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NATIONAL MATERNAL AND CHILD HEALTH  
POLICIES AND STRATEGIES

Report by the Regional Director

Significant progress has been made in maternal and child health/family planning over the last two decades but in some developing countries of the Region maternal and infant mortality still persists as a major problem.

Ninety per cent of the cases of maternal mortality in the developing countries of the Region can be prevented with known and practical technologies for maternal care during pregnancy, WHO is seeking to encourage Member States to review the existing situation and to take urgent steps for the reduction of maternal and perinatal mortality and morbidity.

The Committee's attention is drawn to resolution WHA40.27 adopted by the recently concluded Fortieth World Health Assembly, which is presented in Annex 2.

## 1. INTRODUCTION

Maternal and child health, including family planning (MCH/FP) concerns the health of all mothers and children.<sup>1</sup> The maternal and child health/family planning programme, through its life-saving, life-giving and life-improving health activities, contributes substantially to the amelioration of human development. Like the two sides of a single coin, the programme, on the one hand, responds to the basic maternal health care needs, including family planning, while, on the other hand, it satisfies the need for continuing health supervision and total medical care of all children from birth through childhood and adolescence.<sup>2</sup> Because of the sheer magnitude of its target population, who constitute two thirds of the total population in developing countries, the maternal and child health/family planning programme clearly plays a decisive role in attaining the health-for-all goal in the Region. This paper will focus more on maternal and perinatal mortality and morbidity as these are felt to be the crucial issues of the programme at the present time.

## 2. POLICIES, OBJECTIVES AND STRATEGIES

As with all programmes, the impact of maternal and child health/family planning largely depends on the volume of the technical and financial resources allocated and the strategies adopted. The main bases of the policy guidelines and strategies adopted in countries of the Region are provided by the various resolutions of the World Health Assembly, the Executive Board and the Regional Committee. World Health Assembly resolution WHA32.42 on the long-term programme for maternal and child health and the recently adopted resolution WHA40.27 on maternal health and safe motherhood are presented in Annexes 1 and 2 respectively. In addition, a joint WHO/UNICEF statement: Maternal care for the reduction of perinatal and neonatal mortality, issued in 1986, is an important guide to programme policy.<sup>3</sup> The WHO Western Pacific Region has

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<sup>1</sup>WHO Technical Report Series, No. 600, 1976 (Sixth report of the WHO Expert Committee on Maternal and Child Health).

<sup>2</sup>WHO Technical Report Series, No. 731, 1986 (Report of a WHO Study Group on Young People and "Health for All by the Year 2000").

<sup>3</sup>Maternal care for the reduction of perinatal and neonatal mortality. A joint WHO/UNICEF statement. Geneva, World Health Organization, 1986.

collaborated with countries of the Region in translating maternal and child health-related policies emerging from World Health Assembly, Executive Board and Regional Committee resolutions into concrete activities through the respective national maternal and child health/family planning programmes.

### 3. REGIONAL SITUATION

Significant progress has been made in the maternal and child health/family planning programmes over the last two decades. The infant mortality level has declined. Most countries or areas in the Region have achieved infant mortality rates of below fifty. This may also be due to the large technical and financial resources invested in special programmes such as immunization, diarrhoeal diseases, acute respiratory infections, nutrition and family planning. However, despite the impressive gains in infant mortality reduction, maternal mortality persists at high levels in some of the developing countries of the Region (as high as 900 per 100 000 live births in one country).

### 4. MATERNAL MORTALITY AND MORBIDITY

As in most other parts of the developing world, maternal care in the developing countries of the Region has remained a neglected component of the maternal and child health programme. Concern about this tragic issue has been expressed for some years by WHO.

A WHO estimate, based on the available data, reports that 86% of the world's live births and 99% of maternal deaths occur in the developing countries (Annex 4). A comparative analysis of the maternal mortality rates in the Region reveals not only an alarmingly high maternal mortality rate in developing countries but also a high level of disparity between the developing and developed countries. The disparity is even 100 times greater in some developing countries compared with the developed countries of the Region (Annex 5). Clearly, this underlines the continuing neglect of women's health, particularly in the developing countries. To this extent, maternal mortality is an indicator of inequity or neglect on the part of the health services.

Whether a woman becomes socially and biologically fit at a given age for child bearing depends largely on her access to an equitable share of food, health care and education. Short stature, low body weight, anaemia combined with unwanted pregnancy may set a young girl on the maternal death trail, particularly if she is drawn into the vicious circle of repeated pregnancies. Once these women enter the reproductive cycle, many lack access to good prenatal care with early

and efficient detection and referral of complications or the assistance of a trained person during child birth. The most distressing fact about maternal mortality is that most women requiring life-saving care for obstetrical emergencies, such as postpartum and antepartum haemorrhage, obstructed labour, infection and toxæmia, do not get them at the time of need. Of the few who somehow arrive at the first referral level, quite a number die through lack of appropriate facilities. The reasons for this are principally related to shortcomings in the health care system, which is not only out of reach of the prospective mother for financial and logistic reasons but is also often technically deficient.

Furthermore, if maternal care is inadequate, any further reduction in infant and child mortality will be impossible, for it is well established that more than half of infant deaths occur within the neonatal period.

Another important problem, but less related to the maternal and child health services, is that of illegal abortion. This is a significant cause of maternal mortality in early pregnancy and often passes unreported. The problem is twofold - first, absence of liberal legislation regarding abortion, and second, lack of access to the health services, even where abortion is legal.

The next step in the maternal mortality issue is to identify the policy strategies that would give the "M" of MCH its technically and socially justifiable priority. The studies carried out on maternal mortality in China, Papua New Guinea and Viet Nam, as well as risk approach studies in China, have provided much important information which could be used in formulating technically feasible and financially affordable policies and strategies for the prevention of maternal mortality and morbidity. For example, puerperal sepsis, haemorrhage, ectopic pregnancy and ruptured uterus were found to be leading causes of maternal mortality in Viet Nam,<sup>1</sup> while in China also obstetric haemorrhage topped the list followed by pregnancy-induced hypertension, heart disease in pregnancy, amniotic embolism, pregnancy-related hepatic diseases and puerperal sepsis.<sup>2</sup>

Ninety per cent. of the causes of maternal mortality are preventable with technologies having a proven record of safety and cost-effectiveness.

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<sup>1</sup>Survey on institutional maternal mortality in selected areas of Viet Nam. Institute of Gynaecology and Obstetrics, Hanoi and WHO, 1985.

<sup>2</sup>Maternal mortality in Shanghai, China, Chen Ru Jun. WHO Interregional Meeting on Prevention of Maternal Mortality, Geneva, 11-15 November 1985.

The question, however, is how to make these health care technologies easily accessible to women according to their health needs, regardless of their socioeconomic status and geographical location. The risk approach as an appropriate management methodology is being tested in several countries of the Region. The Malaysian study<sup>1</sup> on the risk approach has reported a better rapport between the community and the health care system and a decline in maternal mortality from 190 to 0 per 100 000 live births in the project area in 1982 during the project period (4577 deliveries in 1982 in Krian District). In China, the Government, based on the positive experience gained in Shunyi County as a result of a WHO collaborative risk approach study, has incorporated the risk approach into its overall Seventh Five-Year Plan starting in 1987. According to the plan, the risk approach will be implemented in all cities with a population of more than 300 000 (159 cities).

The use of a simplified home-based maternal record (HBMR) was found to be effective in the Lao People's Democratic Republic and the Philippines, where it is now being expanded in other provinces. Use of the record has been initiated in several other countries of the Region, notably in Papua New Guinea.

A Conference on Safe Motherhood was held under the sponsorship of the World Bank, WHO and UNFPA in Nairobi, Kenya, in February 1987. In addition to arousing global awareness about the neglect of women's health, particularly in the developing countries, both the World Bank and UNDP have pledged funds to a programme of "Safe motherhood operational research", under the management of WHO.

## 5. PERINATAL MORTALITY AND MORBIDITY

Related to the care of pregnancy and the problem of maternal mortality is the risk to the baby during pregnancy. It is obvious that proper antenatal care can have a major impact on perinatal mortality. Perinatal mortality is defined as the total number of still births after 28 weeks of pregnancy plus the number of infant deaths under one week per 1000 births. Neonatal mortality is defined as the number of deaths under 28 days per 1000 live births.

It has already been noted that neonatal and perinatal mortality may account for up to 50% of the infant mortality rate and this proportion will rise as childhood diseases such as measles, acute diarrhoea and acute respiratory infections are controlled.

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<sup>1</sup> Ministry of Health, Malaysia. WHO country report, Risk approach in maternal and child health care, November 1983.

There are four main components of perinatal mortality: stillbirth, low birth weight and prematurity, death during delivery, and death in the first week of life. The first two are very much related to the health of the mother, especially her nutritional status, and to the quality of antenatal care.

The commonest factors associated with still births are lack of antenatal care, antepartum haemorrhage, maternal anaemia, and toxæmia in pregnancy. In some areas of the Region, malaria is a special problem during pregnancy. Low birth weight is a major cause of perinatal mortality in most developing countries.

Congenital abnormalities are a major concern in some countries, notably in China, where other causes of perinatal mortality are being reduced.

The commonest obstetrical complications causing death in the perinatal period are obstructed or prolonged labour, prolapsed cord, and placenta preavia.

Most early neonatal deaths are in low birth weight and premature babies. Other associated causes of neonatal death are respiratory distress syndrome, brain damage due to birth trauma, congenital abnormalities and infections. Hypothermia is also an easily preventable problem. Prevention of neonatal tetanus and pneumonia, and promotion of breast-feeding are issues that should receive much more attention from the health services.

It can be seen from the foregoing paragraphs that, as with maternal mortality, the causes of perinatal and neonatal mortality are largely preventable by proper health care.

## 6. CONCLUSIONS

(1) Maternal mortality and morbidity in the developing countries of the Region continue to remain high and reflect the wide disparity between the developing and developed countries of the Region. Perinatal mortality is also a major concern.

(2) Maternal mortality is clearly an indicator not only of maternal health but also of maternal and child health care. Designation of maternal mortality as one of the national indicators for health for all would be appropriate.

(3) The use of a home-based maternal record is increasingly being found to be a feasible management method for the prevention of maternal mortality and morbidity and early identification of high-risk cases.

(4) Paucity of information on the extent and causes of maternal and perinatal mortality, particularly in the developing countries, has impeded the formulation of technically and financially feasible policies and strategies for the prevention of maternal mortality. Studies on mortality should be considered a priority in maternal and child health/family planning programmes.

(5) Even though maternal and perinatal mortality are essential indicators of the maternal and child health programme, their underlying causes are often not limited to the health sector alone. As part of the efforts to prevent maternal and perinatal mortality, consideration should be given to the establishment of a national coordinating group with multisectoral representatives, particularly those from national women's organizations.

(6) More than one half of infant deaths occur within the neonatal period, mostly due to maternal health-related problems. It is impossible to reduce infant mortality rates any further without improving maternal health care.

(7) Apart from the monitoring of the foetus during antenatal care and the proper care of the baby during and immediately after delivery, it is also important that mothers receive adequate support in what used to be called mothercraft - specifically, the establishment of breast-feeding and prevention of infection in the neonatal period.

(8) A few pragmatic solutions to the prevention of maternal and perinatal mortality have emerged from the studies carried out in several countries of the Region. However, what is lacking is the application of already proven technologies in the day-to-day management of maternal health and family planning care.

(9) The maternal and child health/family planning services, therefore, should not only address the issue of safe pregnancy for the mother but also ensure the survival of the baby.



قرار جمعية الصحة العالمية  
RESOLUTION OF THE WORLD HEALTH ASSEMBLY  
RÉSOLUTION DE L'ASSEMBLÉE MONDIALE DE LA SANTÉ  
РЕЗОЛЮЦИЯ ВСЕМИРНОЙ АССАМБЛЕИ ЗДРАВООХРАНЕНИЯ  
RESOLUCION DE LA ASAMBLEA MUNDIAL DE LA SALUD

THIRTY-SECOND WORLD HEALTH ASSEMBLY

WPR/RC38/16

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WHA32.42

ANNEX 1

25 May 1979

WHO LONG-TERM PROGRAMME FOR MATERNAL AND CHILD HEALTH

The Thirty-second World Health Assembly,

Recalling resolutions WHA27.43, WHA31.47 and WHA31.55;

Referring to the social target of health for all by the year 2000 and to the principles regarding primary health care adopted in 1978 at the conference in Alma-Ata;

Recognizing that maternal and child health care including nutrition, family planning and immunization are essential aspects of primary health care;

Convinced that a rapid development and determined strengthening of maternal and child health care are of paramount importance for attaining the goal of health for all by the year 2000;

Realizing that more than one-third of the world's population in the year 2000 is not yet born;

Recognizing also that maternal and child health is the health priority, firmly inter-related with the social and economic development of every country;

Recognizing that definite improvements in the health of mothers and children have been achieved where special efforts and resources have been committed to this area of health development;

Convinced that it is important to ensure continuation of the emphasis on the welfare of children started during the International Year of the Child;

Thanking the Director-General for his comprehensive and informative report providing the background for action now,

1. URGES Member States:

(1) to further develop their overall health and socioeconomic planning giving due and explicit attention to meeting health and other needs of mothers, children and the family, and to ensure appropriate distribution of national resources to this end;

(2) to promote specific governmental regulations and laws to provide free health services at least during periods of high risk: pregnancy, delivery and the first years of life when breastfeeding, immunization and treatment of infectious and parasitic diseases are crucial for survival;

(3) to promote the development of primary health care programmes with concrete plans for maternal and child health care as its essential component that includes care during pregnancy and childbirth, family planning, infant and child care with appropriate focus on improvement of nutrition, prevention of infections, promotion of physical and psychological development of the child, and education for family life;

(4) to ensure the development of appropriate supportive, referral and training services in paediatrics, obstetrics and other related subjects in line with principles of primary health care;

- (5) to ensure active participation of individuals, families and communities in the development and utilization of maternal and child health care;
- (6) to develop, as appropriate, health and related social services such as day-care services, school health, adolescent services and relevant social legislation in support of mothers and children;
- (7) to encourage new approaches for simpler, more direct and massive actions to bring to those families, mothers and children most in need those essential health and educational services which are still unavailable to them and review when appropriate present utilization of all health personnel including traditional health workers in order to ensure a better use of existing resources for maternal and child health;
- (8) to develop and strengthen the information support necessary for the planning and implementation of maternal and child care at different levels of the health care system;
- (9) to include in the planned efforts for maternal and child health specific attempts to reach high-risk and underprivileged groups of mothers and children and their families, and to specifically support all efforts at improving the nutrition of pregnant and lactating mothers and children;
- (10) to support research and development as well as evaluation in the area of maternal and child health as part of health services research;

2. REQUESTS the Director-General:

- (1) to support, in collaboration with UNICEF and UNFPA, and competent nongovernmental organizations in official relations with the World Health Organization and with Member States formulation and implementation of long-term maternal and child health programmes as part of the development of their strategies to reach the goal of health for all by the year 2000;
- (2) to support Member States in setting quantifiable targets and in the utilization of suitable indicators for monitoring the effectiveness of their activities in maternal and child health;
- (3) to assist Member States in implementing the Expanded Programme on Immunization as an integral part of MCH services;
- (4) to assist Member States in implementing systematic and planned chloroquine chemoprophylaxis of malaria for children and pregnant mothers in highly malarious areas;
- (5) to further support Member States in curricular revisions in teaching medical and health sciences to give wider coverage to family health and maternal and child health and in development of training programmes for all categories of workers in the health sector, as well as other sectors aiming at the increase of their awareness of the relationship between health and socioeconomic factors with particular reference to the development of children;
- (6) to further develop the Organization's activities for the development of appropriate technology in maternal and child health care and promote health services research in this field;
- (7) to intensify efforts for providing additional support for the Organization's programme in maternal and child health and to mobilize scientific and financial resources in this field;
- (8) to report progress of this work to a future World Health Assembly.



RESOLUTION OF THE WORLD HEALTH ASSEMBLY  
RÉSOLUTION DE L'ASSEMBLÉE MONDIALE DE LA SANTÉ  
РЕЗОЛЮЦИЯ ВСЕМИРНОЙ АССАМБЛЕИ ЗДРАВООХРАНЕНИЯ  
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FORTIETH WORLD HEALTH ASSEMBLY

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WHA40.27

Agenda item 18.2

ANNEX 2

15 May 1987

**MATERNAL HEALTH AND SAFE MOTHERHOOD**

The Fortieth World Health Assembly,

Recalling resolutions WHA32.42, WHA38.22 and WHA39.18 - on the WHO long-term programme for maternal and child health; maturity before childbearing and promotion of responsible parenthood; and implementation requirements of the Nairobi Forward-looking Strategies for the Advancement of Women in the health sector, respectively;

Noting the extremely high levels of maternal mortality and related morbidity prevailing in many developing countries, constituting in some cases more than 50% of all deaths in women of childbearing age;

Further considering that the low social status of women, and the poor nutrition of girls, as well as the lack of appropriate care in pregnancy and childbirth, contribute to this problem;

Recognizing that maternal and child care, including family planning, forms the core of primary health care;

Recalling the recommendations of the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women and the Forward-looking Strategies for the Advancement of Women, which set a specific target to reduce maternal mortality and morbidity;

Taking account of the recommendations of the International Conference on Safe Motherhood in Nairobi in February 1987 cosponsored by WHO, the World Bank and the United Nations Fund for Population Activities, and supported by the United Nations Development Programme;

1. THANKS the Organization for its initiatives in the field of maternal health;
2. URGES Member States:
  - (1) to give high priority to improving the health of women and reducing maternal mortality and morbidity through appropriate primary health care, adequate food and health programmes for girls from infancy to adolescence, and support to family planning programmes in the context of primary health care, making family planning services available to all those who need them in order to avoid unwanted or high-risk pregnancies;
  - (2) to provide appropriate (prenatal) care with efficient and early detection and referral of high-risk pregnancies;
  - (3) to seek to ensure the attendance of appropriately trained personnel for all women in childbirth;
  - (4) to strengthen referral facilities and supervision measures in maternal and child health and family planning in order to deal with obstetrical emergencies and provide essential obstetrical care, and take the necessary steps to prepare appropriate staff at all levels;
  - (5) to coordinate action within the health and other sectors to improve women's education and nutrition; and the generation of financial and other resources for appropriate social support during pregnancy, delivery and the first year following childbirth;

3. REQUESTS the Director-General:

- (1) to assist countries with high rates of maternal mortality in studies on the dimensions and causes of the problem, and to support national efforts to reorient primary health care action so as to give adequate priority to the reduction of maternal mortality and morbidity;
- (2) to support collaborative operational research on safe motherhood, with emphasis on preventing the five main causes of maternal mortality and finding local solutions to overcome the obstacles to appropriate maternal care;
- (3) to intensify technical cooperation in the field of maternal and child health, including family planning, focusing on measures to reduce maternal mortality and morbidity;
- (4) to increase the Organization's collaboration with appropriate United Nations agencies and nongovernmental organizations, with emphasis on the promotive and preventive aspects of maternal health and family planning and the availability of essential obstetric care at first referral level and in emergencies of pregnancy and childbirth;
- (5) to intensify efforts to mobilize appropriate human, scientific and financial resources for maternal health programmes, including epidemiological and operational research aspects, and in particular to seek financial support from multilateral and bilateral agencies and foundations to this end.

Twelfth plenary meeting, 15 May 1987  
A40/VR/12

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SITUATION OF MATERNAL AND CHILD HEALTH/FAMILY PLANNING INDICATORS  
BY COUNTRY/AREA

| Country/area                              | *Population<br>(000) | *I M R<br>(per 1000) | **M M R<br>(per 100 000)<br>National | *Percentage<br>of deliveries<br>attended by<br>trained<br>personnel | *Percentage of<br>pregnant women<br>attended by<br>trained personnel<br>during pregnancy | *Rate of<br>natural<br>increase<br>(%) | *Percentage<br>of newborns<br>less than<br>2500 grams | **T F R<br>15-49 years |
|---|----------------------|----------------------|--------------------------------------|---|--|--|---|------------------------|
| American Samoa                            | 35                   | 5.80                 | -                                    | -   | -  | 3.92                                   | 2.60  | -                      |
| Australia                                 | 15 379               | 9.59                 | 6                                    | 98.60   | 098.60   | 0.85                                   | 5.80  | 1.90                   |
| Brunei Darussalam                         | 216                  | 12.70                | -                                    | 82.00   | 100.00   | 2.58                                   | 10.00   | 5.10                   |
| China                                     | 1 024 950            | 34.70                | 44                                   | -   | -  | 1.54                                   | -   | 2.60                   |
| Cook Islands                              | 18                   | 16.40                | -                                    | 100.00  | 100.00   | 1.57                                   | 2.00  | 4.20                   |
| Democratic Kampuchea                      | 6 780                | 160.00*              | -                                    | -   | -  | 2.59                                   | -   | 5.10                   |
| Fiji                                      | 700                  | 22.50                | 47                                   | 97.20   | 97.00  | 2.40                                   | 13.90   | 3.40                   |
| French Polynesia                          | 167                  | 18.50                | -                                    | 100.00  | 100.00   | 2.50                                   | 7.30  | -                      |
| Guam                                      | 113                  | 9.10                 | -                                    | 99.90   | 98.00  | 2.40                                   | 7.60  | -                      |
| Hong Kong                                 | 5 364                | 9.10                 | 6                                    | 99.50   | 99.50  | 0.96                                   | F-4.7, M-3.6  | 1.70                   |
| Japan                                     | 120 235              | 6.00                 | 15                                   | 100.00  | 99.00  | 0.63                                   | 5.4   | 1.80                   |
| Kiribati                                  | 62                   | 87.00*               | -                                    | -   | -  | 1.70                                   | 18.00   | 4.70                   |
| Lao People's<br>Democratic Republic       | 3 585                | 104.00               | -                                    | -   | -  | 2.90                                   | 30 - 40   | 5.80                   |
| Macao                                     | 343                  | 12.00                | -                                    | -   | -  | 1.80                                   | 6.00  | -                      |
| Malaysia                                  | 15 204               | 19.26                | 59                                   | 82.00   | 65.50 a/   | 2.60                                   | 10.00b/   | 3.80                   |
| New Caledonia                             | 145                  | 21.90                | -                                    | -   | 100.00   | 2.09                                   | 7.20  | -                      |
| New Zealand                               | 3 250                | 12.54                | 20                                   | 99.00+  | 99.00+   | 0.76                                   | 5.20  | 2.00                   |
| Niue                                      | 3                    | -                    | -                                    | 100.00  | 100.00   | 2.30                                   | 3.50  | -                      |
| Papua New Guinea                          | 3 252                | 72.00                | 900                                  | 33.50   | 54.20  | 2.23                                   | 25.00   | 6.00                   |
| Philippines                               | 53 186               | 58.00                | 80                                   | -   | -  | 2.40                                   | 15.40   | 4.50                   |
| Republic of Korea                         | 40 578               | 34.20                | 34                                   | 65.00   | 78.00  | 1.68                                   | 9.20  | 2.60                   |
| Samoa                                     | 163                  | 35.00                | 40                                   | 52.00   | 92.00  | 2.60                                   | 2.40  | 5.91                   |
| Singapore                                 | 2 502                | 9.40                 | 11                                   | 99.80   | 95.00  | 1.09                                   | 8.00  | 1.70                   |
| Solomon Islands                           | 259                  | 46.00                | -                                    | 80.00   | -  | 3.40                                   | -   | 7.30                   |
| Tokelau                                   | 2                    | 28.00 c/             | -                                    | -   | -  | 1.50                                   | 4 - 6.8   | -                      |
| Tonga                                     | 97                   | 11.10                | -                                    | 60.00   | 80.00  | 0.90                                   | 2.00  | 5.60**                 |
| Trust Territory of<br>the Pacific Islands | 142                  | 17.60                | -                                    | 89.00 c/  | -  | 2.70                                   | 6 - 9.8   | 4.98**                 |
| Tuvalu                                    | 8                    | 45.60                | -                                    | 100.00  | 100.00   | 1.50                                   | 3.00  | 4.98**                 |
| Vanuatu                                   | 130                  | 75.00                | -                                    | 72.00   | 90.00  | 3.20                                   | 4.70  | 6.60                   |
| Viet Nam                                  | 57 442               | 33.50                | 110                                  | 100.00  | -  | 2.20                                   | 25.00   | 5.80                   |
| Wallis & Futuna                           | 10                   | -                    | -                                    | -   | -  | -                                      | -   | -                      |

**Legend:** IMR - Infant mortality rate  
MMR - Maternal mortality rate  
NI - Natural increase  
TFR - Total fertility rate

**Sources:** \* - Evaluation of the strategy for health for all by the year 2000. Seventh report on the world health situation. Vol. 7. Manila, World Health Organization, 1986.

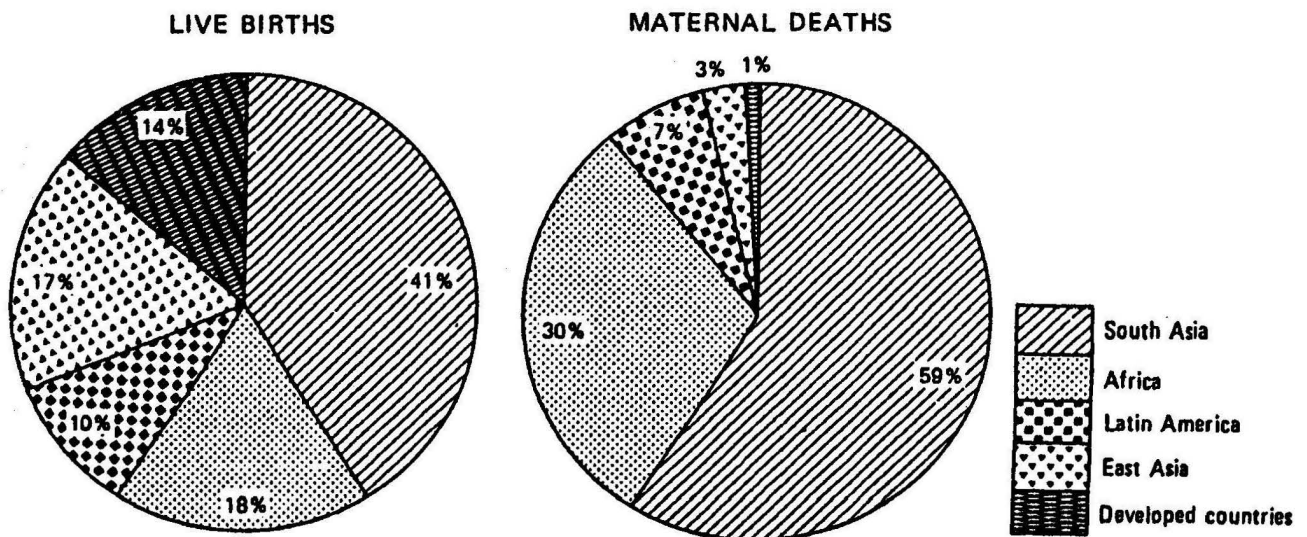
\*\* - Maternal mortality rates. A tabulation of available information. Second edition (WHO document.FHE/86.3), 1986.

**Footnotes:**

a/ - Peninsular Malaysia  
b/ - Rural population only  
c/ - Perinatal death rate

ANNEX 4

LIVE BIRTHS AND MATERNAL DEATHS IN DEVELOPED  
AND DEVELOPING COUNTRIES OF THE WORLD



WHO 861663

Source: Maternal mortality rates. A tabulation of available information. Second edition (WHO document FHE/86.3), 1986.

ANNEX 5

MATERNAL MORTALITY RATES PER 100 000 LIVE BIRTHS IN  
DEVELOPED AND DEVELOPING COUNTRIES OF THE REGION\*

| Developed countries | MMR | Developing countries | MMR |
|---------------------|-----|----------------------|-----|
| Australia           | 6   | China                | 44  |
| Japan               | 15  | Fiji                 | 47  |
| New Zealand         | 20  | Malaysia             | 59  |
| Singapore           | 11  | Papua New Guinea     | 900 |
|                     |     | Philippines          | 80  |
|                     |     | Republic of Korea    | 34  |
|                     |     | Samoa                | 40  |
|                     |     | Viêt Nam             | 110 |

\*Source: Maternal mortality rates. A tabulation of available information. Second edition (WHO document FHE/86.3), 1986.