

# Making Pregnancy Safer

A NEWSLETTER OF WORLDWIDE ACTIVITY

## Saving Mothers and Newborns in Emergencies

When the earthquake and tsunami hit South Asia in 2005, tens of thousands of pregnant women were among the people left homeless. At the time, WHO quickly dispatched medical professionals and essential supplies for the care of these women to the affected areas.

"In every camp, emergency obstetric and newborn care should be available, alongside the essential medical care," says Dr Monir Islam, Director of the Department of Making Pregnancy Safer. "This is the only way to save lives of mothers and babies who experience life-threatening complications."

Timely access to health facilities and services for mothers and babies has been a priority for WHO for many years. In order to also improve the emergency response for mothers, newborns and young children, who are the most vulnerable among the displaced persons in humanitarian crises, the organization is working closely with other international agencies, and a wide range of partners.

As a member of the Inter-agency Working Group (IAWG) on Reproductive Health in Crises Situations WHO participated in the development of the Minimum Initial Service Package (MISP) for Reproductive Health. The MISP outlines the most important reproductive health services to prevent death and disability among

women and girls in emergency settings. It includes the following activities:

- Identification of a lead reproductive health agency;
- Prevent excess maternal and newborn morbidity and mortality;
- Prevent sexual violence and respond to the needs of survivors;
- Reduce the transmission of HIV;
- Plan for the transition to comprehensive reproductive health services and integration into primary health care.



Reducing the unnecessary maternal and newborn deaths includes for example the establishment of a referral system that is functional around the clock to manage obstetric and newborn emergencies. It also involves the provision of midwifery supplies including newborn resuscitation equipment at health facilities. Complete equipment

*Continues on page 8*

500 experts from around the world including for example academics, policy-makers, donors and country programmers discussed reproductive health services in crisis settings during the Reproductive Health in Emergencies Conference in Uganda in June 2008. MPS together with colleagues from Health Action in Crises (HAC) and other WHO units facilitated a discussion on challenges and opportunities for scaling up sexual and reproductive health in crisis settings. For more information on the conference, please check the following web site: <http://raiseinitiative.org/conf2008>

*Childbirth in Crisis Situations - the Reproductive Health in Emergencies Conference 2008*

ISSUE 7: APRIL 2009

HOT TOPICS

Department of Making Pregnancy Safer



World Health Organization

## Director's Message



Dr Q. M. Islam

Across cultures and history, women have been the backbone of their communities as mothers, workers, bread winners and heads of households. During times of humanitarian crisis, when an emergency such as a natural disaster or political unrest strikes a population, the contributions of women become even more vital. Yet the particular health vulnerabilities of women, especially during pregnancy are often overlooked in the rush to provide humanitarian assistance. As hospitals and clinics are destroyed or become inaccessible and health workers become overwhelmed or are displaced themselves, a woman's susceptibility to pregnancy-related death increases. In such periods, access and availability to reproductive health services are limited or frequently not available.

Unfortunately, most national programmes for reproductive health care, including those offering obstetric services, do not include protocols for refugees and internally displaced persons, making access issues even more complicated. As a result, women who flee conflict or are displaced by natural disasters are often forced to give birth without access to even the barest essentials of safe child delivery. With the additional loss of access to family planning services, many women and young girls are left exposed to unwanted or unplanned pregnancies in perilous conditions.

WHO and its partners have repeatedly stressed the importance of improving maternal health and reducing the number of maternal and newborn deaths. It has been demonstrated that access to essential obstetric and newborn care is a vital component to achieving this goal and should therefore be recognized as a crucial intervention also during times of crisis. Efficiency of services could significantly be improved through national preparedness and response plans and strategies, and greater collaboration between humanitarian actors and national health authorities. At WHO, MPS works to identify concrete solutions and inspire action among policy-makers and health providers working in this largely neglected area. This newsletter offers some stories from the field in responding to maternal and newborn health needs during recent humanitarian crises.

## Women leaders committed to fight maternal mortality -

### WHO Director-General's Roundtable on MDG 5

Given WHO's priority area of women's health, Dr Margaret Chan, Director-General, decided to convene a number of women leaders — mainly first ladies — to examine the stubborn issues of maternal mortality and universal access to reproductive health. For the past twenty years there has been little progress in reducing maternal mortality, making Millennium Development Goal 5 the least likely of all the Goals to be achieved. Still, every minute a woman dies of complications due to pregnancy and childbirth.

The WHO Director-General's Roundtable with Women Leaders on MDG 5 took place on 25 September 2008 in the context of the High-Level Event on the MDGs at the United Nations General Assembly in New York. The meeting aimed to build a wider constituency and increased awareness of health issues related to MDG 5, the improvement of maternal health, and see what could be done in the most affected countries. The participants included some 20 women leaders from around the world, i.e. first ladies and UN Agency leaders.



The informal setting of the Roundtable encouraged an open discussion on the underlying causes of maternal death, creative ways to deal with these problems and possible solutions. The first ladies showed great concern of the fact that there has been little progress in reducing maternal death since 1990. During a rich discussion they agreed on the need to act and on the fact that stand-alone solutions will not effectively stop mothers and babies from dying unnecessarily in any country. As the First Lady of Burkina Faso, H.E. Mrs Chantal Compaoré, put it: alliances have to be forged with mothers and their families, with midwives and nurses, and with civil society. The Director-General underlined that "things can change, when influential people - women and men - care enough to make these issues a priority."







### Interview with Dr Eric Laroche, Assistant Director-General of the Health Action in Crises Cluster

#### “Having a baby should not be a disaster!”

Dr Laroche, you were appointed Assistant Director-General of the Health Action in Crises cluster in February 2008. We would like to talk with you about pregnant women, mothers and newborns in crises, as for example the cyclone in Myanmar. Was there a moment during that disaster which particularly struck you?

Yes, in fact there was a particular moment. Three weeks after the cyclone, my colleagues went to a small island by helicopter during a visit to the country. Everything was clearly destroyed. The single rural health centre was completely flattened, there were no medical supplies available and no nurses. They arrived at a setting where, in the middle of all this debris, a woman had just delivered. It was an apocalyptic situation – but the woman was holding her newborn in her arms and had a big smile on her face. She was fortunate to have her baby without complications.



Photo: WHO/AMPS

Before joining WHO you worked 23 years for UNICEF and the UN. From your experience in the field, how much attention do women, newborns and children get in crisis situations?

Today they get more attention than some 20 years ago. Nevertheless, they are by far still the lost cases in emergency settings. Children, mothers and women are particularly vulnerable, they suffer the most and they have higher rates of mortality. We have seen that maternal mortality is closely linked to the disruption of services in war or crises. However, it is often very difficult to get financial aid for activities to reduce maternal mortality in such settings. This is why you often see women delivering on a table, under a tent, without any other equipment than just that table! This is not acceptable. I think there is not enough attention paid to mothers in crisis situations.

What needs to be done to ensure maternal and newborn care in crisis situations?

Well, we send maternity kits and delivery kits to areas in crisis which can be useful resources but we need to make sure these get to women in time. We also need to start thinking about who is going to use this equipment? Often there are no trained health personnel available as people are on the move and many health staff may have been displaced, killed or traumatized during the emergency. In order to improve the situation of maternal and newborn health in crisis settings we should elaborate our framework and approach to working with pregnant women.

In the context of natural disasters, for example, it should not be too complicated to put a special focus on pregnant women. Often the communities already have the data

from before the emergency. They usually already know who is pregnant and about to deliver. Even if people are on the move, they often move together and still know where to find the women who are going to deliver.

Why are the mothers often forgotten?

We know that a maternal mortality ratio of 1500 deaths per 100 000 births in a country is a high number. The more the humanitarian system is professionalized, the more we forget that there are people behind the numbers. The “humanitarian imperative” to help is missing more and more and I think this is why women are forgotten.

But if you are a doctor, a nurse or any humanitarian actor and you see a mother dying while she is delivering – because she had to travel for a whole week to get to a place to deliver and when she finally gets there it is too late – you should keep your capacity of being revolted. Show the world that the death of a mother is an unbearable fact. Remind all different stakeholders, the donors and the public that delivery is where the value of life is. Having a baby should not be a disaster.



### WHO Regional Office for Africa

#### How a new vehicle is saving mothers' and babies' lives in Malawi

Pregnant women in Malawi are at constant risk of developing complications during childbirth. The maternal mortality rate in the country is high also because it is often difficult to get the women to a health centre safely and on time. In a country where maternal care for rural populations is underserved and under-resourced, pregnant women often have to wait up to four days before they are referred to a hospital. To make matters worse, many roads are in such bad condition that they are difficult for normal cars and busses to use. This situation inspired the industry to look for cost-effective transportation solutions. One of these solutions is the eRanger motorbike.



Photo: ERANGER

This creative vehicle is a motorcycle that is equipped with a sidecar which has a comfortable mattress in it to transport patients quickly to remote hospitals even on bumpy and hard-packed dirt roads.

To help address some of the barriers pregnant women are experiencing, the Safe Motherhood Initiative in the Dowa district in Malawi purchased some of the motorbikes for their maternal health services. While the full potential of the motorbikes needs to be further investigated, some preliminary data are showing interesting outcomes. Since better transportation has been made available, the district has seen a continued increase in facility deliveries -from 25% in 2003 to 49% in 2007-, a reduction of 50% in referral times, and a reduction in MMR from 586 per 100 000 live births in 2004 to 235 per 100 000 live births in 2007. Some Malawian hospitals have even seen a 200% increase in the number of women giving birth in the facility.

Meanwhile, patients in the district have gotten used to the new form of transportation and women are said to find the speed, efficiency and availability of motorbike ambulances to be better than those of car ambulances. A rural health facility midwife suggests that *"the women appreciate the motorbike ambulances because they are maybe the same women who had relatives that have been delayed waiting for ambulance"*. Economical considerations also speak in favour of the new vehicles. Compared to normal all-terrain cars, the cost for the purchase of a motorbike and its ongoing maintenance is much lower. In the spirit of being sustainable, the company has tried to ensure that the maintenance of the vehicle can be entirely carried out by Safe Motherhood Initiative staff, using local products.

Based on the positive experience from Malawi, some WHO partners are considering to use these mini-ambulances in natural disaster and post conflict settings.

More information on eRangers: [www.eranger.com](http://www.eranger.com)



## WHO Regional Office for the Americas

### Emergency response to flood-stricken Guyana

The largest disaster to hit Guyana in over 100 years occurred in January 2005, when torrential rains caused serious flooding along the coastal region, giving rise to extensive health threats. Over 300 000 Guyanese, almost 50% of the total population, were affected. Over half of them were women and almost one third children under nine years.

During the initial weeks, it was estimated that 66% of the health centers in the affected area were flooded, 33% were out of operation and 8% with limited functional capacity. Access to food was a major challenge, especially for children as well as pregnant and lactating women.

With the in-kind support of UNDP and UNFPA, the WHO Regional Office for the Americas (AMRO) was able to support the delivery of so-called dignity kits which include hygiene essentials such as soap and sanitary napkins. In addition, AMRO contributed to ensuring rapid recovery of health services, including the re-establishment of mother and child health services and reproductive health care for women and adolescent girls.

In the process of responding to the floods, AMRO developed innovative strategies to address growing public health needs. In close collaboration with the Ministry of Health and other health partners, the country office developed a strong communication strategy to reach out to affected communities. In particular, a health promotion campaign targeting children, adolescents and pregnant women was set up. Three stakeholder coordination groups were established to assess and intervene in water supply, solid waste/sanitation and post-flood cleanup. 131 black tanks were dispatched to supply potable water on the East Coast of Demerara. Daily water quality monitoring identified needs for local water disinfection. Some 29 standpipes were also established on high ground in these areas. The water and sanitation facilities for a total of 33 schools



were rehabilitated. 13 public service announcements were developed and produced (flyers, posters, radio and television) with a focus for example on safe water and sanitation, personal hygiene, food hygiene, disinfection of homes and prevention of diseases. More than 75% of the population was reached through the electronic media, and the people affected by the floods on the East Coast of Demerara and in Georgetown were reached via television and printed messages.

The experience of the floods in Guyana in 2005 prompted the regional and the country office in collaboration with the Ministry of Health (MOH) to develop a strategy to respond to future emergencies and to reach isolated communities more quickly. It includes ensuring that affected communities and the authorities will get together and decide on a package of interventions to ensure more rapid response.



## WHO Regional Office for the Eastern Mediterranean

### Training birth attendants in Somalia

In the past two decades, Somalia has been devastated by a civil war that seriously compromised its health system capacity. Today, the country has one of the highest mortality rates in Africa with a maternal mortality ratio of 1600 per 100 000 live births, and 90% of maternal infection after delivery. Pregnancy-related complications are mostly due to limited access of pregnant women to trained midwives, as most of the skilled health personnel have been displaced or fled the country.





Health workers in central and southern Somalia have not undergone any refreshment course on how to prevent infection or the application of aseptic and hygienic measures for a very long time. During some assessment visits carried out at hospitals it has been observed that repetitive errors on proper wound infection management are made. To improve the skills of local health personnel, the WHO office in Somalia helps to carry out training programmes.

*“These trainings are crucial to create awareness among health workers. At the end of the sessions, the participants did not only gain important knowledge about aseptic and hygienic measures, but they were also encouraged to identify the challenges that health workers face in their job and to advocate for solutions”,* says Omar Saleh, who is responsible for the training of midwives at WHO Somalia.



In May 2008, WHO Somalia organized a 3-day training course on basic hygiene and clinical care for safe delivery together with national partners. This training involved 71 participants including qualified and auxiliary nurses as well as midwives, all working in mother and child health care centers (MCH), out-patient departments (OPD) and operating theatres in the Lower Shabelle region. At the end of the training, WHO Somalia recommended to follow up with regular refresher courses to make the training more sustainable, to carry out advocacy activities aimed at strengthening the aseptic and hygiene measures in health facilities and to provide basic drugs and supplies.

Service delivery in Somalia is not only limited by the lack of technical knowledge, but also, and as much, by the lack of organizational capacity and the inability to generate behavioural change among service users. In the northeast of Somalia, where health workers struggle to deliver an effective health service, 29 midwives attended a six-day

workshop on communication techniques, organized by a local partner in collaboration with WHO Somalia. Most of the participants, like Halima and Sadia, had barely received any training in the many years since they qualified. Others had been to workshops that had reportedly not made use of the participants’ personal resources but focused on programme rather than human resources development. The workshop on communication, however, involved the midwives and their 460 years of collective experience and requested their active participation. Fadmo Hussaen like many other participants appreciated that *“most of the information was given in such a friendly way”*. The midwives learned to develop and present skills, and promote an ownership of activities. The training also



provided the opportunity to learn and practise interactive techniques such as asking questions to expectant mothers, inquiring about the views of family members, community elders and student midwives, synthesizing experiences, and recapitulating options.



### WHO Regional Office for South-East Asia

#### Life-saving care for pregnant women remains critical as Myanmar recovers from cyclone Nargis

Within the international community’s coordinated response to cyclone Nargis that hit Myanmar in May 2008, WHO, as health cluster lead, aimed to strengthen emergency health response on specific issues, including reproductive health and HIV. These efforts were only possible through collaboration and coordination with multiple partners. In a country where pregnancy and childbirth are already relatively risky, response plans to the cyclone included restoration of delivery rooms in damaged facilities, establishment of additional reproductive health service delivery points, and counselling of women experiencing distress.

The disaster did not only kill thousands of people, but also traumatized many of the survivors in the Irrawaddy delta. The cyclone lasted so long that some villagers witnessed their children, husbands or wives gradually being swept away by the current while tightly holding onto trees.



Photo: WHO/ARTPEISCAN

Some women who were in an advanced stage of pregnancy were able to save themselves by clutching palm trees, and finally gave birth to healthy infants weeks later.

As of 2 May 2008, in the Ayeyawardy Division, 130 000 pregnant women were in urgent need of health services. During the initial period of the cyclone, in the little town of Bogale, the hospital maternity ward had gotten busier with 4 to 5 deliveries a day, without a parallel increase of incubators, labour beds or staff. The greatest problem was the delay caused by the distance and time it takes to bring pregnant women from their remote villages to the hospital when they experience difficulties in labour. Some mothers arrived after a 10-hour canoe trip accompanied by local midwives.

To overcome this problem, the health cluster partners opened mobile clinics that travelled to cyclone-affected areas, offering general and prenatal care in remote villages. At the end of June 2008, the mobile teams had already provided services to more than 2200 people in 10 hard-hit and difficult to reach villages, including nearly 300 pregnant women.



Photo: WHO/SEAKO

Khin Mar Oo was among the lucky ones. When she experienced complications during the late state of her pregnancy, the young woman was brought by boat within an hour, to the floating health clinic operated by the UK charity **Merlin**. The health facility of her small village in Laputta district was destroyed in the cyclone. Khin Mar Oo gave birth to the first baby delivered in the floating clinic and named her Pandawlin, after Pandar, the name of the boat, and **Merlin** for the staff who delivered her. Maternity waiting homes have also been opened, where expectant mothers who live far from hospitals can stay while awaiting labour. In the waiting home they receive antenatal care and can reach hospitals on time in case of complications.

The health cluster also provided basic maternity supplies to health facilities in affected communities. A wide range of auxiliary material from rubber gloves for midwives to hospital equipment, were delivered to the Ministry of Health. The prevalence of home births made it imperative to provide the midwives working in the delta with clean delivery kits designed to make home births safer. One midwife was often responsible for covering 5 to 10 villages, and in some places up to 20 villages. Some 20 000 clean delivery kits were distributed through various partners, international and local NGOs, community-based organizations, mobile clinics and individuals.



## WHO Regional Office for the Western Pacific

### Sichuan earthquake: the struggle to save infants and pregnant women's lives

The health sector response to the earthquake that hit the mountainous Sichuan Province of Western China on the afternoon of 12 May 2008 was very quick. With the collaboration of WHO, the Ministry of Health deployed medical teams all over the affected area, including health workers coming from 18 Chinese provinces.

In the immediate aftermath of the tragedy, rescuers miraculously found completely unharmed babies, protected by their dead mothers' curled bodies and lowered heads. They also managed to save the lives of pregnant women who gave birth to healthy infants a few weeks later. The story of 8-month pregnant Zhang Xiaoyan hit international headlines. She had been trapped under a huge concrete slab for 50 hours before she was rescued by soldiers and firemen after 30 hours of drilling and hammering to uncover her. She finally gave birth to a healthy girl in Urumqi Maternal Care Hospital and named her Xiao Ai, or *love*, in honour of the rescuers and health workers who saved her and her baby's life.

In the small earthquake-hit city of Shifang, the Lohuan Temple became a refuge for all patients when the Women and Children's Hospital building collapsed. As soon as the earthquake stopped, 3 new mothers and more than 40 pregnant women were escorted by doctors and nurses to the Buddhist Temple where monks installed 2 beds and 2 tables as a temporary delivery room in the kitchen. A few days later, six tents were placed in the courtyard while workers from Dalian in Northeast China's Liaong province were erecting prefabricated huts. In these tents, doctors performed caesarean sections with flashlights, often during rainstorms, and using mops to suspend intravenous medications. In these very harsh conditions, 81 infants were born in a matter of just two months. The hospital finally shifted from the temple to prefabricated huts in the middle of July 2008.

The affected area received support from WHO, particularly for helping to reactivate essential functions of damaged health facilities, providing a wide range of essential medicines, health supplies and equipment, and assisting with the Chinese translation of the WHO publication *Child Health in Emergencies*, which was distributed by the Ministry of Health.



## Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice

2nd edition revised - English and French



This guide provides evidence-based recommendations to guide health-care professionals in the management of women during pregnancy, childbirth and postpartum period, and post abortion, and newborns during

their first weeks of life. It is a guide for clinical decision-making. It facilitates the collection, analysis, classification and use of relevant information by suggesting key questions, essential observations and/or examinations, and by recommending appropriate research-based interventions. It supports the early detection of complications and the initiation of early and appropriate treatment, including timely referral, if necessary.

## Fistule obstétricale



This manual is intended to be a practical guide to be read and used at many different levels by health-care professionals and planners, policy-makers and community leaders.

Its three main objectives illuminate its wide reach and potential utility:

- it draws attention to the urgent issue of obstetric fistula and advocates for change.
- it provides essential, factual background information along with principles for developing fistula prevention and treatment strategies and programmes.
- it contributes to the development of more effective services for women under treatment for fistula repair.

## KEY PUBLICATIONS

MATERNAL AND NEWBORN HEALTH



This interactive CD-ROM provides a cost-effective means of accessing a wide range of topics and publications related to maternal and newborn health published by the WHO Department of Making Pregnancy Safer. This user-friendly tool archives more than

50 downloadable and printable publications in acrobat format (PDF). Users without acrobat will have the opportunity of installing or reinstalling Acrobat from the CD.

The CD also provides complete data on each publication and a search function.

## World Health Day 2009 Save Lives. Make Hospitals Safe in Emergencies

World Health Day 2009 will be dedicated to the theme of *Save Lives. Make Hospitals Safe in Emergencies* which aims to promote the resilience of all hospitals, primary health centres and other facilities to any kind of crisis.

Extreme weather events, natural calamities like earthquakes, and conflicts pose major threats to all nations, particularly those in the developing world, where health services are often weak and require major improvements. In 2008, 321 disasters killed more than 235 000 people.

A key goal of World Health Day 2009 will be to advocate for the safe design and construction of all types of health care facilities. The Health Action in Crises and Health Systems and Services clusters within WHO are working with all other clusters, departments and regions on a technical programme and communications strategy.

Many countries in the developed and developing worlds have implemented simple measures that can both safeguard their health facilities from various emergencies and provide services for their populations when they are needed most - in the wake of a crisis.



Bangladesh has implemented a cyclone early warning system that can move hundreds of thousands of people quickly out of harms way. Japan and Peru use earthquake-proof techniques in the design and construction of their hospitals.

Events will be held in the lead up to World Health Day, on 7 April itself and throughout the following year to ensure that the issue of emergency preparedness in health facility design, construction and functionality is spread and adopted as broadly as possible.

<http://www.who.int/world-health-day/2009/en/index.html>



Continued from page 1

and supplies for the MISP are included in the Reproductive Health Kits, available from UNFPA.

Together with partners, WHO also developed the *Interagency Emergency Health Kit 2006* that is often rapidly made available in humanitarian crises. Its content is based on the health needs of 10 000 people for a period of three months. Although this kit contains some of the supplies required for the MISP, such as a midwifery kit and supplies for HIV prevention, the Reproductive Health Kits are more comprehensive.

Despite the availability of these tools, critical gaps related to maternal and newborn health in emergency situations still remain, including the availability of trained health personnel to use this equipment and provide the priority services. Emergency obstetric care to deal with complications such as excessive bleeding must be recognized as crucial, lifesaving interventions to which all women and girls affected by crises are entitled.

It is imperative that the basic needs of mothers and newborns in emergency settings are no longer overlooked and the Department of Making Pregnancy Safer works with partners to make sure that reproductive health services become an integral part of immediate emergency response.

## WHO Director-General visits Sichuan Province in November 2008

Dr Margaret Chan, the WHO Director-General visited Sichuan five months after the devastating earthquake that rocked the province in May 2008. Dr Chan was accompanied by the WHO Goodwill Ambassador for Maternal, Newborn and Child Health, the Ethiopian fashion model Liya Kebede.

The Director-General took the opportunity to meet with several doctors and nurses from the Xiaoyuan Township Hospital that had been partly destroyed by the quake. The

affected parts of the hospital had been torn down and the DG gave a short speech at the groundbreaking ceremony for a new wing of the facility. In her address, Dr Chan said that “we can never prevent natural disasters, but we can strive to mitigate their impact.”

She also stressed the need to ensure that health facilities can better cope with emergencies and to increase awareness of their vital role in emergencies. “We can build hospitals that will withstand the worst of what nature can devise, in order to protect the lives of those in these structures and assure that the best possible care is available for victims.”



Photo: WHO/CHINA



Photo: WHO/CHINA

© World Health Organization 2009

All rights reserved. Publications of the World Health Organization can be obtained from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (☎ +41 22 791 2476; 📠 +41 22 791 4857; ✉ bookorders@who.int). Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to WHO Press, at the above address (☎ +41 22 791 4806; ✉ permissions@who.int).

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

For additional information please visit our web site at [http://www.who.int/making\\_pregnancy\\_safer/en](http://www.who.int/making_pregnancy_safer/en)

Department of Making Pregnancy Safer, World Health Organization, 1211 Geneva 27, Switzerland ☎ +41 (0) 22 791.58.53 ✉ MPSinfo@who.int (If you order by e-mail please include your full postal address.)

Editors: Marie-Agnes Heine, (heinem@who.int), Geetanjalée Khosla and Eva Probst  
Designer: Duke Gyamerah, gyamerahd@who.int.

The WHO Director-General was shown around the building and introduced to various aspects of the hospital's work. She learned that health staff had moved into the hospital for several months to look after their patients after the disaster had hit the province.

During her trip, Dr Chan also had the opportunity to visit the rural Wuhui Village Clinic and the West China Hospital at Sichuan University where a rehabilitation center especially for the survivors of the earthquake has been established.