in Mongolia to a cascading sequence of events that ultimately resulted in the death of a mother[87] and yet another examines the direct effects of HIV/AIDS on pregnant women[88]. However much of WHO's policy regarding the achievement of MDG 5 is narrow in focus. Areas of focus include promoting evidence-based clinical and programmatic guidance, promoting skilled care at every birth and developing educational tools for health professionals[89]. In light of WHO's recognition that improving maternal health is much more complicated than simply providing technical support to healthcare workers WHO's narrow focus is disappointing especially considering that so many of the concurrent improvements required to improve maternal health, such as those related to HIV/AIDS and other infections are unambiguously part of WHO's mandate.

Assessing WHO's progress: an Alternative View

Assessing WHO's performance against the MDG's paints a bleak picture however if WHO's achievements in the area of maternal health are measured against WHO's functions as outlined in the *Eleventh General Programme of Work 2006-2015* quite a different picture emerges. Looking at the functions of MPS outlined above and comparing these functions to the functions that WHO sets itself in its *Eleventh General Programme of Work 2006-2015* also discussed above one can see that on this measure WHO is performing quite well.

In the *Eleventh General Programme of Work 2006-2015* WHO defines itself largely as an agency for providing leadership in the area of international public health and international public health policy. This is exactly the function WHO performs through MPS in the area of maternal health. MPS's functions are very much geared towards providing countries, regions and international bodies with the information and expertise required to improve maternal healthcare. It does this through a number of avenues including advocacy, norm setting and the dissemination of technical knowledge and expertise.

As argued above a large part of WHO's work at the international, regional and national levels in the area of maternal health involves the setting of norms. WHO has been far more successful in this function than it has been in its attempts to achieve any of the MDG targets. Additionally it is entirely possible that positioning WHO as an international normative body geared towards the achievement of long-lasting changes in maternal health through the setting of new norms and standards is both a far more realistic and in the long-term far more positive use of WHO's finite resources than channelling all of WHO's resources into the unrealistic achievement of the MDGs.

Conclusion

This paper has looked at two questions. The first concerns the functioning of WHO and the second concerns how

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well WHO functions in relation to a specific area of its mandate. The specific area of WHO's mandate this paper has addressed is the area of maternal health, an area often ignored by IR scholars in favour of areas of WHO's functioning that present traditional, hard security threats, particularly infectious disease. The choice to focus on maternal health came out of an interest in the human security paradigm and the belief that because of the emergence of this paradigm IR scholars need to broaden their interest in WHO beyond the traditional interest in infectious disease.

The first section of this paper examined WHO's functioning on a general level and discovered that WHO's mandate is far broader than the control of infectious disease. Put succinctly WHO's role in the international system is nothing short of ensuring the attainment of the highest level of all forms of health, physical, mental and emotional by all human beings.

The paper then turned its attention to maternal health, examining what maternal health is and what WHO's role in ensuring the improvement of maternal health is. It was discovered that maternal health is an important indicator of overall development. More importantly however it was discovered that maternal health is an incredibly multifaceted idea, taking in physical, mental and emotional health and complicated by a great many issues linked into larger questions of development. It was also shown that WHO's operations are complex. WHO functions not only at the international level but at regional and national levels as well.

The final section of the paper examined two alternative critiques of WHO's functioning in relation to maternal health. One was focused on WHO's functioning in relation to the MDGs. By this account WHO had made little progress in the area of maternal health and by some measures had gone backwards. This account is important because so much of WHO's energy over the course of the last decade has been placed into achieving the MDGs. However the other account which focused on WHO's functions as defined by the *Eleventh General Programme of Work 2006-2015* presented a brighter prognosis. It argued that instead of focusing on the achievement of the MDGs WHO should place its energy into becoming a catalyst for long-term improvement in the field of maternal health by acting as a setter of norms for international health and international health policy.

One of the questions this paper set out to answer is whether or not it is possible to assess the functioning of an international body with a mandate as broad as the one WHO is required to fulfil by focusing on only a small area of its functioning. After only a brief assessment of WHO's functioning in the relatively narrow area of maternal health the only conclusion that can be drawn is that it is not possible. In assessing WHO's functioning in the area of maternal health this paper came to two entirely different conclusions regarding WHO's effectiveness. Considering this it could be strongly argued that it is impossible to objectively and fairly assess the functioning of WHO as a whole. It may in fact be impossible to assess WHO's functioning in individual policy areas in a manner that is objective, fair and just.

[1] Mark W. Zacher and Tania J. Keefe, *The Politics of Global Health Governance: United by Contagion* (New York: Palgrave MacMillan, 2008) p. 26.

[2] Ibid, p. 37.

[3] WHO Constitution, pp. 2-3.

[4] Ibid, p.5.

[5] Ibid, p. 8.

[6] Ibid, p. 4.

[7] Ibid, p. 9.

[8] Ibid, pp. 11-12

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[9] Ibid, p. 10.

[10] Eleventh General Programme of Work, p. iii

[11] Ibid, p. iii.

[12] Ibid, p. 25.

[13] Ibid, p. ii.

[14] Ibid, pp. 32-33.

[15] MDG 5 Fact Sheet

[16] WHO MDG website

[17] Ibid.

[18] Ibid.

[19] http://europa.eu/pol/dev/index_en.htm (EU)

[20] <http://www.aseansec.org/21918.pdf> (ASEAN)

[21] <http://www.ifrc.org/docs/news/speech10/bg220910.asp> (Red Cross)

[22] <http://www.oxfam.org/en/campaigns/health-education/millennium-development-goals> (OXFAM)

[23] <http://www.un-ngls.org/orf/MDG/civilsocietyaction.htm> (Civil Society)

[24] http://www.who.int/topics/maternal_health/en/

[25] ???

[26] *Beyond The Numbers*, p. 23.

[27] ???

[28] ???

[29] ???

[30] ???

[31] ???

[32] ???

[33] MDGs Report 2010, p. 31..

[34] MDG 5 factsheet

[35] Ibid.

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[36] Ibid.

[37] Ibid.

[38] Ibid.

[39] WHR 2005, p. 26

[40] Ibid, p. 23

[41] Ibid, p. 26.

[42] MPS Annual Report 2005, p. 5.

[43] Ibid, p. 5.

[44] Ibid, p. 7.

[45] MPS Annual Report 2005, p. 9.

[46] Ibid, p. 9.

[47] WHO MPS Website.

[48] MPS Annual Report 2005, p. 8.

[49] MPS Annual Report 2008, p. 13.

[50] Ibid, p. 13.

[51] Ibid, p. 15.

[52] http://www.who.int/making_pregnancy_safer/documents/en/

[53] WHO recommended Interventions

[54] MPS Regional Highlights 2009, p. 9.

[55] PAHO Health Report.

[56] Roadmap for Africa.

[57] Strategic Directions EMRO.

[58] MPS Regional Strategy WPRO.

[59] Euro strategic Approach MPS.

[60] Improving Maternal Health SEARO.

[61] PAHO Health Report, p. 14.

[62] SEARO, p.2

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[63] WPRO, p.2

[64] Euro, pp. 12-13.

[65] EMRO pp. 11-14.

[66] Africa Roadmap, p. 4.

[67] Ibid, p. 3.

[68] EURO, p. 8

[69] AFRO, p. 5.

[70] Care in Normal Birth

[71] Standards, p. 2.

[72] Ibid, p. 2.

[73] Ibid, p. 1.

[74] Assessment Tool EURO.

[75] WHR 2005, p. 11.

[76] Ibid, p. 11.

[77] MDG 5 Factsheet

[78] AFRO Road Map, p. 3.

[79] MDG 5 Factsheet

[80] Ibid.

[81] Ibid.

[82] Ibid.

[83] ???

[84] ???

[85] Africa Roadmap, p. 4.

[86] WHR 2005, p. 11.

[87] Ibid, p. 22.

[88] Ibid, p. 23.

[89] MDG 5 Factsheet.

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