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Maternal and child health and family planning: Current needs and future orientation[1]

Report by the Director-General

This report reviews the health situation of women and children 15 years after the introduction of primary health care and 18 years after the sixth meeting of the Expert Committee on Maternal and Child Health. Major advances in policies and programmes have occurred since then. While many of the recommendations of the Expert Committee have been implemented at a policy level and are reflected in the strategy for health for all through primary health care, there have been notable gaps between policy and programme implementation in a number of areas. Integration of the elements of maternal and child health and family planning and sustainability of programmes elude many countries, particularly the least developed, with their weak infrastructures and dependence on external support for specific components of care.

Nearly all countries have adopted policies recognizing the importance of family planning, and direct or indirect support to programmes is found in 144 countries. However, a great continuing need for the spacing and limiting of births is noted in many countries, and facilities for family planning are often limited to the maternal and child health services.

Immunization coverage shows substantial increases in all regions of the world and infant mortality rates continue to decline. New problems have emerged, and many have been reflected in policies and programmes.

Maternal health has become a high priority in most countries, underlined by the tragic figure of over 500 000 maternal deaths each year. The health of the newborn is inseparable from the health of the mother. Despite progress, significant differences in maternal and child health and family planning coverage continue to exist between countries, and differences between groups within countries may even be on the rise. Analysis of the patterns of coverage and accessibility reveals major gaps in the quality of care provided in services.

Approaches appropriate to both developed and developing countries are described in the final sections. The Executive Board is invited to consider resolutions on traditional practices that are harmful to the health and development of women and children and on quality of care in maternal and child health and family planning.

[1] For a tabular summary the reader is referred to document EB93/INF.DOC./3.

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INTRODUCTION

1. At its ninety-first session the Executive Board requested that a report on progress in maternal and child health and family planning be prepared for the ninety-third session. Subsequently, the Health Assembly in resolution WHA46.18, *inter alia,* requested the Director-General to give particular attention in his report to traditional practices affecting the health of women and children. The last comprehensive review of maternal and child health was made at the sixth meeting of the WHO Expert Committee on Maternal and Child Health in 1975.[1] In 1978 the Thirty-first and in 1979 the Thirty-second World Health Assembly, considering the report of the Expert Committee and on the occasion of the International Year of the Child (1979), requested the Director-General *inter alia* to report on progress in maternal and child health and family planning to a future Health Assembly.[2] While progress in specific programme areas relevant to maternal and child health and family planning have been reviewed by subsequent Health Assemblies,[3] this report is the first review of progress in nearly 15 years. The recommendations of the sixth meeting of the Expert Committee have been taken as the point of departure for this report.[4] Since then the world has undergone monumental social, political and economic changes. The information revolution and rapid advances in technology have affected the health of women and children in nearly all countries and communities. Problems of maternal health, HIV/AIDS and the large numbers of refugees and people displaced by natural and man-made disasters, unnoticed or unimagined in 1975, came to the fore in 1993. Violence affecting women, children and adolescents is being recognized as a public health problem. Newer evaluation techniques have provided better insight into such issues as the content and quality of care, adequacy of skills and the organization of services as district systems. The new emerging needs are summarized in document EB93/INF.DOC./3.

2. This report deals with major developments in maternal and child health and family planning as they relate to the overall provision of services. Recent reports of the Director-General and reports of Technical Discussions at the Health Assembly have dealt with the Expanded Programme on Immunization, "Women, health and development", "The health of youth", "Health of the newborn", "Women and AIDS", and "Control of diarrhoeal disease". While there have been references by the Board and Health Assembly to maternal health and safe motherhood, family planning, and the need for an integrated approach to maternal and child health and family planning, the Board has not explicitly examined the needs and experience of countries with respect to these problems. Information for this review has been forthcoming from: the monitoring of the global strategy for health for all; the development of monitoring and evaluation methods within specific programmes; the data from Demographic Health Surveys; reports of regional committees; preparatory work for the International Summit for Children; the development of readily accessible databases relevant to the health of women and children; and the documents and background papers for the seventh meeting of the Expert Committee on Maternal and Child Health in December 1993.

POLICIES AND INTERNATIONAL INSTRUMENTS

3. As noted in document EB93/INF.DOC./3, there has been no dearth of policy responses to most of the matters raised by the sixth meeting of the Expert Committee on Maternal and Child Health, or to a

[1] *New trends and approaches in the delivery of maternal and child care in health services.* WHO Technical Report Series, No. 600, 1976.

[2] Resolutions WHA31.55 and WHA32.42.

[3] Relevant Health Assembly resolutions on maternal health; women, health and development; infant and young child feeding; Expanded Programme on Immunization; diarrhoeal diseases; human reproduction research, etc. are noted in document EB93/INF.DOC./3.

[4] Although the Expert Committee's report included recommendations on research, the subject will not be covered in this report since an earlier meeting of the Advisory Committee on Health Research dealt with this subject and because space is limited.

number of those that have arisen subsequently. Alma-Ata at the time of the International Conference on Primary Health Care represented a sea of change for policy and programme development in maternal and child health and family planning. The Declaration, *inter alia*, affirmed that family planning as part of maternal and child health was an essential element of primary health care, and that equity and participation of communities were essential in health development. Many of the goals set to meet the needs of women and children are common to WHO, UNICEF, UNFPA and UNDP. They have been reiterated and expanded upon in: the WHO/UNICEF Common Goals for the Fourth United Nations Development Decade; a series of joint policy statements by WHO and UNICEF on such subjects as immunization, control of diarrhoeal and respiratory diseases, breast-feeding, and maternal and neonatal care, and - with UNFPA - on reproductive health of adolescents, traditional birth attendants, breast-feeding and family planning, and HIV/AIDS and maternal and child health and family planning (the latter also with UNDP). The Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child, *inter alia*, establish legal frameworks for action by national authorities to give effect to many of the health goals and targets adopted by the Health Assembly and other international bodies. Target-setting as a means for guiding and providing a stimulus for national and international action has been introduced since the sixth meeting of the Expert Committee on Maternal and Child Health.

PROGRESS IN THE HEALTH STATUS OF WOMEN, CHILDREN AND FAMILIES

4. The greatest strides in this domain in the last two decades have been made in child health and family planning. Life expectancy at birth increased from 51 to 64 years between 1960 and 1990. From estimated global childhood immunization coverage of about 5% in 1975, coverage reached about 80% in 1991 (see document EB93/INF.DOC./3). Infant mortality declined from 76 per 1000 live births in 1985[1] to 68 per 1000 in 1991. Emphasis on breast-feeding and the introduction of oral rehydration therapy in the management of diarrhoeal disease have resulted in sharp declines in the case-fatality rate for this disease. For nearly all areas of the world stunting - an indicator of long-term malnutrition - declined from 40% to 34% between 1975 and 1990.

5. There is much evidence that family planning affects the health and well-being of women in many ways. Among the most significant benefits are: improvement in health status, self-esteem and educational and employment opportunities. More specifically, the possibility to avoid an unwanted pregnancy and to space out or limit childbearing enables women better to exercise their rights as women in their productive and reproductive lives. Currently 144 countries provide direct or indirect support to family planning programmes. The total number of contraceptive users in developing countries is estimated to have risen from 31 million in 1960-1965 to 381 million in 1985-1990. Progress in and unmet needs for family planning (by United Nations regions) is presented in document EB93/INF.DOC./3. To meet these needs, taking into account the United Nations projection for medium population growth, the current estimated "contraceptive prevalence" (51% of people protected) will have to increase to 59% by the year 2000.

6. Little notice was accorded to maternal health until WHO, UNFPA, UNDP and the World Bank focused world attention, at the International Conference on Safe Motherhood in 1987 in Nairobi, on the tragic figure of 500 000 maternal deaths each year. Awareness and policy commitment are widespread but progress has been slow. The negative indicators of women's health - maternal mortality, anaemia, unsafe abortion, low birth weight and perinatal mortality - remain high, and where data on trends are available they show only slow improvement or none - even a deterioration, particularly in the least developed countries or disadvantaged communities. WHO estimates that in the period from 1983 to 1988 numbers of maternal deaths remained the same but in some areas of Africa maternal mortality rates increased by 3% to 9%. The declines over that period in Asia and Latin America were in large part attributable to declining fertility. While earlier data suggested that countries with at least 70% coverage by trained birth

[1] *Implementation of the Global Strategy for Health for All by the Year 2000, Eighth report on the world health situation, Vol. 1.* Geneva, World Health Organization (1993).

attendants do not appear to have maternal mortality rates higher than 150 per 100 000 live births, more recent data from a few urban centres in Africa and Asia have shown rates ranging from 200 to 500 per 100 000. These rates are much higher than expected in areas where the coverage by prenatal care and trained attendants in childbirth were thought to be adequate. It is apparent that the content and quality of care must be assured simultaneously if maternal health is to benefit. Low birth weight and anaemia during pregnancy, two other negative indicators of newborn and maternal health, have not shown any improvement for the world as a whole in the decade from 1980 to 1990. The current global rate for low birth weight is 17%, while the rate of anaemia among pregnant women is 51%.

7. Despite the emphasis on lowering infant mortality there is only limited direct activity in countries to reduce neonatal mortality, which accounts for half of infant mortality, and to combat low birth weight, another major factor. The causes of the 4.2 million deaths in newborn infants each year are linked to complications of pregnancy and/or birth: neonatal tetanus, low birth weight and pre-term births, asphyxia/hypoxia, birth trauma and infections. The millions of newborn infants who survive the consequences of maternal ill health, poor nutrition and poor quality of care are left with poor health, increased risk of death or life-long morbidity. Infants with low birth weight or born prematurely are more likely to suffer the effects of birth trauma and asphyxia, with permanent and severe damage from seizure disorders, retardation or learning disabilities. Yet, most of the conditions that result in neonatal death and severe morbidity can be prevented or treated without resorting to sophisticated and expensive technology. The health needs of newborn infants, inseparable from those of the mother, are mistakenly thought to involve high technology and sophisticated services.

EMERGING HEALTH NEEDS FOR WOMEN, CHILDREN AND FAMILIES

8. Children and women are particularly vulnerable to the effects of poverty, disaster and displacement. Even in natural disasters they bear a disproportionate share of the morbidity and mortality. In most catastrophic situations - war, famine, refugee movements, natural disasters - children are separated from their families. Studies of children's response to extreme violence, death of those around them, abuse and hunger indicate that they are able to resist emotional stress and physical hardship as long as they remain with their parents and families; emergencies become significant in this sense as soon as separations occur and the child's primary attachments are disrupted. Sexual violence against women and sexual exploitation are all too common in mass conflicts. Mental illness is a much neglected but serious consequence of violence, social disruption, refugee situations or displacement. The behavioural implications, in adulthood, for children exposed to widespread senseless violence and death - as such events become banal - and to disruption of the social fabric, are serious. Studies of ghetto children have shown that violent conditions at home and in the environment tend to breed violence.

9. Child labour and the phenomenon of street children persist as economic crisis deepens. The International Labour Organisation conservatively estimates that over 18% of children between 10 and 14 years of age in developing countries are working: at least 7% in Latin America, 18% in Asia and 25% in Africa. Hazards to health include malnutrition (as energy for growth is diverted to work), exposure to toxic substances, and occupational illness and injury, and they can be fatal.

10. Families, and especially the women members, have been seen as the "under-utilized" resource for care. Yet, the family needs internal support if it is to function, providing for the basic requirements of its members. Very little information is available on family functioning and the health of families. The burden of maintaining a family as a functioning entity is on women in much of the world, and often they have limited decision-making authority. There are few indicators of the health of families.

(Emerging needs related to HIV/AIDS must not be forgotten. They have been and must continue to be considered by the Board in another context - see provisional agenda item 9.)

PROVISION OF CARE: ACCESSIBILITY, COVERAGE AND QUALITY OF CARE

11. Adequate coverage is the aim of programmes, and it is often used as an unofficial indicator for the effect of care; however, it is imprecise and of limited use managerially. For example, low levels of coverage could be attributed to inaccessibility (in terms of delays, or distance from services), or to lack of motivation to use services, a more complex factor with economic and cultural aspects, perception of need and belief that the services will meet the need, as well as the acceptability of the services and those providing them. Even when coverage is reported to be high, the system may not be working according to expectations because of lack of equipment or supplies, or health workers may fail to perform tasks correctly.

12. Accessibility of care has not been considered methodologically except in isolated studies and in recent Demographic and Health Surveys (DHS) in a limited number of countries. A wide discrepancy between the population considered to have access to services and those actually using services provides programme managers with an indicator of problems in terms of communities' knowledge, perceived needs or motivation. An analysis of the accessibility of different components of maternal and child health and family planning care provides a measure of the degree to which services are functionally integrated within a community. Data from the DHS during the period 1988-1991 showed a wide variation in accessibility and degree of integration of the different components of maternal and child health and family planning; the widest discrepancy between accessibility and use concerned family planning activities and the use of oral rehydration salts. There is also a wide gap between rates of diphtheria/pertussis/tetanus (three doses) in children and tetanus toxoid vaccination (two doses) for women at risk. An analysis of the use of services in relation to distance from the services provides a useful measure of the importance of the latter. Among 10 countries in which this was examined in DHS studies, distance was not a factor in five while in two it was a severe constraint, and in three a lesser constraint.

13. Significant improvement in maternal health is not possible in the absence of the essential obstetric care generally found at the level of a district or small rural hospital. Yet even in developing countries with well developed health infrastructures, only a minority of the rural population has access to such facilities. As noted in the WHO/World Bank analysis for the 1993 World Development Report, many of the essential obstetric functions could be provided at the level of the health centre where staff had the necessary midwifery skills and supplies and equipment to deal with emergency treatment of haemorrhage, infection, etc. The DHS comparative analysis indicated that in most countries the majority of rural women live within eight kilometres of a health centre.

14. Access to services does not ensure the availability of service or the necessary quality of care. Evaluations of the performance of the maternal and child health and family planning services in several countries have confirmed that essential tasks, such as testing for anaemia or measuring blood pressure, cannot be performed because equipment and supplies are not available or are out of order. Even when they are available, they may be misused; in one evaluation 40% of the health workers did not perform their tasks correctly or did not perform them at all. Thus, while countries may report reasonably high levels of maternal and child health and family planning coverage, *effective* coverage should be the criterion by which to judge progress. Less effective coverage may account for the contradictory data on the effect of antenatal care on pregnancy outcome, as it is also likely to explain the very wide discrepancy between claimed numbers of trained delivery attendants and high rates of maternal mortality. Some countries with maternal mortality rates of 500 per 100 000 live births, or higher, reported that 50% to 70% of birth attendants were trained. Similar discrepancies are observed in data from at least two African urban settings. Before extending maternal and child health and family planning services, the content and quality of care provided remain among the highest priorities.

15. A critical method for the evaluation of quality is maternal and perinatal death audit. In one recent national study, failure in diagnosis or incorrect case management by the obstetrician was noted in over 40% of the instances where the mother died, shortcomings in the facilities were noted in over 10% of the instances and "self-neglect" when women failed to seek care was noted in over 50%. Only 7% of the deaths

were considered unavoidable, and over 50% of the problems could have been detected during antenatal care.

16. In many countries, particularly those with weak infrastructures, new maternal and child health and family planning programme components, such as the Expanded Programme on Immunization and diarrhoeal disease control, were introduced with their own structures and procedures for planning, management, training, information and evaluation. Often they were strongly supported by external resources in contrast to other aspects of maternal and child health care. By 1990 immunization programmes had made spectacular progress, but - in Africa at least - there was a 10% decline in immunization coverage between 1990 and 1991; countries with the best overall maternal and child health coverage maintained high levels.[1]

17. The deployment of maternal and child health personnel is inequitable; midwifery is the backbone of maternal and child health and family planning services; many countries have enough trained midwives in theory but most are located in the urban areas, some in private practice. Rural clinics are often not provided with the equipment and skills to handle the common complications of pregnancy. Rural areas have to make do with traditional birth attendants who, while a useful adjunct to the modern midwife, are not an adequate substitute alone and without the supervision or referral services essential to prevent maternal mortality.[2] Some countries have no alternative but to train traditional birth attendants. In some countries in Africa and Latin America maternity waiting homes have been established close to the referral hospital. Malawi, Mozambique and Zaire are among countries that have upgraded the obstetric and surgical skills of medical assistants and midwives to provide essential obstetric care.

TRADITIONAL PRACTICES AFFECTING THE HEALTH OF WOMEN AND CHILDREN

18. All societies have evolved norms of care, feeding and related behaviour with variations according to age and sex. These "norms", often referred to as traditional practices, have social or cultural origins or are based on empirical observation of individuals or society and their well-being. The health effects of traditional practices may be beneficial, harmful or benign. Many of the traditional practices of childbirth are beneficial, including delivery in an upright position, the presence of a companion during labour and delivery, and measures to ensure a warm, draught-free environment.

19. While many traditional practices have no health rationale they may have a profound health effect, particularly those relating to female children, relations between males and females, including marriage, and sexuality. The socially disadvantaged position of women and girls is manifested in feeding patterns, health care, work, play and schooling. The effects are often cumulative, the most severe consequence being death in childbirth. The last to be fed, the least educated, in many societies the girl child is kept indoors, out of the sun and without other sources of vitamin D, and her pelvic bones are apt to become deformed. Because of menses and later pregnancies and lactation, the adolescent girl requires, but rarely gets, 18% more iron per kg body weight than male adolescents. Globally, 37% of women, and 51% of pregnant women, suffer from anaemia. In developing countries, up to 7% of pregnant women suffer from severe anaemia (below 7 gm% haemoglobin). The common practice of drinking tea with meals interferes with the biological availability of whatever quantity of limited iron may be present in the diet. The practice of eating less or doing without certain nutritious foods during pregnancy is widely described but poorly documented (ACC Subcommittee on Nutrition, 1988). It is presumably thought to guarantee a small infant, thus reducing the chance of obstructed labour due to cephalopelvic disproportion. No published research results confirm or disprove the concern that food supplementation before and during pregnancy might increase such risks while reducing the risk of low birth weight of the baby and malnutrition of the mother.

[1] UNICEF, *Progress of Nations*, 1993.

[2] World Bank, *Better Health in Africa*, 1993; Joint WHO/UNFPA/UNICEF Statement, 1992.

20. Child marriage persists in many communities. With marriage comes the pressure to bear a child, preferably a son. Unfortunately for the girl, the capacity for reproduction is attained about three years before full growth and, more importantly, before the pelvic bones reach adult dimensions. Pregnancy, without nutritional supplementation, before completion of growth will retard or stop further growth, leaving the girl-cum-woman at high risk of obstructed labour, vesiculo- or ano-vaginal fistula, infection and death. In Ethiopia, for example, the maternal mortality rate in the age group 15-19 years is three times higher than that in the age group 20-24 years. In northern Nigeria, in the absence of antenatal care, 5% to 7% of girls under 17 years may die. When such "children bearing children" survive and are still fertile, they face the prospect of repeated complications in future childbearing. If the girls have had the misfortune to undergo one or another form of genital mutilation, and have survived, they are doubly endangered.

21. Female genital mutilation is a collective name given to a series of traditional surgical operations performed on female genitals in several countries in the world. It is a cultural practice and not a disease. Its physical and psychological effects on girls and women, particularly on normal sexual function, affect their reproductive health in a way which lasts all their lives, since none of the procedures are reversible. In all types of female circumcision part or the whole of the clitoris is removed. More severe forms, such as excision and infibulation, remove larger parts of the genitals and close off the vagina, leaving areas of tough scar tissue, permanent damage and dysfunction.

22. Although it is practised in many societies with diverse cultures and religions there is no definitive proof that circumcision of girls is required by any religion. At present, it is estimated that between 85 million and 114 million girls and women in the world are genitally mutilated (Table 1). Most of them live in 26 African countries, a few in Asian countries and increasing numbers in Europe, Australia, Canada and the United States of America. It is estimated that at least two million girls every year are at risk of genital mutilation. The information on total prevalence and rates by type of operation is incomplete (Toubia, 1993). It is estimated, for example, that more than 80% of women in Somalia, Djibouti and North and Central Sudan have undergone the more severe procedure, infibulation. Most of the studies and reports contain inadequate or biased samples and use unclear or faulty methods of data collection. The only country with nationwide data is Sudan, where three countrywide surveys included questions on female genital mutilation.[1]

23. The immediate and long-term consequences will vary depending on the procedure performed. The immediate consequences may include: haemorrhage, tetanus or sepsis, vesiculo-vaginal fistula and most recently, HIV transmission from the performer of the operation or when the procedure is part of a group ritual among older girls. Other consequences include cysts and abscesses, keloid and severe scar formation, difficulty voiding and during menstruation, bladder and urinary tract infection, etc. For the most severe form, infibulation, difficulties in intercourse may lead to the cutting open of the vagina, which usually becomes necessary in any event in the course of delivery. Though no data exist, it is likely that the risk of maternal death and a stillbirth is greatly increased by these factors, particularly in the absence of skilled personnel and appropriate facilities. During childbirth the risk of haemorrhage and infection is certainly greatly increased, and long-term morbidity becomes cumulative and chronic.

24. For several years increased attention has been focused on female genital mutilation by women's organizations, human rights groups, and national and international media. National authorities in many countries in Africa, working with the network of nongovernmental organizations, the Inter-African Committee for the Elimination of Harmful Traditional Practices and others, have developed programmes to educate and inform women and persuade them to abandon mutilation. Combined efforts have been made to convert men in order to ensure a positive effect for the campaign by women. Many lessons have been learned, resulting in the present approach through national and/or local organizations and using as

[1] University of Khartoum Survey 1979, World Fertility Survey [WFS] 1979/80, and Demographic and Health Survey [DHS], 1990. Comparison of WFS and DHS data shows an overall decline of about 6%-8% and a shift from infibulation to clitoridectomy affecting 12% of those mutilated.

far as possible the skills and experience of those whose work is among villagers, such as teachers, social workers and health personnel.

25. Although it is now generally accepted that the initiative for abolition of female circumcision must be taken by women from the societies that practise it, it is also recognized that national and local initiative can benefit greatly by outside support. For the past 15 years, WHO's role has included technical and financial support for national surveys, for the relevant training of health workers, and for grassroot initiatives. A joint task force of nongovernmental organizations and WHO is also being established to strengthen coordination between the various agencies and organizations active in this field.

WHO RESPONSE TO THE PERSISTING PROBLEMS AND NEW CHALLENGES

26. The health of women and children is among the highest priorities for all regions of the Organization. The governing bodies at global and regional levels have discussed the majority of previously identified and emerging needs in maternal and child health and family planning, although they have yet to respond to some of the critical problems of management and performance in programmes. At all levels WHO has attempted to maintain its leadership in supporting Member States in the development of policy and of technical programmes. However, too often, its presence and coordinating role in many countries is limited by material and human resources; resources, and not reason, often have the greater influence on health development priorities. The Organization's development and application of a number of methods for "empowerment" to improve the quality of care, programme performance and training, have been effective in pinpointing many of the questions raised in this report.

27. Regional and global programmes have asserted policy and technical leadership in support of Member States to tackle the most glaring manifestation of inequity and years of neglect for women's health, namely maternal mortality. With the support of a number of major agencies, a global programme on maternal health and safe motherhood has been launched. Activities are focused on national programme development and the global support necessary for that process. Particular attention has been given to the role of health centres, midwifery skills and essential obstetric care in the programme's strategy. A "mother-baby package" of measures to be implemented in any country within the context of national health development has been prepared.

CONCLUSIONS: OLD NEEDS UNMET, EMERGING NEEDS WITH NEW CHALLENGES

28. WHO has been increasingly successful in monitoring the health situation of women and children, documenting global and regional progress and spotting situations requiring urgent attention. The strategies and tools for improving maternal and newborn health have been found. The urgency with which the Organization has taken the lead in this field has in large part been matched by the commitment of many, if not most, countries. Many more countries must take the next step of adapting the global and regional policies, strategies and technology for national programmes. Maternal and newborn health and family planning require even higher commitment of the donor community, governments and WHO. Strengthening of country coordination, and cooperation with nongovernmental organizations, together with rapid exchange of country experience, will facilitate the attainment of the global target of reducing by half the 1990 level of maternal mortality by the year 2000.

29. Considering the analysis reflected in this report and recognizing that the goals of health for all and the Child Summit will not be realized without sustained support for the health of women, children and adolescents, a concerted effort must be made:

- to improve the quality of care and programme performance as a prerequisite for any major investment in extending the coverage of services for maternal and child health and family planning;

- to strengthen the understanding, training and commitment of staff of the entire health system regarding the importance of family planning and their contribution to related services;

- to ensure the functional integration of all the elements of maternal and child health and family planning services, their planning, management and evaluation, to serve not only women and children but young people and families, and including activities for the prevention of sexually transmitted diseases and HIV/AIDS;

- to focus on and plan the elimination of harmful traditional practices affecting the health and development of women and children, in close cooperation with governments and nongovernmental organizations, and stress the public health implications of violence and abuse of women and children, and the need for action to prevent them;

- to increase sustainability of maternal and child health and family planning programmes through decentralization and integration of services and appropriate delegation of responsibility for care within the community, relying on people's involvement and participation, and improve the quality of care.

ACTION BY THE EXECUTIVE BOARD

30. After reviewing this report, submitted in accordance with resolution WHA46.18, and the complementary document EB93/INF.DOC./3, and noting the action of WHO in response to country needs, the Board may wish:

(a) to recommend that the programme's financing should be allocated distinctly within WHO's overall accounts in order to give the necessary attention to the activities and the need for increased external funding, and approve the establishment of a Special Account for the Maternal Health and Safe Motherhood Programme within the Voluntary Fund for Health Promotion as from 1 January 1994;

(b) to consider the following two draft resolutions:

(1) Traditional practices harmful to the health of women and children

The Executive Board,

Having considered the report by the Director-General on maternal and child health and family planning: current needs and future orientation,

1. WELCOMES the report;

2. NOTES that the full report of the seventh meeting of the Expert Committee on Maternal and Child Health is expected to be presented to the ninety-fifth session of the Board;

3. RECOMMENDS to the Forty-seventh World Health Assembly the adoption of the following resolution:

The Forty-seventh World Health Assembly,

Recalling resolutions WHA32.42 on maternal and child health, including family planning; WHA38.22 on maturity before childbearing and promotion of responsible parenthood; and WHA46.18 on maternal and child health and family planning for health;

Reaffirming its support for the United Nations Convention on the Rights of the Child, and United Nations Economic and Social Council resolution 251 of 1992 on traditional practices affecting the health of women and children;

Recognizing that although some traditional practices may be beneficial or harmless, others, particularly those relating to female genital mutilation and early marriage and reproduction, cause serious problems in pregnancy and childbirth and have a profound effect on the health and development of children, including child care and feeding, creating risks of rickets and anaemia;

Acknowledging the important role that nongovernmental organizations have played in bringing these matters to the attention of their social, political and religious leaders, and in establishing programmes for the abolition of many of these practices, particularly female genital mutilation,

1. WELCOMES the initiative taken by the Director-General in drawing international attention to these matters in relation to health and human rights in the context of a comprehensive approach to women's health in all countries, and the policy declarations to the United Nations Special Rapporteur on traditional practices by governments in countries where female genital mutilation is practised;

2. URGES all Member States:

(1) to assess the extent to which harmful traditional practices affecting the health of women and children constitute a social and public health problem in any local community or sub-group;

(2) to establish national policies and programmes that will effectively abolish female genital mutilation, marriage and childbearing before biological and social maturity, and other harmful practices affecting the health of women and children;

(3) to collaborate with national nongovernmental groups active in this field, draw upon their experience and expertise and, where such groups do not exist, encourage their establishment;

3. REQUESTS the Director-General:

(1) to strengthen WHO's technical support to and cooperation with Member States in implementing the measures specified above;

(2) to continue global and regional collaboration with the networks of nongovernmental organizations and other agencies and organizations concerned in order to establish national, regional and global strategies for the abolition of harmful traditional practices;

(3) to mobilize additional extrabudgetary resources in order to sustain the action at national, regional and global levels.

(2) Quality of care in maternal and child health and family planning

The Executive Board,

Having considered the report by the Director-General on maternal and child health and family planning: current needs and future orientation,

1. WELCOMES the report;

2. NOTES that the full report of the seventh meeting of the Expert Committee on Maternal and Child Health is expected to be presented to the ninety-fifth session of the Board;

3. RECOMMENDS to the Forty-seventh World Health Assembly the adoption of the following resolution:

The Forty-seventh World Health Assembly,

Recalling resolutions WHA32.42 on maternal and child health, including family planning; WHA32.30 on primary health care and monitoring health for all; and WHA46.18 on maternal and child health and family planning for health;

Noting that the Organization has successfully developed and adapted a number of management and evaluation methods that involve the participation of all levels of the health system and community, that can be rapidly applied to a wide range of service delivery problems, and that may provide guidance on action needed to improve the functioning and performance of maternal and child health and family planning services;

Recognizing that enormous progress has been made in many aspects of maternal and child health, as evidenced by the great increase in immunization coverage, accessibility and use of family planning services and numbers of trained attendants at childbirth;

Concerned nonetheless that in many countries such increases in coverage are not having the expected effect because of poor quality of care and performance of health systems;

Emphasizing that rapid progress in the health of mothers and the newborn and in family planning can be assured by improving the quality of care and the performance of the existing services and staff,

1. URGES all Member States:

(1) to give priority to assessing and improving the quality of care for women and children in district-based health systems;

(2) to adapt and apply standard protocols for the diagnosis and clinical management of the common problems encountered in services for the health of mothers, infants and children;

(3) to strengthen health centres so as to ensure a high level of midwifery care, and to provide regular supervisory, managerial and logistic support to peripheral health posts, community health workers and trained traditional birth attendants applying local strategies for the health of mothers and the newborn;

(4) to reorient training curricula to community-based and problem-solving approaches, and to ensure that health workers are made aware of the attitudes and needs of women and other members of the community;

2. REQUESTS the Director-General:

(1) to continue to provide technical support and guidance to Member States in the further development, adaptation and application of indicators of quality of care in maternal and child health and family planning and other aspects of primary health care;

(2) to continue to prepare guidelines and training material and devise approaches that improve the quality of care through standardized case definition, diagnosis and case management for the major health problems affecting mothers, the newborn, infants and children, and providing the necessary supervisory support;

(3) to ensure that the components of maternal and child health care and family planning are promoted and provided to Member States in a coherent and integrated manner, and that they correspond to national priorities and demand.

TABLE 1. PREVALENCE OF FEMALE GENITAL MUTILATION (FGM)

Benin*	50%	1 200 000	
Burkina Faso*	70%	3 290 000	
Cameroon*	-	-	Information on prevalence not available.
Central African Republic*	50%	750 000	
Chad	60%	1 530 000	Prevalence based upon 1990 and 1991 studies in three regions.
Côte d'Ivoire*	60%	3 750 000	
Djibouti	98%	196 000	Infibulation almost universally practised. The Union Nationale des Femmes de Djibouti (UNFD) runs a clinic where a milder form of infibulation is performed under local anaesthesia.
Egypt	50%	13 625 000	Practised throughout the country by both Muslims and Christians. Infibulation reported in areas of south Egypt closer to Sudan.
Ethiopia and Eritrea[1]	90%	23 940 000	Common among Muslims and Christians and practised by Falahas (Jewish population, most of whom now live in Israel). Clitoridectomy is more common, except in areas bordering Sudan and Somalia, where infibulation seems to have spread.
Gambia*	60%	270 000	
Ghana	30%	2 325 000	A 1987 pilot survey in one community showed that 97% of interviewed women above age 47 were circumcised, while 48% of those under 20 were not.
Guinea*	50%	1 875 000	
Guinea-Bissau*	50%	250 000	
Kenya	50%	6 300 000	Decreasing in urban areas, but remains strong in rural areas, primarily around the Rift Valley. 1992 studies in four regions found that the age for circumcision ranged from eight to 13 years, and traditional practitioners usually operated on a group of girls at one time without much cleaning of the knife between procedures.
Liberia*	60%	810 000	
Mali	75%	3 112 500	
Mauritania*	25%	262 500	
Niger*	20%	800 000	
Nigeria	50%	30 625 000	Two national studies conducted, but not released. A study of Bendel state reported widespread clitoridectomy among all ethnic groups, including Christians, Muslims, and animists.
Senegal	20%	750 000	Predominantly in the north and south-east. Only a minority of Muslims, who constitute 95% of the population, practise FGM.

Sierra Leone	90%	1 935 000	All ethnic groups practise FGM except for Christian Krios in the western region and in the capital, Freetown.
Somalia	98%	3 773 000	FGM is general; approximately 80% of the operations are infibulation.
Sudan	89%	9 220 400	A very high prevalence, predominantly infibulation, throughout most of the northern, north-eastern and north-western regions. Along with a small overall decline in the 1980s, there is a clear shift from infibulation to clitoridectomy.
United Republic of Tanzania	10%	1 345 000	Clitoridectomy reported only among the Chagga groups near Mount Kilimanjaro.
Togo*	50%	950 000	
Uganda*	5%	467 500	
Zaire*	5%	945 000	
Total		114 296 900	

* Anecdotal information only; no published studies. (By Donna Sullivan and Nahid Toubia for the World Conference on Human Rights, Vienna, June 1993.)

[1] Reported jointly in the absence of separate statistics.

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