

REFRAMING MATERNAL HEALTH IN NEPAL

NICOLE FARKOUH

Uterine Prolapse (UP) is a common maternal disability in Nepal, affecting 10 percent of women between the ages of fifteen and forty-nine. International priorities, primarily the Millennium Development Goals (MDG), narrowly define maternal health as preventing maternal death, proscribing initiatives that effectively address UP. This paper recommends an expanded policy frame that includes maternal health (morbidity) as a necessary precursor to addressing UP. This expanded policy frame lays the groundwork for horizontal programming that values local knowledge, improves health outcomes for children, and empowers women by engaging them in efforts to address UP.

INTRODUCTION

Every day 1,600 women die during child birth. For each death, 30-50 women end up with a permanent disability.[1] Non-governmental organization (NGO) workers and health professionals recognize the scope of this problem, but a narrow international policy frame, too focused on maternal mortality (death), has prevented adequate resources and attention from being directed to maternal morbidity (chronic illness or disability). This paper uses Uterine Prolapse (UP) in Nepal as a case study to explore how international agendas influence the identification of local needs and programming while evaluating how the current international maternal health frame impacts the lives of Nepalese women. The paper concludes that the current maternal health frame should be expanded to include maternal morbidity and offers an analysis of how this re-framing will support efforts to address the UP epidemic in Nepal.

CASE STUDY: UTERINE PROLASE IN NEPAL

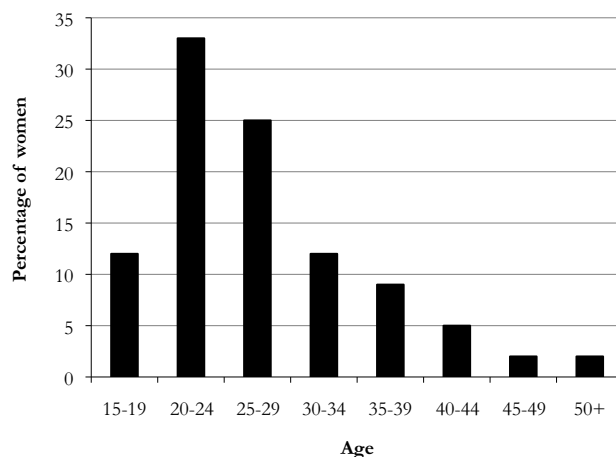
UP is the major cause of maternal disability in Nepal, affecting an estimated 10 percent[2] of women aged 15-49,[3] although community-based population studies estimate rates as high as 44.5 percent in certain districts.[4] Caused by a weakened pelvic floor, UP occurs when a women's uterus falls through her vagina, ultimately hanging between her legs if left untreated.[5] Between 65-80 percent of women with UP in Nepal experience difficulty lifting, standing, sitting, and walking, while other common symptoms include pain during intercourse, urination and defecation, abdominal and back pain, discharge, and incontinence (Table 1).[6]

Typically, UP affects women who have given birth many times or who are post-menopausal. However, in Nepal, 62 percent of women experience UP by their second delivery and 70 percent have had UP by the age of 30 (Figure 1).[7]

Table 1: Symptoms Commonly Exhibited by Women with UP

Symptom	Percentage
Itching	27.0
Difficulty urinating	30.7
Foul-smelling discharge	32.0
White, watery discharge	33.0
Abdominal pain	34.9
Painful intercourse	41.1
Burning upon urination	49.0
Bachache	55.0
Difficulty standing	65.5
Difficulty walking	79.0
Difficulty sitting	82.0
Difficulty lifting	88.6

Figure 1: Age Distribution of Uterine Prolapse Onset



Source: Pradhan, 2007

Box 1: Stories from Health Workers about Women with UP

The way women manage Uterine Prolapse (UP) underscores the pain they experience. These anecdotes from doctors and NGO workers illustrate the challenges of UP:

- Women report that when their uteri descend while they are getting water or working in the fields, they can only push it back inside and keep working. - *Rakesh Yadav, NGO worker*
- Many women go for thirty to forty years without telling anyone about their problem, afraid of abuse or shame. These women hide their UP from their husbands, fearing abandonment and being replaced by a new wife. - *Dr. Aruna Uprety, Physician*
- Women with UP report significantly reducing their food intake to minimize abdominal pressure and prevent their uteri from descending. This reduction often leads to malnourishment. - *Ambika Poudel, Health Worker*
- In desperation, women try keep their uteri in place by inserting available items in their vaginas, such as glass bangles, wads of cloth, and balls. - *Dr. Bimala Lakhey*
- In Western Nepal, people believe women should eat only oil and rice for eleven days after giving birth, while in Eastern Nepal, for nine days after delivery, women eat only a mixture of ginger and jaggary. - *Samita Pradhan, NGO worker*
- One woman in our working area tried to remove her uterus herself, saying she would rather die than live with the pain of this condition. - *Aruna Chaudary, NGO worker*

The most common risk factors for UP in Nepal include: excessive physical labor during and immediately after pregnancy, low maternal weight and malnutrition, chronic coughing, and harmful practices performed by untrained birth attendants.[8] Women with UP face increased risk of domestic violence and social stigma due to reduced productivity and sexual debilitation. Driven by fear of conjugal abandonment, isolation, shame, and lack of emotional support, women often suffer in silence without seeking treatment (Box 1).[9]

Nepal is one of the poorest countries in the world, with a largely subsistence-based economy. Eighty-six percent of the population lives in rural areas, often lacking basic services.[10] Nepal faces significant geographic and infrastructure challenges, as well as political instability. Pervasive resource challenges and corruption impede effective social programming, leaving Nepal heavily-reliant on external funding.

In addition to persistent poverty and lack of access to health care, an array of cultural factors also contribute to the severity and high rates of UP in Nepal. Women disproportionately bear the burden of rural life due to a greater workload, lower status in a rigid social hierarchy, and limited decision-making power. Nepali society tends to devalue girl children and women who do not bear sons. In addition, birth is seen as a natural occurrence requiring little special attention. As such, 81 percent of women deliver at home and only 23.4 percent of women deliver with the assistance of a trained birth attendant.[11] Consequently, the maternal mortality rate is thirty-five times higher in Nepal than in the US.[12]

THE CURRENT MATERNAL HEALTH FRAME

The dominant international framework for development, including maternal health, is guided by the UN's Millennium Development initiative. Notably, Millennium Development Goal (MDG) number five calls on the international development community to "Improve Maternal Health," and sets targets of a three-quarter "reduction in maternal mortality and universal access to reproductive health care." [13] Such targets delineate the current work around maternal health and influence everything from the structure of interventions to funding allocations. The reproductive health target, which could encompass maternal morbidity, has received minimum attention. Most morbidity-reduction efforts are largely focused on decreasing fertility through increased access to contraception.

Nepal is a signatory to the MDGs and is sincerely working to achieve these targets. Due to the overwhelming international emphasis on reducing maternal mortality, Nepal's maternal health programs are narrowly-defined, vertically-organized, and exclude issues of chronic maternal disability. The implications of the international agenda for local program and policy development are evident in Nepal's struggle to move beyond a single-minded focus on preventing maternal death in order to adequately address UP.

THE EFFECT OF THE CURRENT INTERNATIONAL FRAME ON NEPAL'S MATERNAL HEALTH POLICIES

The Nepalese government has developed many policies to work toward reducing the maternal mortality rate. The most pertinent are the Maternal Neonatal Health (MNH) package

and the Maternal Incentive Scheme (MIS); both intended to address the underlying conditions that lead to high rates of mortality. These are particularly important due to their potential for addressing both maternal mortality and maternal morbidity. Government agencies have invested substantial effort in implementing these programs and with slight modifications they could advance UP awareness and early stage treatment.

The MNH package aims to provide high-quality maternal and newborn health care by delivering priority services and empowering women and their families to engage in behaviors protective of maternal and newborn health during and after pregnancy. The MNH package includes an array of preventative and follow-up services provided through a series of maternal and newborn visits. These services include vaccinations, delivery planning, early detection of health problems, and nutrition management.[14] The 2005 MIS is designed to curtail maternal mortality with incentives that increase the likelihood of rural women delivering in well-equipped birth facilities or with trained attendants.[15] This policy is complimented by a government commitment to provide all maternal care free of charge as of January 2009.

In 2006, the momentum for addressing UP substantially increased when the Institute of Medicine & the United Nations Fund for Population Activities (UNFPA) released their joint maternal morbidity study, which contained national-level data on UP prevalence. In fiscal year 2008-2009, the government of Nepal responded by allocating funds to provide surgery for twelve thousand women.[16] While this program indicates that the Nepalese government acknowledges the widespread nature and urgency of UP, Nepal's government still has not finalized a UP-specific policy or program. In contrast to the numerous programs targeting mortality, there is no comprehensive government plan in place to address UP and no staff at the Health Ministry devoted to the issue.

The international response to UP has been increasing, although it remains insufficient. Despite the high prevalence of UP among women of reproductive age, it is receiving much less attention than Malaria, HIV/AIDS, and Tuberculosis, the "big three" diseases of the Global Fund (Table 2).[17]

Table 2: Incidence of Global Fund Diseases and Uterine Prolapse in Nepal

Disease	Incidence
Malaria	154,765
HIV/AIDS	70,000
Tuberculosis	67,425
Uterine Prolapse	600,000

Of the few resources that have been galvanized, the majority goes to providing surgery for late stage UP. UNFPA, the World Bank, and other donors have provided funding to run mobile surgery camps across the country.[18] However, little

Table 3: Treatments Appropriate to Stage I – IV Uterine Prolapse

Stage	Medical Definition	Treatment	Unit Cost
Stage I	Initial descent of the uterus into the vaginal canal	Exercises	No materials cost, only human resources
Stage II	Moderate descent of the uterus into the vaginal canal	Insertion of pessary ring	\$3.00-5.00
Stage III	Descent of the uterus outside of the vagina	Surgery (hysterectomy)	\$200-300
Procedentia	Descent of the uterus completely outside the	Surgery (hysterectomy)	\$200-300

attention is being paid to early stage treatment or prevention. Given the international focus on mortality-reduction and inadequate funds for addressing maternal health, it is not surprising that international agencies prioritize the most severe manifestations of UP. Access to surgery is essential for women with late-stage UP, but to only focus on providing costly and unsustainable surgical treatment is short-sighted, inefficient, and devalues the well being of women with earlier state UP.

A comprehensive response to UP requires interventions in three distinct domains: prevention, non-surgical treatment, and surgical treatment (Table 3).

Costly surgical treatment is appropriate only in late-stage UP, after a woman has already experienced considerable suffering. While surgeries satisfy funder-driven demands to engage in discreet and quantifiable activities, they can result in negative side effects and only reach small numbers of women.[19] Furthermore, rural Nepal lacks surgeons and adequate operating facilities so that surgical services are often provided in mobile camps, which have quality of care challenges.[20]

Non-surgical treatment arrests the condition early, when UP is both less painful and less expensive to treat. Interventions such as pelvic floor strengthening exercises and pessary rings are inexpensive and low-tech, lending themselves to sustainable, local level implementation. Currently, early-stage treatment options are receiving little attention. Prevention activities can seek to limit harmful birth-related practices while increasing access to skilled birthing attendants, promoting sufficient rest for women during and after pregnancy, and encouraging sufficient maternal diet and weight. These prevention methods support pelvic health and reduce the risk of UP while at the same time helping to prevent maternal mortality.

BENEFITS OF A NEW MATERNAL HEALTH FRAME IN NEPAL

In order to effectively tackle UP and fully recognize the value of maternal well being, the maternal health frame should be expanded to include maternal morbidity. Following from the logic of the expanded maternal health policy frame, the

“Expanding the maternal health frame to include morbidity would result in broadly defined programs that are more cost-effective, resource-efficient, and empowering for women.”

Nepali government and donor community can dovetail with efforts to reduce maternal mortality by inserting information about UP into existing efforts, thus leveraging resources and increasing the impact of current programs.

Expanding the maternal health frame to include morbidity would result in broadly-defined programs that are more cost-effective, resource-efficient, and empowering for women. This new frame can expand opportunities for integrated programs, attract new resources, and build new partnerships while reflecting a morality that values the health and well-being of women and mothers.

Cost Effective Options for Addressing UP

The most cost-effective way to addressing UP is to integrate UP-programming into existing Safe Motherhood programs, as opposed to creating vertical, UP-specific programs likely to duplicate existing Safe Motherhood services. Safe Motherhood programs, such as the MNH Package and the MIS, address maternal mortality through education, access to skilled care, and increased engagement of women with health care providers. Building a UP-component into these programs is an opportunity for health-workers to inform at-risk populations about UP, provide nutritional information, and promote important preventative practices. The pre- and post-natal care visits proposed by the minimum MNH packages and the skilled birth attendants provided by the MIS should incorporate UP prevention, screening, and referrals for treatment.

In the long run, as more emergency obstetric care centers are able to provide surgical services, these centers should also be equipped to provide surgical treatment for UP. Providing surgery centers through existing programs is more cost-effective than designing and implementing UP-specific surgery services. Additionally, as Safe Motherhood programs expand post-partum care, simple interventions like post-partum evaluations of women’s uteri and teaching pelvic floor strengthening exercises should be included.

The Nepali Government has policies in place to increase the skill and capacity of maternal health providers. For example, the 2006 Skilled Birth Attendance Policy urges curriculum revision for pre-service health workers and the addition of in-service training.[21] Including UP training related to identification, early-stage treatment, and late-stage referrals in health worker training and curricula is a crucial way to create linkages with existing mortality-focused efforts and another cost effective way of tackling UP.

Improved Child Outcomes

Child survival is linked with maternal health. In Nepal, infants whose mothers die are six times more likely to die themselves within their first week of life.[22] Furthermore,

women’s physical and mental health is positively correlated with the physical health, language development, and positive behaviors of their children.[23] No research exists as to the effect of UP on a woman’s ability to care for her children but logic suggests that the physical and emotional pain a woman endures due to UP impairs her ability to care and advocate for the needs of her children. Thus, prevention and early treatment of UP may also have positive impacts on children.

Improved Productivity

“Disability Adjusted Life Years” is an international measure used to calculate the amount of productivity lost from a medical condition or disability. While this information has not been gathered for UP, it likely that women who are disabled by UP, physically or emotionally, have a decreased potential for income generation. The only information available on this topic comes from a small survey of 126 women, 82 percent of whom reported experiencing reduced family income as a result of their prolapse.[24] As Nepal has a high poverty rate and a low development index, the marginal loss of a small amount of productivity within a family can be substantial. Regained productivity through successful prevention or treatment of maternal disability may result in positive economic gains for the families of women who have UP.[25]

Empowerment, Participation and Advocacy

Due to the social stigma surrounding UP and the rigid social hierarchies of Nepal, addressing UP early can have a positive impact on a woman’s status, enabling community participation. Women’s participation in Nepalese community is particularly important as Nepal is transitioning out of a protracted armed conflict, and women often play a significant role in stabilizing post-conflict communities.[26]

Grassroots efforts to address UP are already capitalizing on Nepal’s decentralized structure and strong civil society presence, which allows for local flexibility and decision-making. For example, the Women’s Reproductive Rights Program of the Center for Agro-Ecological Development (CAED-WRRP) helps local women understand the medical reality of UP, connects them with treatment services, and has successfully organized women with UP to lobby local governments for services. After generating support from local policy-makers, CAED-WRRP began collaborating with local officials to ensure successful service delivery, provide training for district health workers about diagnosis and early-stage treatment of UP, develop supply stocks necessary for treatment, and design referral systems to provide surgical services to women.[27] Rural women have been trained by CAED-WRRP on local budgeting processes, and these women are now working to secure budget allocations and ensure local politicians fulfill their

commitments. This process has empowered women while simultaneously engaging them in advocacy efforts related to their personal experience with UP.

Such community-driven efforts implicitly rely on a holistic frame of maternal health, which values women's well being and their contributions to the democratic process. Importantly, these programs provide the opportunity for women to gain valuable skills of organization, advocacy, budgeting, and civic engagement, while they work on issues of personal relevance.

New Partners, Integrated Programs and Increased Awareness

Including morbidity, and thus UP, in the working definition of maternal health creates the potential for integrated collaboration with organizations working on issues of women's welfare but not traditionally concerned with health. There is a complex relationship between women's empowerment and their health, as women cannot fully participate in society when they are negatively impacted by the physical, social, and emotional effects of maternal disabilities. Conversely, women's empowerment is a necessary precursor to large-scale management of UP. These women's empowerment programs will target culturally-rooted factors contributing to UP such as the early age of marriage, the expectation that women perform heavy manual labor pre- and post-partum, and the taboos surrounding women's health issues. While local groups are more suited to develop socially-appropriate programs than outside aid agencies, appropriate support from the international community will help to ensure that grassroots, morbidity-focused efforts are prioritized and funded.

While the awareness of UP has increased in the media, amongst the NGO community, and within the government and international donor community, more attention is needed to adequately address UP and other maternal health issues. Additionally, funding directed to UP will also support interventions which reduce maternal mortality.

CHALLENGES TO REFRAMING MATERNAL HEALTH

Funding Constraints, Time Commitments, & Donor Priorities

While expanding the Maternal Health frame to include morbidity offers the opportunity to more adequately address UP and other maternal disabilities, challenges remain. Comprehensive solutions will require more funding from the international community and a commitment from the Nepalese government to direct adequate funds to UP. The global economic decline has reduced aid from developed countries and thus, the Nepalese government faces severe budget constraints, making it challenging to expand priorities and funding.

Furthermore, effective interventions addressing UP require systemic and cultural changes with more emphasis on local planning, engagement and implementation. However, horizontally-organized programs may require a long-term commitment by donors, not produce easily-quantifiable results, and be more challenging to manage as they necessarily rely on local advocates instead of outside aid workers.

Data Challenges

Gathering data on morbidity is more complicated and costly than data collection for mortality due to the private nature and convoluted set of conditions that lead to the onset of UP. Furthermore, the prior lack of attention to morbidity has led to a dearth of data, creating obstacles for new morbidity focused programming[28] —particularly in the current context, which relies heavily on evidence to inform practice.

CONCLUSION

The dominant policy frame defines maternal health as preventing mortality and thus, morbidity has been excluded from discussions and programs about maternal health. Consequently, Nepal has an inadequate approach to addressing UP, despite knowledge of the problem and the magnitude of local need. Furthermore, the response to UP has been limited and vertically-organized, focusing on surgical programs that are inadequate given the context and situation of women in Nepal.

Additionally, there is a moral imperative to construct UP-focused programs that fully value the health and well being of Nepali women and that recognize the important role they play as caretakers, bread-winners, and citizens of an emerging democracy. It is unrealistic to expect Nepali government officials, local health advocates, and international aid agencies to develop a perfect approach to managing UP in Nepal. However, through reframing maternal health to include morbidity and linking UP-specific strategies to existing maternal health programs, the health community can make significant strides toward reducing incidents of UP. This can be done cost-effectively while incorporating strategies that value local knowledge and empower women.

Ms. Farkoub has a master's degree in education from the University of New Orleans and a master's degree in public policy from the Goldman School of Public Policy. She is currently living in Nepal and working on grassroots programming and policy efforts related to women's health.

ENDNOTES

- [1] Kirti Iyengar and Sharad D. Iyengar, "Research Needs in Maternal Morbidity," (paper presented at the annual Global Forum for Health Research Conference, Mexico City, Mexico, November 2004).
- [2] Nepal Institute of Medicine and Tribuvan University, "The Status of Reproductive Morbidities in Nepal: A Reproductive Morbidity Report on Clinic Based Study," Nepal UN Fund for Population Activities, (2006).
- [3] Estimates for older women may be higher as the post-menopausal reduction in estrogen is a key risk factor for the condition.
- [4] Nepal Institute of Medicine and Tribuvan University, "The Status of Reproductive Morbidities in Nepal: A Reproductive Morbidity Report on Clinic Based Study," Nepal UN Fund for Population Activities, (2006).
- [5] Beus, Tamara, "Pelvis Organ Prolapse" Women's Health UK (2003): <http://www.womenshealthlondon.org.uk/leaflets/prolapse/prolapse.html>.
- [6] T.R. Bonetti, A. Erpelding, and L. Raj Pathak, "Listening to 'Felt Needs': Investigating Genital Prolapse in Western Nepal," *Reproductive Health Matters*, 23 no. 12 (2004): 166-175.
- [7] Samita Pradhan, "Unheeded Agonies: A Study on Uterine Prolapse Prevalence and Its Causes in Siraha and Saptari Districts," Women's Reproductive Rights Program, Center for Agro-Ecological Development, (2007).
- [8] Barbara Bodner-Adler, Chanda Shrivastava, and Klaus Bodner, "Risk Factors for Uterine Prolapse in Nepal," *International Urogynecology Journal*, 18 (2007): 1343-1346.; S. Pradhan, "Report on Uterine Prolapse Survey in Eastern Nepal," Women's Reproductive Rights Program, Center for Agro-Ecological Development, (2007).; T.R. Bonetti, A. Erpelding, and L. Raj Pathak, "Listening to 'Felt Needs': Investigating Genital Prolapse in Western Nepal," *Reproductive Health Matters*, 12 no. 23 (2004): 166-175.
- [9] Jelle M. Schaaf, Anjana Dongol, and Loes van der Leeuw-Harmsen, "Follow Up of Prolapse Surgery in Rural Nepal," *International Urogynecology Journal*, 19 no. 6 (2007): 851-855.
- [10] Nepal Ministry of Health and Population, "Demographic Health Survey 2006," Population Division, Ministry of Health, Kathmandu, also available at: <http://www.measuredhs.com/pubs/pdf/FR191/FR191.pdf>.
- [11] Babu Ram Marasini, "The Maternity Incentive Scheme in Nepal: Increasing Demand & Equity," (paper presented at the Women Deliver Conference, London, England, October 18 – 20, 2007): [http://64.233.169.104/search?q=cache:l8Yfqec6XM4J:2007.womendeliver.org/presentations/slides/103_Marasini.ppt; Nepal Ministry of Health and Population, "Demographic Health Survey 2006," Population Division, Ministry of Health, Kathmandu, also available at: http://www.measuredhs.com/pubs/pdf/FR191/FR191.pdf](http://64.233.169.104/search?q=cache:l8Yfqec6XM4J:2007.womendeliver.org/presentations/slides/103_Marasini.ppt; Nepal Ministry of Health and Population,).
- [12] The Maternal Mortality Ratio (MMR) is the number of women who die in childbirth per 100,000 live births. In Nepal the MMR is 281, 35 times higher than the ratio in the US (8 deaths per 100,000 live births); UNICEF, "Information by Country: Nepal," (2007): http://www.unicef.org/infobycountry/nepal_nepal_statistics.html.
- [13] United Nations Development Program, "End Poverty 2015: Millennium Development Goal 5: Improve Maternal Health," <http://www.un.org/millenniumgoals/maternal.shtml>.
- [14] Carol E. Barker, Cherry E. Bird, Ajit Pradhan, and Ganga Shakyad, "Support to the Safe Motherhood Programme in Nepal: An Integrated Approach," *Reproductive Health Matters*, 15 no. 30 (2007): 1-10; Madhu Devkota and Pam Putney, "Reaching Consensus on Minimum Package of MNH Service," Support to the Safe Motherhood Programme, (2005).
- [15] Babu Ram Marasini, (2007).
- [16] Nepal Ministry of Health and Population, Family Health Division.
- [17] The author acknowledges conditions of morbidity are fundamentally different than fatal diseases like HIV, TB, and Malaria, and uses this comparison loosely to underscore the emphasis on preventing mortality and lack of attention to women's quality of life.
- [18] World Bank "World Bank Supports Nepal's Efforts to Consolidate Peace and Development," (2008): [http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:21759715~pagePK:64257043~piPK:437376~theSitePK:4607,00.html?cid=3001](http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:21759715~pagePK:64257043~piPK:437376~theSitePK:4607,00.html?cid=3001;).; Personal communication between author and members of Nepal's Uterine Prolapse Alliance (UPA), (Summer 2008).
- [19] In Nepal, the most widely used procedure is a hysterectomy, though there are more expensive procedures commonly use in developed nations that can treat UP while leaving the uterus intact.
- [20] Personal communication between author and members of Nepal's Uterine Prolapse Alliance (UPA), (Summer 2008).; Field work conducted by the author, (Summer 2008).
- [21] Support to Safe Motherhood Programme, "Strategic Issue Paper: Skilled Birth Attendance: Strategies for Implementation," (2007). (The original policy is not cited directly due to the lack of English translation).
- [22] The Lancet, "Maternal Health Survival Series, Health Motherhood: An Urgent Call to Action," http://www.womendeliver.org/pdf/Maternal_Lancet_series.pdf.
- [23] Robert S. Kahn, Barry Zuckerman, Howard Bauchner, Charles J. Homer, and Paul H. Wise, "Women's Health after Pregnancy and Child Outcomes at Age 3 Years: A Prospective Cohort Study," *American Journal of Public Health*, 92 no. 8 (2002): 1312-1318.
- [24] Brad Watson and Sharon Heise, "Uterine Prolapse: The Self-Reported Knowledge and Impacts of a Uterine Prolapse and Hysterectomy on Underprivileged Nepali Women and Families," (Paper presented at the Asia Pacific Conference of the International Consortium for Social Development, Dhulikhel, Nepal, November 2008).
- [25] United Nations Development Program, Nepal Human Development Report 2004: Empowerment and Poverty Reduction, (Kathmandu, Nepal: Jagadamba Press, 2007).
- [26] Tsjard Bouta and Georg Frerks, Women's Roles in Conflict Prevention, Conflict Resolution, and Post-Conflict Reconstruction: Literature Review and Institutional Analysis, (The Hague, Netherlands Institute of International Relations, Clingendael, Conflict Research Unit: 2002).
- [27] Personal communication between author and members of Nepal's Uterine Prolapse Alliance (UPA), (Summer 2008); Field work conducted by the author, (Summer 2008).
- [28] Abdo Yazbeck, "Challenges in Measuring Maternal Mortality," *The Lancet*, 370 no. 9595 (2007): 1291-1292.