Folder Title:	Safe Motherhood Conference - Donor Funding - Correspondence
Folder ID:	30197618
Dates:	12/10/1986 - 04/10/1987
Fonds:	Records of the Population, Health, and Nutrition Sector
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THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

Date: January 13, 1987

To: Tony Measham, PHNDR

From: Jacques Baudouy, PHND1 JB

Extension: 60192

Subject: Safe Motherhood Fund for Operational Research

A few comments:

1) It is an excellent idea;

2) Who will be responsible for realizing the operational research projects: groups like Family Health International, local in-country researchers, or a combination of both? (It can make a large difference in terms of costs/quality);

3) What will be the criteria for selecting the projects and who will make the decision for selecting them: WHO or a panel of agencies, including the Bank:

4) The Burundi Population and Health Project preparation team is planning to realize this type of operational research during the first year of project implementation (1988). Do you think that they have a chance to use the Fund; and

5) Is a fund planned for AIDS research?

THE WORLD BANK/INTER.FINANCE CORPORATION

OFFICE MEMORANDUM

Date: January 15, 1987

To: Dr. Anthony Measham, Health Adviser, PHN

From: Oscar Echeverri, PHND3 OE

Extension: 61556

Subject: Safe Motherhood Fund for Operations Research

1. The initiative of funding operational research on the Safe Motherhood strategy will be most welcome. The following are my comments on such initiative:

2. Rationale: Among the crucial technical questions in para 5. (a),(b) and (c), it would be important to mention how the role of the medical and nursing professions would be affected by establishing a safe and cost-effective pregnancy-risk screening procedure made by non-professionals, and what changes in those roles would be necessary. This has to do with the difficulties already encountered in making some safe and effective screening tools a routine practice in Primary Health Care strategies.

3. Organizational arrangements: Two suggestions:

a) The organizations mentioned "with proven operational research expertise" belong to the developed world. It would be more appropriate to mention, and indeed restrict the funding, to organizations of the developing world, which might look for advice and technical support when needed from others in the developed world;

b) It is feasible to identify local NGOs or research groups who could match funds for supporting local research studies. As an example, I mention the FES in Colombia which may contribute with x amount of pesos for each dollar granted for research in the safe motherhood approach. In this way, funds could be used more efficiently.

4. Expected outcome: I fully agree that the main question is the extent to which the findings will be applied. This statement contains itself one major area of operational research, namely, how to remove political and bureaucratic barriers in public management for applying new primary health care technologies in a country-wide scale. Successful and practical research findings should become part of the country's health policies and these policies must be translated to the routine practice of health care. We know of technologies for safe motherhood tested in small-scale projects whose effectiveness go beyond the usual explanation -the charismatic leader, missionary seal of the staff, generous funding-, however they are not introduced in large scale PHC programs because they (albeit being small innovations) imply substantive institutional changes ((I understand how the cuckoo feels when somebody flies over his nest!).

Cleared and cc: E. Schebeck

cc: J. North; A. Berg; F. Sai; N. Birdsall; S. Denning PHN.

File pls. cc: FS ARMV

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MISC 141 NORTH. AFTER IN-HOUSE DISCUSSIONS
UNDP TECHNICAL ADVISORY DIVISION, WOMEN'S DIVISION, DGIP AND
MSELF WE SUGGEST FOLLOWING ARRANGEMENTS SAFO MOTHERHOOD FUND TO
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27821V OMS CH
8675 FOR JOHN NORTH, DIRECTOR, POPULATION, HEALTH AND NUTRITION DEPARTMENT STOP HEREBY EXPRESS ORGANIZATION'S SINCERE GRATITUDE TO YOU AND YOUR COLLEAGUES AT WORLD BANK FOR PREPARATION, CONDUCT AND FOLLOW-UP OF SAFE MOTHERHOOD CONFERENCE STOP THE PLEDGE BY THE PRESIDENT OF WORLD BANK OF ONE MILLION US DOLLARS TOWARDS SAFE MOTHERHOOD OPERATIONAL RESEARCH, TO BE EXECUTED BY WORLD HEALTH ORGANIZATION, IS PARTICULARLY APPRECIATED STOP HAVE FINALIZED A PROPOSAL BASED ON COMMENTS OF YOUR COLLEAGUES, FOR WHICH WE ARE GRATEFUL STOP ARE FAXING THIS PROPOSAL TODAY FOR YOUR FORMAL PROCESSING IN ORDER THAT FUNDS CAN BE MADE AVAILABLE FOR IMMEDIATE IMPLEMENTATION STOP PLANS INCLUDE: AAA) PREPARATION FOR AND HOLDING OF STEERING COMMITTEE MEETING ON SAFE MOTHERHOOD OPERATIONAL RESEARCH 13-17 JULY; BBB) PROVIDING FUNDING SUPPORT FOR THOSE RESEARCH PROPOSALS CONSIDERED BY STEE RING COMMITTEE SUITABLE FOR FUNDING STOP AS YOU ARE AWARE, WE ARE CONSULTING, ON 6 APRIL IN NEW YORK, WITH WORLD BANK, UNDP AND UNFPA COLLEAGUES ON DETAILS OF IMMEDIATE PLANS STOP LOOKING FORWARD TO CONTINUED COLLABORATION ON THIS PRIORITY ISSUE OF OUR MUTUAL CONCERN
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THE WORLD BANK/IFC

ROUTING SLIP	DATE: 4/10/87

NAME	ROOM NO.
Messrs. North, Hodgkinson, Berg	
Sai, Liese, Akin, Cuca, Denning, Vogl	
Mmes. Birdsall, Herz, Maguire Schwartz	

	APPROPRIATE DISPOSITION		NOTE AND RETURN
	APPROVAL		NOTE AND SEND ON
	CLEARANCE		PER OUR CONVERSATION
	COMMENT		PER YOUR REQUEST
	FOR ACTION		PREPARE REPLY
	INFORMATION		RECOMMENDATION
	INITIAL		SIGNATURE
	NOTE AND FILE		URGENT

REMARKS:

Attached are two articles on Safe Motherhood. One from the New York Times, in case you did not see it, the other a report on the Conference published in The Lancet.

FROM:	ROOM NO.:	EXTENSION:
ARMeasham	N440	61573

NEW YORK TIMES
SATURDAY, APRIL 4, 1987
Pg 26

When Childbirth Is Fatal

For women in the developing world the most worrying question about pregnancy is not "Will it change my life?" but "Will it end my life?" Reducing this maternal mortality rate — a goal recently, and commendably, set by the World Bank — depends heavily on birth control and health care services. Sadly, over the last three years the United States Government's commitment to this noble cause has continued to diminish.

Ideally, women ought to bear children between the ages of 18 and 35, probably have no more than four and space them two years apart. For a woman in Kenya, say, or Bangladesh, the ideal is far off; childbearing often begins with puberty and ends with menopause, assuming that the woman lives till menopause. Women in poorer countries may be 100 times more apt to die in pregnancy or childbirth. A quarter of the deaths that occur before term are the result of illegal abortions.

An estimated 500,000 pregnant women die each year. During a recent conference in Kenya, the World Bank launched a campaign to cut that in half by the year 2000. Barber Conable, the bank's president, pledged $1 million for a Safe Motherhood Fund. "Sometimes," Mr. Conable said, "we forget that development is the work of women as well as men . . . that they are the sustaining force of families, communities, nations."

Safe motherhood, however, requires access to family planning services and safe abortion — both of which the Reagan Administration insists on making cruelly difficult for the world's poor. In 1984, at the World Population Conference in Mexico City, the United States said it wanted to cut off funds to any agencies that so much as mentioned abortion, even though they used no Federal funds for their abortion-related activities.

As a result, the Agency for International Development withdrew support for the United Nations Fund for Population Activities and for the International Planned Parenthood Federation, the primary global network for family planning programs.

In bringing the world's attention to those 500,000 maternal deaths, the World Bank shows welcome concern for what Mr. Conable calls "the growth that comes from the bottom up." Would that the Reagan Administration could show similar understanding.

Maternal Health

The World Bank, the World Health Organisation, and the United Nations Fund for Population Activities were joint sponsors of a conference on Safe Motherhood, held in Nairobi on Feb 10–13. The participants from 37 countries included 5 Ministers of Health, the Director-General of WHO, the President of the World Bank, the Administrator of the UN Development Programme, the Assistant Executive of UNFPA, and staff from 14 non-governmental organisations and 7 bilateral aid agencies. They reviewed the extent of maternal mortality and morbidity, its causes and contributory factors, and the possible strategies and costs that would be required to ensure safe pregnancy and delivery for all women.

The article that follows is based on an address to the conference by the Director-General of WHO.

THE SAFE MOTHERHOOD INITIATIVE: A CALL TO ACTION

HALFDAN MAHLER

Director-General, World Health Organisation

THE most striking fact about maternal health in the world today is the extraordinary difference in maternal death rates between industrialised and developing countries. In the industrialised countries maternal deaths are now rare: the average lifetime risk for a woman of dying of pregnancy-related causes is between 1 in 4000 and 1 in 10 000. For a woman in the developing countries the average risk is between 1 in 15 and 1 in 50. These countries commonly have maternal mortality rates 200 times higher than those of Europe and North America—the widest disparity in all statistics of public health.

Why have these inequities in maternal death rates only recently become apparent and a cause of grave concern to governments and to WHO? The main reason is that until lately the size of the problem was largely unknown. Most of the countries where maternal mortality is high are also countries where even registration of deaths, let alone certification of cause of death, is greatly deficient or absent. Since 1974, however, some very careful community-level surveys have been carried out in at least ten countries in Africa, Asia, and the Americas. They have enabled us to correct the false impression which emerged from under-registration and thus to see, for the first time, the problem as it really is.

Sound estimates based on new data are thus the foundation of our current understanding and concern. There are other features of maternal mortality which impel us to give it a special priority. It has been a *neglected* tragedy; and it has been neglected because those who suffer it are neglected people, with the least power and influence over how national resources shall be spent; they are the poor, the rural peasants, and, above all, women.

DISCRIMINATION AGAINST WOMEN

One of the defects of modern society that is most damaging and impossible to justify is the persisting discrimination against women. "Women hold up half the sky", goes the Chinese saying. Somewhat more than half in many parts of the third world. They plant and harvest much of the food; they process and preserve it; women always cook the food, and they carry the fuel and the water needed. All this in addition to bearing, feeding, and in general caring for the children. They nurse those of the family, old or young, who need such care. They make, in short, an indispensable contribution to the national, the local, and the domestic economy, and they are the main providers of comfort and care to every family. There persist, however, many forms of obvious discrimination against women: a much smaller proportion of girls than boys is enrolled in primary or secondary school; in some parts of the world girls under the age of 5 years still endure much higher death rates than boys; higher proportions of girls than boys are severely malnourished. All such discrimination is not merely reprehensible in itself: it also has a more or less direct relation to maternal mortality.

The cause of a maternal death often has some of its roots in a woman's life before the pregnancy. It may lie in infancy, or even before her birth, when deficiencies of calcium, vitamin D, or iron begin. Continued throughout childhood and adolescence, these faults may result in a contracted pelvis and eventually in death from obstructed labour or in chronic iron-deficiency anaemia and often death from haemorrhage. The train of negative factors goes on through the woman's life: the special risks of adolescent pregnancy; the maternal depletion from pregnancies too closely spaced; the burdens of heavy physical labour in the reproductive period; the renewed high risk of childbearing after 35 and, worse, after 40; the compounding risks of grand multiparity; and, running through all this, the ghastly dangers of illegal abortion to which sheer desperation may drive her. All these are like links in a chain from which only the grave or the menopause offer hope of escape.

A WAY TO BREAK THESE CHAINS

The commitment by all the governments of the world to the Health for All Strategy gives a ray of hope. The only solution must involve a certain basic equity not merely from an ethical or political point of view, but because these deaths strike disproportionately on the poor in remote rural areas. We can succeed in making a major impact only by ensuring for all women access to the essential elements of preventive and promotive maternal health and family planning care—and, particularly, essential obstetric care in life-threatening emergencies of pregnancy and childbirth.

To take this combination of preventive and therapeutic care to the most peripheral level possible, the only approach which can succeed is that of primary health care. A well-planned combination of the community's and the families' own efforts with the inputs of governments and agencies offers the best hope of success.

Local health care, however, cannot exist in a vacuum. It needs technical and management support. It is at the district level (or governorate or county or department, however it is termed) that the health centres, aid posts, and the whole network of primary health care are administered. It is the district team that provides almost all the support and supervision of the health personnel and much of their training too. It is the district hospital that provides, or could provide, the most essential elements of midwifery and obstetric care. The district, therefore, is where we must

focus more of our efforts to reduce maternal mortality, in addition to the efforts to mobilise communities.

In many developing countries an even greater number of women survive only with severe damage to their health. Some of the worst forms of this maternal morbidity are so devastating to the personal, marital, and social life of the woman that many a time she must bitterly wish she had died. But exactly the same kind of measures that would prevent maternal deaths will also prevent this morbidity: from the practical point of view, I will not distinguish further between mortality and morbidity.

Over 50% of women in the world do not have in childbirth the assistance of any trained person whatsoever. Not only are they thus exposed to grave dangers, such as sepsis or other complications, but also they have no means whatever for the relief of pain. For them, obstetric analgesia is a remote dream. They are exposed to the full rigours of labour pains, the very existence of which their fortunate sisters of the developed countries have by now almost forgotten.

Among the many underlying causes of maternal mortality, the contribution made by unregulated fertility is particularly important. WHO's policy on family planning is based on the recognition of family planning as an integral and inseparable part of maternal and child health programmes. Family planning is indispensable in the struggle to prevent maternal deaths. We would be wilfully blind if we failed to acknowledge the millions of illegal abortions carried out every year, and the resulting scores of thousands of deaths from haemorrhage and septicaemia. Since the great majority of abortions arise from lack of knowledge of contraception, or failure to use it, or inability to obtain the means, family planning is the obvious way to save these thousands of pitifully wasted lives.

We face a tragedy of multiple causes and we must confront the challenge with a multiple strategy. There are the long-term objectives of social and economic development and a need for a more determined effort to end female illiteracy.

THE FOUR OBJECTIVES

We must stop behaving as if there were a single magic bullet that could slay this dragon. We need four strings to our bow. Under the umbrella of the Health for All Strategy, the four elements are:

Adequate primary health care and an adequate share of the available food for girls from infancy to adolescence; and family planning universally available to avoid unwanted or high risk pregnancies.

After pregnancy begins, good prenatal care, including nutrition, with efficient and early detection and referral of those at high risk.

The assistance of a trained person for all women in childbirth, at home as in hospital.

Women at higher risk, and, above all, women in the emergencies of pregnancy, childbirth, and puerperium, must all have effective access to the essential elements of obstetric care.

ACCESS TO ESSENTIAL OBSTETRIC CARE

The ability of small district and rural hospitals to carry out essential functions of midwifery and obstetrics, such as a caesarean section or a blood transfusion, saves many more lives than any amount of high technology at the tertiary hospital of the capital city. Family planning and good primary health care before and during pregnancy could greatly reduce the number of potentially fatal complications —perhaps by a half or two-thirds. Yet investigations have shown that a significant proportion of complications could not have been predicted or prevented. Speedy access to emergency care can be a matter of life or death. All the inquiries into the causes of maternal mortality in which WHO and UNFPA have lately collaborated with institutions in developing countries show clearly that the essential elements of obstetric care must be brought much nearer to the women of these regions than they are today.

NEED FOR RESEARCH

If we are effectively to apply existing knowledge in a wide range of different conditions, much further research is essential. In each country's circumstances the particular pattern of preventable causes of maternal deaths must be clarified; and the potentials for improvement in that country's own context must be identified. Health systems research (operational research, as it is sometimes termed) is essential to the evaluation of feasibility and effectiveness of many recent ideas and technologies. They cover a range as diverse as plasma substitutes, maternity waiting homes, detection of anaemia, delegation of clinical functions, improving the organisation of existing health facilities, and improving the logistics of supply and blood transfusion services.

NO REASON FOR DELAY

The need for research should not delay action. We know how to prevent most of the common causes of maternal death (eclampsia, obstructed labour, haemorrhage, or puerperal or post-abortion sepsis). The fact that they have become rarities in the industrialised world, in some developing countries, and in all but some rural areas of China, proves conclusively that we know enough to act now. What of the means, the resources? Could they be made available? We are not speaking of building great hospitals or whole new medical schools. We are speaking of resources that already exist in most developing countries, but not in adequate quantity. We are talking about training more midwives, traditional or otherwise; about extending and strengthening, at district and subdistrict level, the primary health care system for the provision of good prenatal care and family planning service. We are speaking about upgrading district hospitals and rural maternity centres so that they can perform at least the most essential lifesaving functions in midwifery and obstetric care. Where new hospitals are needed, it will be these modest units, and not great urban disease palaces, which are so costly to build and maintain.

Even in our present wintry economic climate these kinds of modest resources can be made available and deployed effectively, through a combined effort of central and district governments, of international and bilateral agencies, of non-government organisations, and of the communities and families themselves. We are not speaking of some kind of supranational campaign, but an initiative; the beginning of a renewed emphasis and more intense effort to make pregnancy and childbirth as safe for all women in the future as it is for the minority today. It could be done; it ought to be

done; and in the name of social justice and human solidarity, it must be done.

* * *

The conference came to the following conclusions:

The Problem

500 000 maternal deaths take place every year—99% of them in the developing world.[1] In the developed world, there are only 5–30 maternal deaths per 100 000 live births; in developing countries the figures range from 50 to 800 or more. Women in developing countries run 100 to 200 times the risk of dying in pregnancy and childbirth than do women in an affluent country. These figures do not convey the full measure of the risk, because women in, for example, Africa and Asia have on average 4–6 children compared to fewer than 2 in Europe. The lifetime risk of a woman in a developing country dying in pregnancy or from pregnancy-related illness may be 1 in 50 or as high as 1 in 14; this contrasts sharply with the 1 in several thousand women in the developed world. These measures of maternal death have not been used as part of the quality of health and quality of life index. They should be so used. No country can claim to be advancing if its maternal death rates remain poor.

The Causes

The causes of these deaths are tragic indeed. Illegal abortion from unwanted pregnancies causes some 25–50% of these deaths, simply because women do not have access to the family planning services they want and need, or have no access to safe procedures or to humane treatment for the complications of abortion. For the thousands of women who die in pregnancy and childbirth, millions more are permanently disabled. Many of them are ostracised by their families and communities. For every death, it is estimated that 10–15 women suffer serious health consequences in one way or another.

The question we must ask is why this happens: is it because the majority of these women are poor that they are allowed to suffer this silent carnage?

There must be a commitment to stop these deaths. We need to mobilise the political will, to mobilise community involvement among men and women, and to implement specific programmes to stop these tragedies from taking place. We must do this for common humanity as a human right. We must do this also because women are a major resource to any nation, to any community, and above all to any family. They make a crucial contribution to the productivity and wellbeing of their families and communities. When a woman dies in childbirth, the death sentence of the child she carries is almost certainly written. Often the children she leaves behind suffer the same fate, and the family stands a good chance of disintegration.

The causes are deeply rooted in the adverse social, cultural, political, and economic environment of societies, and especially the environment that societies create for women. Women are discriminated against in terms of legal status, access to education, access to financial resources, and access to relevant health care, including family planning services. This discrimination begins at birth and continues through adolescence and adulthood, where women's contributions and roles are ignored and undervalued.

These deep-rooted causes need to be addressed if we are to improve the long-term situation of women's health and status. The problems will only grow in magnitude with population growth if we do not address these basic causes. We must reduce the pool of women who are most likely to suffer from the complications that result in so many deaths. Let us reduce the risk and help women achieve healthier, happier lives.

There was a consensus at the United Nations International Conference on Population in 1984 in Mexico on the need for action in these areas. The End of the Women's Decade Conference in Nairobi in 1985 also emphasised this need, and there was consensus. We must cut the vicious circle that creates the conditions that cause women to suffer and die so needlessly.

The critical point, however, is that there are a number of immediate causes that result in the overwhelming majority of maternal deaths. These are obstructed labour, eclampsia, toxaemia, infection, and complications from both spontaneous and induced abortion. The challenge is that there exist low-cost effective and available interventions that can have a major impact on reducing these mortalities and morbidities if these interventions are specifically planned and practised as a priority.

What is needed now is dedication and action.

What Actions are to be Undertaken?

We need to generate the political commitment to reallocate resources to implement the available strategies that can reduce maternal mortality by an estimated 50% in one decade.

We need to remember that the industrialised countries faced this challenge in the past. For some the change has taken place in our lifetime, through dedication and the reallocation of priorities.

We need an integrated approach to maternal health care that makes it a priority within the context of primary health care services and overall development policy.

We need to reach decision-makers in family and government to change laws and attitudes, and improve the legal and health status of women generally, especially in areas such as adolescent marriage and restrictions on health care delivery.

We need to mobilise and involve the community and particularly women themselves in planning and implementing policies, programmes, and projects, so that their needs and preferences are explicitly taken into account.

We need to utilise a range of information, education, and communication activities to reach communities, women, men, boys, and policy-makers, through the media and all culturally appropriate channels.

We need to carry out additional studies to gain better country-specific and locale-specific information on maternal mortality: its immediate causes, which we know, and its root causes, some of which we either do not know or ignore.

We need to have continuous operational research and evaluation activities to assess the effectiveness of various programmes.

We need to expand family planning and family life education programmes, particularly for young people, and make services for planning families socially, culturally, financially, and geographically accessible.

We need to use appropriate technologies at all levels so that women have better care at lower cost.

We need to strengthen community-based maternal health care delivery systems, upgrade existing facilities, and create relevant new ones where necessary.

We need to ensure that pregnant women are screened by supervised and appropriately trained non-physician health workers were appropriate, with relevant technology (including charts to monitor labour [partograms] as needed), to identify those at risk, and to provide prenatal care and care during delivery as expeditiously as possible.

We need to strengthen referral facilities and site them appropriately—hospitals as well as health centres. They need to be equipped to handle emergencies effectively and efficiently.

We need to implement an alarm and transport system which ensures that women in need of emergency care reach the referral facilities in time.

These activities need to be seen within a comprehensive, multisectoral approach, although they do not have to wait for all the sectors to achieve improvement simultaneously. These activities need to involve governments as well as take advantage of the flexibility, responsiveness, and creativity of non-governmental organisations. They need to stimulate and support input from the communities themselves.

Perhaps the most important contribution to this initiative will be to call attention to the problems related to it, and to create an awareness that something can and must be done, starting with the commitment of heads of states and governments.

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1. Maternal mortality rates: a tabulation of available data. 2nd ed. WHO document no FHE/86.3.

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION
OFFICE MEMORANDUM

DATE: April 10, 1987

TO: Ms. I Husain and Messrs. R. Cuca and S. Denning

FROM: Anthony R. Measham, Health Adviser, PHNDR

EXTENSION: 61573

SUBJECT: WHO Safe Motherhood Operational Research Programme and Working Group on Safe Motherhood

1. Attached, as agreed in the Safe Motherhood follow-up meeting of April 9, 1987, is a copy of the proposal for a Safe Motherhood Operational Research Programme, to be managed by WHO beginning on July 1, 1987. As you know, the Bank will provide US$1 million in support of this Programme over the next three years.

2. We encourage staff to bring this source of funding to the attention of our member countries, and to assist those who are interested in requesting support from WHO for operational research and demonstration programs. We would also encourage early contact and correspondence with Dr. Robert Cook, Family Health Division, who is the responsible officer in WHO/Geneva.

3. Barbara Herz, Fred Sai and I would be pleased to attend divisional meetings to describe the Programme and to answer questions on this or other Safe Motherhood topics. Please let us know when this would be convenient.

4. Safe Motherhood Working Group. John North has proposed that we set up a small working group, initially to be composed mainly of PHN staff, to coordinate Safe Motherhood activities. Would you please nominate a representative and an alternate for your division. Other members will be Barbara Herz, Fred Sai and myself. The working group will hold its initial meeting at 11 a.m. on Tuesday, April 21, 1987 in Room N-550. I would be grateful if you would let Mita Sanyal (ext. 60015) or Cecilia Mangini (ext. 61573) know who will attend on behalf or your division.

cc w/attachment: Messrs. Hodgkinson, Sai, Akin, Mahar
Ms. Herz

Attachment

cc w/o attachment: Messrs. North, Berg, Liese
Mmes. Birdsall, Sanyal

ARMeasham/cjm

WORLD HEALTH ORGANIZATION
CH - 1211 GENEVA 27 SWITZERLAND

Telegr.: UNISANTE GENEVA
Tel.: 91 21 11 Telex: 27821
FACSIMILE: 910746

WHO FACSIMILE

Message No. 598 Page 1 of 12 pages Date: 1 April 1987

From: Director, FHE/HQ(Geneva)

To: JOHN NORTH, DIRECTOR, POPULATION, HEALTH AND NUTRITION DEPARTMENT, WORLD BANK, WASHINGTON 8484 6391

Fax No.: 001 202 4778164

Our ref.: M3/445/41

Subject: SAFE MOTHERHOOD OPERATIONAL RESEARCH: A Proposal for Fundir (WHO, Division of FamilyHealth, Geneva)

TEXT

AS PROMISED IN MRS I. BRUGGEMAN'S TELEX OF TODAY'S DATE, PLEASE FIND ATTACHED OUR ABOVE-MENTIONED PROPOSAL

PETROS-BARVAZIAN UNISANTE GENEVA

1987 APR -1 AM 9:40
CABLE SECTION

Signed: Director, FHE

Copies to: COR
HRM
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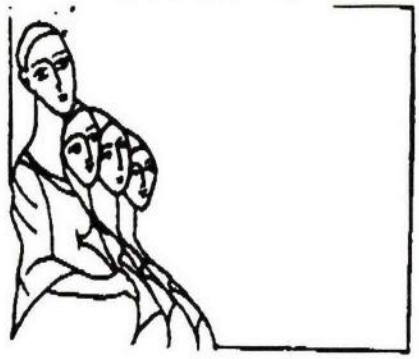

SAFE MOTHERHOOD OPERATIONAL RESEARCH

A Proposal for Funding

World Health Organization

Division of Family Health
Geneva, Switzerland

SAFE MOTHERHOOD
OPERATIONAL RESEARCH

A Proposal for funding
from the
World Health Organization
Division of Family Health
Geneva, Switzerland

Contents

SAFE MOTHERHOOD
OPERATIONAL RESEARCH

1. Introduction

1.1 Problem Statement

It has only been in the last few years that maternal mortality has begun to attract broad attention as a problem for the health sector. Maternal mortality and morbidity have their impact when women are at the height of their productivity and family responsibility. Maternal mortality is an indicator of social inequity and discrimination against women, it represents an impediment to development and must become a priority concern for social justice. While many sectors may take credit for the dramatic declines in infant mortality in many parts of the world, in large apart, the credit for progress or blame for failure to achieve a sharp decline in maternal mortality rates rests with the health sector. (Ref. BMJ) However, although many of the actions for lowering maternal mortality must come from health technologies and health systems, including the provision of family planning, all sectors of society bear a responsibility for creating a social climate in which women may fully realize their personal and social potential, and not merely relegated to a role of child bearing and care.

In the absence of skills and knowledge in managing pregnacy and conducting a delivery each time a woman becomes pregnant she has between a one and two percent risk of dying. In some sub-groups, particularly young adolescents who receive no prenatal care, there may be a 5.0 to 7.0 percent risk of dying. (Harrison 1985) Progress in health technology and health systems can be measured by the observation that in many industrialized and even a few developing countries maternal mortality is 1/200th to 1/500th that in the least advantaged countries.

The road to a maternal death begins with the health and nutrition of the furture mother during childhood. A childhood legacy of short stature, low body weight and anemia coupled with childbearing before social and biological maturity are major contributors to maternal death. The geographic and cultural inaccessability of family planning services and the erosion of traditional mechanisms of child spacing add their contribution to the risk of a maternal death.

Even in circumstances where an infrastructure exists for some maternal health care components the full benefit of knowledge and affordable technologies is not being applied. The result is that maternal mortality rates in the majority of developing countries range between 100 and 600/100,000 live births (the maternal mortality rate in the Nordic countries is between 2 and 6/100,000 live births). (WHO 1986) Among the reasons for this gap, two could readily be remedied: existing and proven technologies and skills for pregnancy and delivery care are not at the point where the problems arise; and, there is insufficient attention to the quality of care in both case and programme management. In many countries and regions it is

unfortunately not unusual to find that a large percentage of the maternal deaths are preventable with attainable resources and skills. For example, in the presence of prenatal care, even provided by traditional birth attendants or primary health care workers, it is unconscionable that a woman dies from eclampsia. Timely action and referral are usually possible. Yet 10 to 25 percent of maternal deaths are due to eclampsia, the risk having already been identified by a health worker. At the same time, increased literacy among women and their involvement in their own health care increases their awareness and understanding of their own health needs and the cultural accessibility and utilization of maternal health services.

2. OBJECTIVES

The overall objectives of accelerated action for operational research in maternal health would be:

2.1 To promote, stimulate and support through operational research the selection, adaptation and application of known technologies and innovative approaches for maternal health care at the country level

2.2 To monitor and evaluate national and local experiences in operational research in maternal health care in order to develop general principles and guidelines for the planning, management and evaluation of maternal health care services

2.3 To disseminate the results of operational research in maternal health care and to share the information and experiences on the application of research methods

3. Areas of operational research in maternal health

Recognizing, as noted in the previous section, that there has been little appreciation by both policy makers and health researchers as to the magnitude and nature of the problem of maternal mortality and health, even less attention has been directed at the operational and programmatic issues in the provision of maternal health care. In contrast to infant mortality, dramatic and accelerated improvement in maternal health will not come about as a secondary consequence of overall social and economic development. Such improvement requires: explicit action in terms of the organization of maternal health services; the placement of human, technical and institutional resources at points that are geographically and culturally accessible to the community; the application of already known technologies; and, changes in health behaviour in the community. The broad principles for meeting these requirements exist; what does not exist is an extensive experience in the adaptation, adoption and evaluation of the application of existing epidemiological, social science and managent sciences knowledge to the different circumstances and settings where maternal mortality is a priority problem, ie. operational research.

In any specific setting the selection of priorities for operational research in maternal health will be based upon:

- the perception of the need for operational research by the national health authorities and decision makers
- knowledge or reasonalble estimates of the magnitude and major causes of maternal mortality
- an examination of the existing system for and the cultural perceptions of maternal health and health care
- the community's perception of maternal health

Common concerns or problems in the provision of maternal care may be found in several settings in different countries. Under these circumstances the development of multi-centred collaborative research is likely to facilitate the implementation, analysis and dissemination of the results of such research.

Operational research issues can be approached from the perspective of:

1) the organization and management of services

2) development and adaptation of specific technologies

3) case and programme management of specific conditions

Within each of these three perspectives there is the need to focus on issues related to the quality of care, management or the application of the specific technologies. In a variety of settings and depending on the needs of local programmes, mant of the following issues and others would need to be examined through operational reserch in terms of the safety, effectiveness, managerial efficiency and social acceptability.

3.1. Examples of operational research issues:

3.1.1. Organization and management

Integrated programmmes and community participation: In any given setting what is the optimal mix of services provided both in managerial terms and from the perspective of the family; to what extent can community-based distribution of contraceptives be extended to other maternal health technologies, such as iron folate and antimalarials; other interventions, including social support, affecting women's work, nutrition and energy expenditure

Maternity waiting area: Community acceptance and participation in the development and maintenance of maternity waiting "villages" or houses for women at high risk of complications during pregnancy or delivery

Transfer and delegation of skills and tasks: Training and delegation to

General Medical Officers, Midwives, Medical Assistants, etc of functions of cesarian section, vacuum extraction, manual removal of placenta, administration of anesthesia; use of community groups, eg women's organizations, teachers, etc in identification of pregnant women at risk of complications

Emergency transport: Community participation in emergency transport of pregnant women, including regulations requiring government vehicles to respond to an emergency signal

Supervision and management: Indicators and techniques for monitoring case and programme management of maternity care at different levels in the health system

Service performance problems: Development of simple techniques for maternal health investigations at facility and district levels to identify immediate improvements of services; methods for risk case tracking through the levels of care

Cost of services: The relative cost effectiveness and acceptability of different combinations of maternal health, nutrition and family planning interventions

Prenatal care: identification of the minimal pre-natal care required for different categories of risk cases in different settings, including the number of contacts, the minimal technical content of each pre-natal contact and the supervisory mechanisms for ensuring quality of care and appropriate referral

3.1.2. Specific technologies

Plasma substitutes: The use and effectiveness of plasma substitutes by health centre staff to replace blood loss in shock

Home-based maternal record: The effectiveness and programme impact of the Home-based Mother's Record (HBMR) in self-identifcation and referral of women at high risk of complications during pregnancy or delivery; acceptability of the HBMR by different levels of health workers and by the community

Labour graph: The effectiveness of a labour graph in identifying the timing for referral or operative intervention

3.1.3. Specific conditions

Sepsis: The use of routine antibiotics in cases of prolonged labour or pre-mature rupture of membranes; gloves versus alternative solutions and handwashing techniques in control of infection

Hypertensive Disease of Pregnancy and Eclampsia: Training TBAs and PHC workers in the use of pitting edema as a screening tool for hypertensive disease of pregnancy

Anemia: Use of simple devices for discrimination of severe anemia (< 8gm%); comparison of different regimen combinations and duration of therapy of anti-malarial drugs, iron and folic acid in the treatment of anemia; evaluation of community-based distribution of these drugs

Haemorrhage: Safety and effectiveness of the routine use of oxytocics by all birth attendants after the delivery of the anterior shoulder; manual removal of the placenta after thirty minutes by health centre staff; TBA catheterization of the bladder in prolonged third stage of labour.

4. Resources Requirements for Operational Research in Maternal Health

Operational research can be implemented as part of an overall national strategy for health development or in an ad hoc fashion in relationship to specific issues of priority concern. Both approaches will be useful and productive so long as mechanisms exist for the utilization and application of the results in health systems. Part of that mechanism is the interest and involvement of a senior decision maker in formulating the research questions and his/her commitment to use the results should for the improvement of the services.

Implementation of operational research requires the drawing on the expertise and experience from a wide variety of disciplines from the health, social and managerial sciences. It is greatly facilitated by a network of collaborating centres sharing both concerns and experiences, both in the specific field of maternal health as well as in other areas of health systems research.

Certain approaches facilitate the development and application of operations research. Sensitization of decision makers to the importance and applicability of operational research is a critical first step. Short national or regional seminars have been useful in such sensitization. The demystification of operational research and the motivation and mobilization of researchers and other health workers in undertaking it have been successfully accomplished in training workshops.

The application of the results of operational research in maternal health care in countries would be both facilitated and accelerated by sharing the results of studies and the exchange of of experiences both within and between countries. National workshops have been effective means of promoting the application of study results. The development of a database of the results and methodsoperational research and the wide dissemination of the information in such a database would also facilitate the sharing of experiences.

Within a country, operational research on maternal health is likely to involve either one large project with several sub-components, or a series of smaller, but programmatically linked projects. In the development of activities in a country it can be anticipated that a training workshop would be held as part of the development of specific research protocals. Following the completion of the studies a workshop should be held to review the results and to identify their application in the national programme. On the average each country project will require approximately 3 person-months of consultant

... additional hardware or software for analysis.

Within country project costs		$20,000 - $70,000
Country training workshop		5,000 - 7,000
Staff/consultant facilitator		approx. 3,800
Consultant (project development, implementation & analysis)	3 person months	16,500
Equipment/supplies (hardware & software)		1,000 - 8,000
Information dissemination, (workshop, publications, audio-visual, etc)		7,500

5. Background of Programme Development and WHO Involvement

Improving the coverage of maternal health care has always been a priority objective of the World Health Organization. Since its inception UNFPA has also had as one of its major objectives the strengthening of services for maternal and child health, including family planning (MCH/FP). The past four decades has seen the development and promotion of activities supportive of the maternal component of MCH/FP. These efforts have been supported in all or in part by WHO, UNFPA and the Bank and have included the development of training programmes and materials for delivery care; up-grading, training and integration of traditional birth attendants as part of national health development strategies; and, support to research, training and programme development of the family planning component of MCH/FP.

In monitoring the world health situation it was evident to the Organization that information on maternal mortality was lacking in just those countries and circumstances that it was most needed for programme development and planning. Based on the experiences and methods of the Confidential Enquiries into Maternal Deaths as developed in Britain and a few other countries, the approach was promoted in the Eastern Mediterrainian Region, and adopted in a modified form for monitoring maternal deaths in at two large countries of the region. Scientific Working Group meetings on maternal health were held in EMRO in 1980.

In 1982 the headquarters programme initiated the systematic review of indexed medical literature, non-indexed publications and reports from national or local authorities, consultants, etc. to create a micro-computer data base on maternal mortality and maternity care coverage. At present, well over 1,300 entries are included, covering national and local data, as well as time trends in mortality rates. (WHO 1986) On the basis of that review it has been estimated that there are 500,000 pregnancy related deaths per year, most of which could and should be prevented. A monograph on Maternal Mortality, its magnitude, causes and contributory factors, will be published in 1987. In 1985 the Bank had commissioned an in-depth review of maternal mortality with particular reference to Africa.

In 1984, with the support of UNFPA, WHO rapidly mobilized the interest and expertise of a network of collaborating institutions and consultants in all regions to initate a programme of research on maternal mortality and on unmet needs in maternal health and family planning. A flexible approach, yet

with strong technical support, was used in promoting and adapting research questions and methods to the local circumstances in 12 countries. The intention of these studies was to promote an awareness of the problem in the national setting. They were designed, using a variety of approaches, to define or estimate the magnitude and major causes and to identify possible interventions. In addition to direct financial and technical support to these 12 studies (and 8 subsequent studies in 1986/7), WHO has established a network of collaboration and exchange of information with other research groups and institutions that have been working in the field. This network has included the International Federation of Obstetrics and Gynecology (FIGO), the Federation of Obstetric and Gynecology Societies of India, Indian Institute of Management, Family Health International, the London School of Hygiene and Tropical Medicine, Columbia Universty in New York, Save the Children Fund (Sweden), etc.

The principal investigators of the WHO supported studies and representatives of the other concerned institutions, UNFPA and the UN Population Division participated in a WHO Inter-Regional Meeting on the Prevention of Maternal Mortality in November, 1985. The results of the studies were reviewed and the broad lines of a four pronged attack on the problem was drafted in terms of defining the magnitude and major causes in different settings; establishing needs for research, training and appropriate technology research; defining and detailing the essential elements of obstretric care necessary at the first referral level; and, highlighting the specific role of family planning. (Ref) Subsequently a Technical Working Group met in June 1986 to initiate the development of guidelines for Essential Obstetric Functions at the First Level of Referral. (FHE/86.1) The latter document provides the basis of a more comprehensive maternal health care programme development, including the implications for facilities, supplies and equipment, allocation of tasks and training, transport and communications and programme planning and resource allocation.

The studies undertaken by national researchers have been in many instances, as part of the original plan of work, led to further regional and national workshops, aimed both at further promotion of research and action. The epidemiological methods applicable to defining maternal mortality have been developed and are being published as a guideline for such research. These methodologies are an essential step in operational research, both for defining the problem and for evaluating the results of interventions.

Culminating in the joint sponsorship of the International Conference on Safe Motherhood, it is reasonable to conclude that UNFPA, WHO and the World Bank have played a critical role in generating an awareness of the importance of maternal mortality to overall health and development. Approaches to the defining of the problem in any given setting have been established and technical resources to support such efforts are immediately available. Interest and commitment have been generated at many levels. What is required now is a catalytic action to crytalize this common will.

6. Resources available to the World Health Organization

Staff: Within the WHO Division of Family Health and other technical programmes of the Organization will be mobilized in support of this accelerated action for operational research in maternal health. These include staff experienced in clinical, epidemiological, psychosocial and health systems research along with staff with a broad range of cultural perspective and experienced in programme planning, management and training.

Collaborating institutions and centres: As part of the activities of the Programme of Maternal and Child Health, including Family Planning and the Special Programme in Human Reproduction, there is a network of institutions, governmental, academic and non-governmental that have entered into formal or informal collaborative arrangements with WHO to undertake and support research relevant to the overall aims and objectives of the Organization. Found in all regions, many of these institutions posses the requisite staff expertise, experience and access to on-going programmes that will be required for the programme of accelerated action for operational research in maternal health. Those institutions that are formally designated as WHO collaborating centres are so designated for a period of four years. The broad lines of their programmes are approved by their governments at the time of the designation, thus facilitating subsequent technical collaboration and communications in the implementation of agreed upon research. There is also close collaboration between centres, both with respect to sharing experiences, strengthening of research resources, training and coordination of research on common themes.

Databases and Other Sources of Programme Information: Within the Family Health Division and elsewhere in the Organization databases on the health situation are being maintained. Within FHE currently functioning databases cover the global, regional, national and where available, local situations with regard to maternal mortality, maternity care coverage, low birth weight and pre-mature gestation, perinatal mortality, and the prevalence of breast-feeding. Currently being established are databases covering the areas of adolescent reproductive health, infertility, and the health consequences of abortion.

The Risk Approach: Over the past ten years the WHO has developed the application of the risk approach to the health problems of mothers and children. Training workshops in all regions have resulted in the development of innumerable operational research projects, and have provided researchers and national authorities with an understanding of what is involved in risk selection.

Rapid Evaluation Methodology (Joint Programme Review): Initially developed as a tool to assess coverage and the management of the Expanded Programme of Immunization, the Rapid Evaluation Methodology has been adapted by the Maternal and Child Health Programme to the wide range of performance, management and resource issues in MCH/FP services.

12

7. DRAFT BUDGET for a THREE YEAR PROGRAMME of OPERATIONAL RESEARCH for MATERNAL HEALTH

BUDGET LINE	1987	1988	1989	
Personnel				
Consultants/Temporary Advisors	$120,000	$180,000	$200,000	
Grants to Institutions	$300,000	$1,100,000	$1,900,000	
Meetings				
Steering Committee	$30,000	$33,000	$33,000	
Workshops				
- training/project development	$28,000	$56,000	$56,000	
- programme applications	$28,000	$56,000	$56,000	
Travel				
Staff Duty Travel	$15,000	$15,000	$15,000	
Information Dissemination				
Hardware	$20,000	$40,000	$40,000	
Publications	$10,000	$20,000	$20,000	
Programme Support	$71,630	$195,000	$301,600	
TOTAL	$622,630	$1,695,000	$2,621,600	$4,939,230

ARM

WORLD HEALTH ORGANIZATION
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Tel.: 91 21 11 Telex: 27821
FACSIMILE: 910746

WHO FACSIMILE

Message No. 598 Page 1 of 12 pages Date: 1 April 1987

From: Director, FHE/HQ(Geneva)

To: JOHN NORTH, DIRECTOR, POPULATION, HEALTH AND NUTRITION DEPARTMENT, WORLD BANK, WASHINGTON 8454

Fax No.: 001 202 477 8164 6391

Our ref.: M3/445/41

Subject: SAFE MOTHERHOOD OPERATIONAL RESEARCH: A Proposal for Fundin (WHO, Division of FamilyHealth, Geneva)

TEXT

AS PROMISED IN MRS I. BRUGGEMAN'S TELEX OF TODAY'S DATE, PLEASE FIND ATTACHED OUR ABOVE-MENTIONED PROPOSAL

PETROS-BARVAZIAN UNISANTE GENEVA

Signed: Director, FHE

Copies to: COR
HRM
MCH
BUD
ACT

SAFE MOTHERHOOD OPERATIONAL RESEARCH

A Proposal for Funding

World Health Organization

Division of Family Health
Geneva, Switzerland

SAFE MOTHERHOOD
OPERATIONAL RESEARCH

A Proposal for funding
from the
World Health Organization
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Geneva, Switzerland

Contents

4.

SAFE MOTHERHOOD
OPERATIONAL RESEARCH

1. Introduction

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In 1984, with the support of UNFPA, WHO rapidly mobilized the interest and expertise of a network of collaborating institutions and consultants in all regions to initate a programme of research on maternal mortality and on unmet needs in maternal health and family planning. A flexible approach, yet

with strong technical support, was used in promoting and adapting research questions and methods to the local circumstances in 12 countries. The intention of these studies was to promote an awareness of the problem in the national setting. They were designed, using a variety of approaches, to define or estimate the magnitude and major causes and to identify possible interventions. In addition to direct financial and technical support to these 12 studies (and 8 subsequent studies in 1986/7), WHO has established a network of collaboration and exchange of information with other research groups and institutions that have been working in the field. This network has included the International Federation of Obstetrics and Gynecology (FIGO), the Federation of Obstetric and Gynecology Societies of India, Indian Institute of Management, Family Health International, the London School of Hygiene and Tropical Medicine, Columbia Universty in New York, Save the Children Fund (Sweden), etc.

The principal investigators of the WHO supported studies and representatives of the other concerned institutions, UNFPA and the UN Population Division participated in a WHO Inter-Regional Meeting on the Prevention of Maternal Mortality in November, 1985. The results of the studies were reviewed and the broad lines of a four pronged attack on the problem was drafted in terms of defining the magnitude and major causes in different settings; establishing needs for research, training and appropriate technology research; defining and detailing the essential elements of obstretric care necessary at the first referral level; and, highlighting the specific role of family planning. (Ref) Subsequently a Technical Working Group met in June 1986 to initiate the development of guidelines for Essential Obstetric Functions at the First Level of Referral. (FHE/86.1) The latter document provides the basis of a more comprehensive maternal health care programme development, including the implications for facilities, supplies and equipment, allocation of tasks and training, transport and communications and programme planning and resource allocation.

The studies undertaken by national researchers have been in many instances, as part of the original plan of work, led to further regional and national workshops, aimed both at further promotion of research and action. The epidemiological methods applicable to defining maternal mortality have been developed and are being published as a guideline for such research. These methodologies are an essential step in operational research, both for defining the problem and for evaluating the results of interventions.

Culminating in the joint sponsorship of the International Conference on Safe Motherhood, it is reasonable to conclude that UNFPA, WHO and the World Bank have played a critical role in generating an awareness of the importance of maternal mortality to overall health and development. Approaches to the defining of the problem in any given setting have been established and technical resources to support such efforts are immediately available. Interest and commitment have been generated at many levels. What is required now is a catalytic action to crytalize this common will.

6. Resources available to the World Health Organization

11.

Staff: Within the WHO Division of Family Health and other technical programmes of the Organization will be mobilized in support of this accelerated action for operational research in maternal health. These include staff experienced in clinical, epidemiological, psychosocial and health systems research along with staff with a broad range of cultural perspective and experienced in programme planning, management and training.

Collaborating institutions and centres: As part of the activities of the Programme of Maternal and Child Health, including Family Planning and the Special Programme in Human Reproduction, there is a network of institutions, governmental, academic and non-governmental that have entered into formal or informal collaborative arrangements with WHO to undertake and support research relevant to the overall aims and objectives of the Organization. Found in all regions, many of these institutions posses the requisite staff expertise, experience and access to on-going programmes that will be required for the programme of accelerated action for operational research in maternal health. Those institutions that are formally designated as WHO collaborating centres are so designated for a period of four years. The broad lines of their programmes are approved by their governments at the time of the designation, thus facilitating subsequent technical collaboration and communications in the implementation of agreed upon research. There is also close collaboration between centres, both with respect to sharing experiences, strengthening of research resources, training and coordination of research on common themes.

Databases and Other Sources of Programme Information: Within the Family Health Division and elsewhere in the Organization databases on the health situation are being maintained. Within FHE currently functioning databases cover the global, regional, national and where available, local situations with regard to maternal mortality, maternity care coverage, low birth weight and pre-mature gestation, perinatal mortality, and the prevalence of breast-feeding. Currently being established are databases covering the areas of adolescent reproductive health, infertility, and the health consequences of abortion.

The Risk Approach: Over the past ten years the WHO has developed the application of the risk approach to the health problems of mothers and children. Training workshops in all regions have resulted in the development of innumerable operational research projects, and have provided researchers and national authorities with an understanding of what is involved in risk selection.

Rapid Evaluation Methodology (Joint Programme Review): Initially developed as a tool to assess coverage and the management of the Expanded Programme of Immunization, the Rapid Evaluation Methodology has been adapted by the Maternal and Child Health Programme to the wide range of performance, management and resource issues in MCH/FP services.

7. DRAFT BUDGET for a THREE YEAR PROGRAMME of OPERATIONAL RESEARCH for MATERNAL HEALTH

BUDGET LINE	1987	1988	1989	
Personnel				
Consultants/Temporary Advisors	$120,000	$180,000	$200,000	
Grants to Institutions	$300,000	$1,100,000	$1,900,000	
Meetings				
Steering Committee	$30,000	$33,000	$33,000	
Workshops				
- training/project development	$28,000	$56,000	$56,000	
- programme applications	$28,000	$56,000	$56,000	
Travel				
Staff Duty Travel	$15,000	$15,000	$15,000	
Information Dissemination				
Hardware	$20,000	$40,000	$40,000	
Publications	$10,000	$20,000	$20,000	
Programme Support	$71,630	$195,000	$301,600	
TOTAL	$622,630	$1,695,000	$2,621,600	$4,939,230

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION
OFFICE MEMORANDUM

DATE: December 19, 1986

TO: DISTRIBUTION

FROM: Stephen M. Denning, Acting Director, PHN

EXTENSION: 61670

SUBJECT: Safe Motherhood Fund for Operation Research

1. Attached is a proposal for a Safe Motherhood Fund for operational research to support development of country programs and projects to reduce maternal mortality and morbidity. Bank management has approved the proposal and is allocating $500,000 for this purpose in the Special Programs category of the FY88 budget.

2. Your comments on this proposal are solicited, both on the substance and on possible organizational arrangements. Comments received by January 16, 1987 would be especially helpful. Please direct them to Tony Measham, Room N440.

DISTRIBUTION:

Messrs. North o/r, Hodgkinson, Berg, Liese, Measham, Sai, Schebeck
Mesdames Birdsall, Herz, Husain, Sanyal

ARMeasham/tc

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION
OFFICE MEMORANDUM

DATE: December 10, 1986

TO: Mr. Ernest Stern, Senior Vice President, Operations (through Mr. S. Shahid Husain, Vice President, Operations Policy)

FROM: John D. North, Director, PHND and Hans-Eberhard Köpp, Director, PPD

EXTENSION: 61571

SUBJECT: Proposal for a Safe Motherhood Fund for Operational Research

1. The more detailed proposal you requested for the Safe Motherhood Fund for Operational Research is attached. Please let us know if you would like to have additional information.

Attachment: Proposal
Annex

BHerz/ARMeasham/rmf

Proposal for the Establishment of a Safe Motherhood Fund for Operational Research

Recommendation

It is recommended that the Bank take the lead in establishing a Safe Motherhood Fund under WHO, for operational research to support development of country programs and projects to reduce maternal mortality and morbidity. An initial Bank contribution of $1 million is recommended, representing 20% of the proposed three year budget of $5 million.

Background

1. Governments throughout the world have adopted the goal of "Health for All by the Year 2000". Many countries have made rapid strides toward that goal, particularly by improving child health. Yet maternal mortality and morbidity still threaten the health and well being of women, at the height of their productivity and family responsibility, in much of the developing world. In poorer countries, women often run 200 times more risk of dying in pregnancy than do women in developed countries. In fact, approximately 500,000 women in the developing world die each year from causes related to pregnancy. The result is not only tragedy for those women. At least that many infants and young children do not long survive their mothers. And for the women who survive, many millions suffer lasting ill health and disability.

2. This need not happen. Basic maternal health services, in conjunction with development programs to strengthen women's opportunities, can reduce the toll of maternal mortality and morbidity by half or more at affordable cost in many poorer countries within a decade. Some countries in Latin America (e.g. Costa Rica) and Asia (e.g. China, Sri Lanka) have succeeded in reducing maternal mortality very substantially in the past ten or twenty years at affordable cost, proving we have the means to do the job. The key is to make each pregnancy and childbirth safer and to encourage healthy spacing of pregnancies.

3. A three-pronged approach is required:

a) Better community-based health care (relying on non-physican health workers) to screen pregnant women, identify those at high risk, and refer them for help; to provide prenatal care and ensure safe delivery for women at less risk; and to provide family life education and family planning;

b) Adequate first referral level facilities--hospitals and health centers--to take care of complicated deliveries and obstetrical emergencies and provide surgical family planning methods;

c) An "alarm and transport" system to get pregnant women from the community to the referral facilities in time.

The implementation of each measure would of course depend on resource availability in particular cases.

4. These maternal health services would normally be built into government and NGO-sponsored programs of primary health care. (Programs outside the health sector and private health care also can help.) Their cost can be kept to less than $2 per capita per annum--compared to about $10 for primary health care as a whole in many countries. In the poorest countries, a start can be made with services costing less than $1 per capita. Many countries already have health facilities that could be upgraded to deal more effectively with maternal health. And many communities would willingly contribute time and resources to help preserve maternal health and family wellbeing. Private expenditures on health care in poorer countries demonstrate willingness to pay if the investment will produce results. Investments in "safe motherhood" are indeed productive. Thus, even though governments face stringent budget constraints, a safe motherhood initiative makes sense.

Rationale

5. The Bank is taking the lead in drawing the attention of countries and donors to this problem by organizing a Safe Motherhood Conference to launch an initiative to improve maternal health and family planning services. The follow-up will include substantial increases in Safe Motherhood efforts in Bank-financed projects, aimed at 20 projects with major components in five years. These projects would be based on the broad strategy outlined above and elaborated in the program strategy paper (attached). But operational research is needed to tailor this strategy to country circumstances and to answer more refined but crucial technical questions, such as:

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WHO, the World Bank, and other agencies all agree on the need for operational research and intend to support program initiatives which will provided sites for it.

Proposal

6. That the Bank join WHO and UNDP in catalyzing the creation of a Safe Motherhood Fund for supporting operational research projects to strengthen country programs. The Fund would provide funds and technical assistance to governments, NGOs and research institutions wishing to undertake Safe Motherhood operational research projects. Criteria for funding would

include commitment of the government concerned to act on the results of the study, feasibility and affordability of the proposed approach, and probability of major short-term impact, in addition to the merits of project design and competence of the researchers. This proposal is strongly backed by WHO, UNDP and other members of the conference planning committee.

Options for Organizational Arrangements

7. The Fund would be organized to reflect its international character clearly and to attract support from a number of multi-lateral and bilateral donors. WHO is the logical agency to execute the Fund and is enthusiastic about the prospect. It would work in partnership with the World Bank, UNFPA and other sponsoring agencies. It would utilize organizations with proven operational research expertise, e.g. the Population Council, London School of Hygiene and Tropical Medicine, Family Health International, and would seek advice from the World Bank, UNFPA and other sponsors and from appropriate technical groups, e.g. the Subcommittee on Maternal Mortality of FIGO (International Federation of Obstetricians and Gynecologists).

8. There are two promising organizational options under which WHO could operate as executing agency:

a) WHO program model, similar to the Diarrhoeal Diseases Control Programme; or
b) UNDP project model, with WHO as executing agency.

In either case, there would be no need to create any additional structure. The Fund would be executed by the Family Health Division of WHO with links to the Human Reproduction Programme to which the Bank will contribute support for contraceptive research. Both are under the same assistant director general, and good working relationships between the two already exist. Both work on safe motherhood, from the maternal health and family planning standpoints, respectively.

Resource Requirements

8. The Fund would support about 20 operational research projects in the first three years at a cost of $100,000 - $300,000 each. It should be given a minimum 6-year mandate to begin with and assured funds for the first three.

Proposed Budget for Three Years

20 research projects at $200,000 each	$ 4,000,000
Technical assistance, supervisory visits	$ 650,000
Administration	$ 350,000
	$ 5,000,000

Funding for six years would imply a budget of $10 million.

Bank Contribution

9. The Bank would provide $1 million, over the first three years, subject to contributions from other donors of $4 million. Thus the Bank's contribution would be 20 percent higher than the 12-15% for CGIAR and TDR. The higher proportion of Bank support is justified by the leadership role proposed (and taken so far in organizing the Safe Motherhood Initiative) and the lower resource requirements for the Fund. The Bank should contribute $500,000, $250,000, $250,000 in FY88, FY89 and FY90, respectively.

Expected Outcome

10. Strong consensus exists on the need for this operational research program. Very little operational research on this topic is being conducted. The research questions are well known, they can be tested with known methodologies, and competent and interested researchers exist in many developing countries. The main question, as with all research, is the extent to which the findings will be applied. Here the probabilities look promising, because many governments are anxious to improve maternal health and are seeking guidance regarding how best to do it. Moreover, real momentum is building in many countries to give higher priority to this neglected area. The same is true of donors, including the Bank, so that the Safe Motherhood initiative is generating unusual support and enthusiasm. The chances thus appear excellent that research findings will affect the major investments that are and will increasingly be made to reduce maternal deaths. Given the straightforward and practical nature of the operational research questions, lead time until operational pay off should be less than in many areas of population and health research. Three years' work will yield a good deal of urgently needed information.

11. Next Steps

i. Obtain management approval to explore further with developing countries, WHO and other donors.
ii. Secure donor pledges.
iii. Announce creation of the Fund in the Nairobi Conference Declaration.

BHerz/ARMeasham/rmf
11/26/86

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION
OFFICE MEMORANDUM

DATE: December 10, 1986

TO: Mr. Ernest Stern, Senior Vice President, Operations (through Mr. S. Shahid Husain, Vice President, Operations Policy)

FROM: John D. North, Director, PHND and Hans-Eberhard Köpp, Director, PPD

EXTENSION: 61571

SUBJECT: Proposal for a Safe Motherhood Fund for Operational Research

1. The more detailed proposal you requested for the Safe Motherhood Fund for Operational Research is attached. Please let us know if you would like to have additional information.

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Recommendation

It is recommended that the Bank take the lead in establishing a Safe Motherhood Fund under WHO, for operational research to support development of country programs and projects to reduce maternal mortality and morbidity. An initial Bank contribution of $1 million is recommended, representing 20% of the proposed three year budget of $5 million.

Background

1. Governments throughout the world have adopted the goal of "Health for All by the Year 2000". Many countries have made rapid strides toward that goal, particularly by improving child health. Yet maternal mortality and morbidity still threaten the health and well being of women, at the height of their productivity and family responsibility, in much of the developing world. In poorer countries, women often run 200 times more risk of dying in pregnancy than do women in developed countries. In fact, approximately 500,000 women in the developing world die each year from causes related to pregnancy. The result is not only tragedy for those women. At least that many infants and young children do not long survive their mothers. And for the women who survive, many millions suffer lasting ill health and disability.

2. This need not happen. Basic maternal health services, in conjunction with development programs to strengthen women's opportunities, can reduce the toll of maternal mortality and morbidity by half or more at affordable cost in many poorer countries within a decade. Some countries in Latin America (e.g. Costa Rica) and Asia (e.g. China, Sri Lanka) have succeeded in reducing maternal mortality very substantially in the past ten or twenty years at affordable cost, proving we have the means to do the job. The key is to make each pregnancy and childbirth safer and to encourage healthy spacing of pregnancies.

3. A three-pronged approach is required:

a) Better community-based health care (relying on non-physican health workers) to screen pregnant women, identify those at high risk, and refer them for help; to provide prenatal care and ensure safe delivery for women at less risk; and to provide family life education and family planning;

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c) An "alarm and transport" system to get pregnant women from the community to the referral facilities in time.

The implementation of each measure would of course depend on resource availability in particular cases.

4. These maternal health services would normally be built into government and NGO-sponsored programs of primary health care. (Programs outside the health sector and private health care also can help.) Their cost can be kept to less than $2 per capita per annum--compared to about $10 for primary health care as a whole in many countries. In the poorest countries, a start can be made with services costing less than $1 per capita. Many countries already have health facilities that could be upgraded to deal more effectively with maternal health. And many communities would willingly contribute time and resources to help preserve maternal health and family wellbeing. Private expenditures on health care in poorer countries demonstrate willingness to pay if the investment will produce results. Investments in "safe motherhood" are indeed productive. Thus, even though governments face stringent budget constraints, a safe motherhood initiative makes sense.

Rationale

5. The Bank is taking the lead in drawing the attention of countries and donors to this problem by organizing a Safe Motherhood Conference to launch an initiative to improve maternal health and family planning services. The follow-up will include substantial increases in Safe Motherhood efforts in Bank-financed projects, aimed at 20 projects with major components in five years. These projects would be based on the broad strategy outlined above and elaborated in the program strategy paper (attached). But operational research is needed to tailor this strategy to country circumstances and to answer more refined but crucial technical questions, such as:

a) How can pregnancy risk screening be made more efficient? i.e., how best to identify and refer in large scale programs, the 20% of pregnant women who will have 80% of the complications of childbirth? How to reduce numbers of false positives and false negatives? How to make risk screening cost-effective, affordable and sustainable?

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c) What difference (to families, the health system, the economy) does maternal morbidity make?

WHO, the World Bank, and other agencies all agree on the need for operational research and intend to support program initiatives which will provided sites for it.

Proposal

6. That the Bank join WHO and UNDP in catalyzing the creation of a Safe Motherhood Fund for supporting operational research projects to strengthen country programs. The Fund would provide funds and technical assistance to governments, NGOs and research institutions wishing to undertake Safe Motherhood operational research projects. Criteria for funding would

include commitment of the government concerned to act on the results of the study, feasibility and affordability of the proposed approach, and probability of major short-term impact, in addition to the merits of project design and competence of the researchers. This proposal is strongly backed by WHO, UNDP and other members of the conference planning committee.

Options for Organizational Arrangements

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8. There are two promising organizational options under which WHO could operate as executing agency:

a) WHO program model, similar to the Diarrhoeal Diseases Control Programme; or
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In either case, there would be no need to create any additional structure. The Fund would be executed by the Family Health Division of WHO with links to the Human Reproduction Programme to which the Bank will contribute support for contraceptive research. Both are under the same assistant director general, and good working relationships between the two already exist. Both work on safe motherhood, from the maternal health and family planning standpoints, respectively.

Resource Requirements

8. The Fund would support about 20 operational research projects in the first three years at a cost of $100,000 - $300,000 each. It should be given a minimum 6-year mandate to begin with and assured funds for the first three.

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Expected Outcome

10. Strong consensus exists on the need for this operational research program. Very little operational research on this topic is being conducted. The research questions are well known, they can be tested with known methodologies, and competent and interested researchers exist in many developing countries. The main question, as with all research, is the extent to which the findings will be applied. Here the probabilities look promising, because many governments are anxious to improve maternal health and are seeking guidance regarding how best to do it. Moreover, real momentum is building in many countries to give higher priority to this neglected area. The same is true of donors, including the Bank, so that the Safe Motherhood initiative is generating unusual support and enthusiasm. The chances thus appear excellent that research findings will affect the major investments that are and will increasingly be made to reduce maternal deaths. Given the straightforward and practical nature of the operational research questions, lead time until operational pay off should be less than in many areas of population and health research. Three years' work will yield a good deal of urgently needed information.

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BHerz/ARMeasham/rmf
11/26/86

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION
OFFICE MEMORANDUM

Dist circulation

DATE: December 19, 1986

TO: DISTRIBUTION

FROM: Stephen M. Denning, Acting Director, PHN

EXTENSION: 61670

SUBJECT: Safe Motherhood Fund for Operation Research

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Mesdames Birdsall, Herz, Husain, Sanyal

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THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION
OFFICE MEMORANDUM

DATE: December 10, 1986

TO: Mr. Ernest Stern, Senior Vice President, Operations (through Mr. S. Shahid Husain, Vice President, Operations Policy)

FROM: John D. North, Director, PHND and Hans-Eberhard Köpp, Director, PPD

EXTENSION: 61571

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Should emphasize support for local LDC researchers MKB

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Expected Outcome

10. Strong consensus exists on the need for this operational research program. Very little operational research on this topic is being conducted. The research questions are well known, they can be tested with known methodologies, and competent and interested researchers exist in many developing countries. The main question, as with all research, is the extent to which the findings will be applied. Here the probabilities look promising, because many governments are anxious to improve maternal health and are seeking guidance regarding how best to do it. Moreover, real momentum is building in many countries to give higher priority to this neglected area. The same is true of donors, including the Bank, so that the Safe Motherhood initiative is generating unusual support and enthusiasm. The chances thus appear excellent that research findings will affect the major investments that are and will increasingly be made to reduce maternal deaths. Given the straightforward and practical nature of the operational research questions, lead time until operational pay off should be less than in many areas of population and health research. Three years' work will yield a good deal of urgently needed information.

11. Next Steps

i. Obtain management approval to explore further with developing countries, WHO and other donors.
ii. Secure donor pledges.
iii. Announce creation of the Fund in the Nairobi Conference Declaration.

BHerz/ARMeasham/rmf
11/26/86

Measham

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

Date: February 17, 1987

To: Mr. Roberto Cuca, Acting Division Chief, PHND3

From: Oscar Echeverri, PHND3 OE

Extension: 61561

Subject: BRAZIL - Northeast Basic Health Services Project (Ln. 2699-BR)
Project Launch Workshop
- Northeast Endemic Disease Control Project (6BRAPA225)
Back-to-Office Report

Northeast Basic Health Services Project (NEBHS)

1. I participated in the Project Launch Seminar of the NEBHS Project between February 3 and 5, 1987. Other participants were Jacomina de Regt, project officer for the NEBHS Project and coordinator of the seminar; consultants R. Moraes Pinto, lawyer, and R. Barahona, Disbursement Officer; R. Satin, Project Launch Adviser; and guest speaker Dr. N. Ibañez, project manager of the Sao Paulo Health Project. The following institutions were represented in the seminar: CORSANE, Secretary of Planning, Secretary of Finances, and SUCAM, from Ministry of Health (MOH); PAHO; IPEA; and the Central Bank. From the four states involved in the project, only a representative from Bahia State was able to attend due mainly to transport difficulties.

2. The seminar was a success, not only in achieving its goals, but also in arising serious concerns in CORSANE's staff about its huge task and responsibility in implementing the project. Equally important was the impact on SUCAM's project preparation team (Brazil IV Project), who realized the need for strengthening SUCAM's management to ensure an efficient and effective project execution. Other details on the seminar outcomes are reported by J. de Regt in her B.T.O.

Northeast Endemic Disease Control Project Preparation

3. SUCAM response to recommendations made by the Bank Mission in December, 1986, has been very encouraging. The preparation team was formally appointed by the Superintendent of SUCAM, and has been working towards the completion of the proposal. With the assistance given by our consultant in the field (Dr. Boianovsky), I expect to have the project proposal completed by the end of February, thus allowing us to schedule the pre-appraisal mission for the second half of March. The two major concerns with the project remain the same: a) the reserved procurement for vehicles and data processing equipment; and b) the labor intensive character of the campaign activities in the project, which account for about one half of project costs represented in salaries. Up to now, the Government's position is that procurement of vehicles and data processing equipment would remain reserved. The mission made it clear to SUCAM's Superintendent that these

items would not be financed by the loan, but ought to be included in the project and financed by the Government. SUCAM will consult with SEPLAN about this issue and it will have a final response by the time the pre-appraisal mission is in the field. As far as the costs of labor to carry out the campaign activities of the project, it is less an issue than a matter for the Bank to agree with SUCAM on the financing of labor costs. The Bank's position should be cleared before the pre-appraisal mission departs for the field.

Other matters

Sao Paulo Health Project

4. I made a two-days follow-up visit to the Sao Paulo Health Project. I attended the ceremony of transferring the first hospital (400 beds) from INAMPS to the State Secretariat of Health, SES, as part of the administrative decentralization in the health sector. Agreements were signed by the Minister of Social Security and the President of INAMPS, with the Governor of Sao Paulo and the State Secretary of Health, including the mechanisms of financing and administration. The remaining four INAMPS hospitals located in Sao Paulo will be transferred to SES later this year.

5. I met with the new Municipal Secretary of Hygiene to emphasize the crucial role that the municipality of Sao Paulo will have this year in the implementation of the project. He committed himself to speed-up the signature of an agreement between the State and the Prefeitura to formalize its participation in implementing the project. The Mayor of the city has already cleared the draft agreement.

6. I reviewed the plan for implementing the research component, including eight research proposals. I agreed to go ahead with three proposals, after discussing with the researchers and the project manager the relevance, methodology and costs for each one. The other five proposals will be reviewed in Washington for a final decision on project financing.

7. According to different sources, the new State Secretary of Health will be Dr. Pinoti, a Gynecologist/Obstetrician supporter of family planning. The chances that Dr. Ibañez could be replaced as Project manager are small, but real. We should do every effort to retain him on the job.

8. Dr. Yunes (state Secretary of Health) is planning to come to Washington by the end of February to discuss with the Bank a proposal for the second phase of the project, thus advancing some agreements that would be taken over by the new administration commencing on March 15/87.

AIDS

9. I attended a Special Conference on AIDS with the participation of the Brazil Government, PAHO, CDC and WHO, with the purpose of discussing the National AIDS Program. The Government has prepared a Program including 5 components: 1) Clinical services, including AIDS testing for blood donors,

screening for AIDS in blood donated, and ambulatory and hospital care for AIDS patients; 2) epidemiological surveillance, including case finding and reporting of AIDS cases; 3) training of manpower, including all lab and clinical staff dealing with AIDS; 4) prevention, including a nation-wide educative campaign using TV, radio, press, and school teachers;and 5) research, including epidemiologic analysis, and lab tests development. In the opinion of CDC and WHO experts attending the Conference, the proposed Brazilian Program is one of the best in the world, particularly in the use of mass media. I brought a copy of the entire Program Report, whose total cost is CZ$120.0 million (about US$7.0 million), but the Government has allocated only CZ$45.0 for its implementation. I will write a separate summary report on this issue.

Other Initiatives

10. The serious threat that the vector of Dengue and Yellow Fever (Aedes Aegypti) is posing to a large segment of the Brazilian population, is obliging the Government to seek additional resources to finance the campaign against it. Both, the Minister of Health and the Superintendent of SUCAM requested the consideration by the Bank of a possible project loan for the control of Yellow Fever/Dengue, or the inclusion of a component for the same purpose within the Malaria control Project under preparation. A response should be sent to the Minister shortly.

11. A project involving the institutional strengthening of the MOH linked to the implementation of a National Program of Comprehensive Care for Women (safe motherhood approach)/Nutrition is being worked out by Dr. Salomon, (a Minister's close adviser). Preliminary data on population, maternal mortality, fertility trends, and contraceptive use point out towards the need for a program aiming at improving access to and quality of existing public services providing family planning, rather than expanding use of contraceptives. This topic would require more analysis before any definition on the scope and contents of the MOH proposal.

Distribution:

Mr. Gué, LC2DR; Mr. Gonzalez-Cofino, Mr. Klaus, Mr. Knight, LC2BR; Mr. Finzi, LCPDR; Mr. Ping Cheung Loh, WUDDR, Mr. Satin; Mr. Coirolo, Brazil Representative; Mr. Cucullu, Mr. Collell, LEGLC; Mr. Mayer, Mr. Barahona, LOALE; Mr. North, Mr. Hodgkinson, Dr. Measham, Mr. Berg, Dr. Sai, Dr. Liese, PHNDR; Ms. Birdsall, PHNPR; Mr. Schebeck, o/r, Ms. de Regt, Mr. Vassiliou, Mrs. Lister, Mr. de Geyndt, PHND3; Mr. Denning, PHND1; Ms. Husain, PHND2; LAC Information Center (2); Division Files

O/nendbto/oe

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

Date: December 17, 1986

To: Dr. Tony Measham, PHNDR

From: James P. Mullan, Deputy Chief, PHND1

Extension: 61176

Subject: Safe Motherhood Initiative

1. I refer to the memorandum of November 21, 1986 asking for information on FY81-86 projects and proposed FY87-91 projects having "safe motherhood" components, other than family planning. For ongoing projects I attach a table giving the information you requested. As we have discussed, there is a considerable degree of arbitrariness in many of the figures. Services to make pregnancy and childbirth safer are delivered jointly with a host of other services, both preventive and curative, and there is rarely available data that would enable precise estimation of the percentage of the total cost of health service delivery attributable to "safe motherhood" components. The general feeling in the division is that the percentages shown in the table are, if anything, on the conservative side, especially in Eastern and Southern Africa, where some project officers will argue that as much as 40% of project costs of improved service delivery is directed at mothers. Please note that we have considered only direct costs of service delivery and training; we have not attempted to attribute to "safe motherhood" any of the indirect costs of support services or management improvements financed under the project.

2. As you can see from the table, the overall situation is that all but two of the projects under implementation (Bangladesh III and Comoros being the exceptions) would qualify as having major components aimed at "safe motherhood", on your definition of 5% as the appropriate threshold.

3. In looking at future projects, we are hampered by the fact that few of the projects in the FY87-91 pipeline are sufficiently defined to enable quantification of the cost percentage likely to go to "safer motherhood". However, all of the projects which are well defined (Zimbabwe, Malawi II, Rwanda and Zambia) meet the 5% threshold (for Zimbabwe, the estimated percentage is 22%) and, on the basis of our past experience, I would expect that of the other 25 operations in our FY87-91 program (including reserve projects), only three (Sri Lanka Health and Population, India National Training and Bangladesh Population IV) would be unlikely to qualify as including a major "safe motherhood" component, with the "safe motherhood" element (excluding family planning) accounting for between 5% and 25% of total project costs in all other cases.

cc: Mr. Denning, Mrs. Maraviglia, PHND1
JPMullan:jdm

"Safe Motherhood" Elements of Ongoing PHND1 Projects

Project Name	"Safe Motherhood Elements"	% of Project Costs
South Asia		
India. Third Population Project (FY 84)	(i) 10% of training of staff such as traditional midwives, nurse midwives and supervisors;	3%
	(ii) 5% of construction costs of sub-centers and primary health centers used for family welfare service delivery	3%
		6%
India. Fourth Population Project (FY86)	(i) 10% of training costs (as for Third Project)	1%
	(ii) 5% of construction costs (as for Third Project)	4%
		5%
Bangladesh. Third Population and Family Health Project (FY86)	TBA training, immunization against maternal tetanus	<1%
Pakistan. Population Project (FY83)	(i) 10% of cost of training of clinic and population staff	1%
	(ii) 10% of construction cost of facilities	2%
	(iii) 5% of cost of IEC programs	2%
		5%

Project Name	"Safe Motherhood Element"	% of Project Costs
Eastern and Southern Africa		
Botswana. Family Health Project (FY84)	20% of costs of MCH/FP and urban health activities	10%
Comoros. Health and Population Project (FY84)	10% of costs of new and upgraded facilities	3%
Kenya. Integrated Rural Health and Family Planning Project (FY82)	(i) 20% of costs of rural health facilities, drugs, manpower and training	8%
	(ii) 20% of NGO medical activities	2%
		10%
Lesotho. Health and Population Project (FY85)	(i) 20% of costs of clinic construction and renovation, and MCH/FP service delivery	4%
	(ii) 10% of costs of staff training and IEC programs	4%
		8%
Malawi. Health Project (FY83	20% of costs of primary health care and child spacing components	10%
Rwanda. Family Health Project (FY86)	(i) 15% of cost of strengthening family health services	6%
	(ii) 50% of costs of nurse and nurse aide training	12%
		18%

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

DATE : December 5, 1986

TO : Mr. John North, Director, PHNDR

FROM : Ishrat Husain, Chief, PHND2

EXTENSION : 61535

SUBJECT : Projects including "Safe Motherhood" Element

In response to your memorandum of November 21, 1986, and request for information on the above subject, attached please find two charts containing these data for division II.

Attachments

/abf

Table I

Projects including "Safe Motherhood" Element

FY81-FY86

Country/Project Name	FY	Description	Cost
SIERRA LEONE: Health and Population Project	FY86	Promotion of PHC with specific attention to MCH care, training of traditional birth attendants, and community health aides, pre- & post-natal counselling and services, and nutrition/sanitation education.	16%
IVORY COAST: Health & Demography Project	FY86	Includes component to improve nurse training in preventive care including that for mothers and children.	25%
KOREA: Pop I (Sub-Loan Agreement)	(FY86) (Sub-Loan)	Principal objective of the expanded project is to improve MCH services through the establishment of hospital centers to reduce infant and maternal mortality rates.	100% (of sub-loan)
NIGERIA: Sokoto Health	FY85	One of the primary components includes the training of traditional birth attendants thereby improving maternal health care.	
INDONESIA: 2nd Nutrition and Comm. Health	FY86	The overall goal is to assist in reducing infant, child and maternal mortality and morbidity through support for nutrition institutions and surveillance and strengthening of government's village-based community health program. The latter program focusses on 5 key interventions including maternal health care.	10%
BURKINA FASO: Health Services Development	FY85	Promotion of PHC with attention to MCH care, in-service nurse and mid-wife training in MCH programs.	20%
NIGER: Health Project	FY86	Promotion of PHC with focus on MCH care, in-service training in MCH programs, village-level nutrition programs involving women and children, development of health education programs aimed at MCH care.	30%
SENEGAL: Rural Health Project	FY83	Strengthening of basic health service including MCH services (prenatal care, routine and complicated deliveries, postnatal care, child care) and nutrition education.	15%
MALI: Health Development Project	FY84	At the regional level, the project aims to strengthen the public health network in accordance with PHC objectives--two key elements being health education of mothers, and timely care in cases of complicated deliveries, pre- and postnatal problems.	15%

TOTAL: 9 Projects

Table 2

Projects likely to include "Safe Motherhood" Element

FY87-FY91

Country/Project Name	FY	COMPONENT	
		Major (over 5% of loan)	Minor (less than 5% of loan)
SIERRA LEONE: PHN II	FY91R	X	
GHANA: PHNII	FY89S	X	
NIGERIA: Imo Health & Pop	FY88	X	
NIGERIA: 3rd State Hlth & Pop	FY90	X	
NIGERIA: 4th State Hlth & Pop	FY90	X	
NIGERIA: Nat. Essential Drugs	FY91		X
GAMBIA: National Health Development	FY87	X	
PHILIPPINES: Population II	FY88	X	
SENEGAL: Population/Health II	FY90S	X	
MALI: Pop/Health II	FY89S	X	
GUINEA: Pop/Health	FY88S	X	
TOGO: Health	FY89		X
BENIN: Population/Health	FY89S		X
BURKINA: Population/Health II	FY90S	X	
NIGER: Population/Health II	FY90	X	
MAURITANIA: Population	FY89R		X

TOTAL: 16 Projects

SAFE MOTHERHOOD ELEMENTS IN PHND3 PROJECT

Project	LOAN	% of loan proceeds
Tunisia II (PH)	12.5	10
Brazil I	13	11
YAR I	10.5	15
Peru I	33.5	25
PDRY I	7.6	15
Brazil II	55.5	3
Brazil (H Policy Study)	2	u
Jordan I	13.5	35
Morocco I	25.4	5
Colombia I	36.5	2
Brazil III	59.5	10
FY87-91 Projects		
Oman 87	12	20
YAR (H) 88	8	u
Brazil endemic 88	75	u
Jamaica (P) 88	10	30
Panama (H) 88	25	u
YAR 89	50	u
Brazil NE 89	115	u
Brazil NW malaria 89	150	u
Ecuador (H) 89	10	10
Mexico 89	100	u
PDRY (H) II 89	5	u
Jordan (H) 90	20	u
Morocco (H) 90	50	u
Argentina (H) 90	150	5
Colombia 90	120	u
Dom. Rep. 90	30	u
Guatemala 90	10	u
Bolivia 91	u	u
Haiti 91	25	u
Ecuador 91	u	u

u=unknown

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THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION
OFFICE MEMORANDUM

DATE: December 10, 1986

TO: Mr. Ernest Stern, Senior Vice President, Operations (through Mr. S. Shahid Husain, Vice President, Operations Policy)

FROM: John D. North, Director, PHND and Hans-Eberhard Köpp, Director, PPD

EXTENSION: 61571

SUBJECT: Proposal for a Safe Motherhood Fund for Operational Research

1. The more detailed proposal you requested for the Safe Motherhood Fund for Operational Research is attached. Please let us know if you would like to have additional information.

Attachment: Proposal
Annex

BHerz/ARMeasham/rmf

Proposal for the Establishment of a Safe Motherhood Fund for Operational Research

Recommendation

It is recommended that the Bank take the lead in establishing a Safe Motherhood Fund under WHO, for operational research to support development of country programs and projects to reduce maternal mortality and morbidity. An initial Bank contribution of $1 million is recommended, representing 20% of the proposed three year budget of $5 million.

Background

1. Governments throughout the world have adopted the goal of "Health for All by the Year 2000". Many countries have made rapid strides toward that goal, particularly by improving child health. Yet maternal mortality and morbidity still threaten the health and well being of women, at the height of their productivity and family responsibility, in much of the developing world. In poorer countries, women often run 200 times more risk of dying in pregnancy than do women in developed countries. In fact, approximately 500,000 women in the developing world die each year from causes related to pregnancy. The result is not only tragedy for those women. At least that many infants and young children do not long survive their mothers. And for the women who survive, many millions suffer lasting ill health and disability.

2. This need not happen. Basic maternal health services, in conjunction with development programs to strengthen women's opportunities, can reduce the toll of maternal mortality and morbidity by half or more at affordable cost in many poorer countries within a decade. Some countries in Latin America (e.g. Costa Rica) and Asia (e.g. China, Sri Lanka) have succeeded in reducing maternal mortality very substantially in the past ten or twenty years at affordable cost, proving we have the means to do the job. The key is to make each pregnancy and childbirth safer and to encourage healthy spacing of pregnancies.

3. A three-pronged approach is required:

a) Better community-based health care (relying on non-physican health workers) to screen pregnant women, identify those at high risk, and refer them for help; to provide prenatal care and ensure safe delivery for women at less risk; and to provide family life education and family planning;

b) Adequate first referral level facilities--hospitals and health centers--to take care of complicated deliveries and obstetrical emergencies and provide surgical family planning methods;

c) An "alarm and transport" system to get pregnant women from the community to the referral facilities in time.

The implementation of each measure would of course depend on resource availability in particular cases.

4. These maternal health services would normally be built into government and NGO-sponsored programs of primary health care. (Programs outside the health sector and private health care also can help.) Their cost can be kept to less than $2 per capita per annum--compared to about $10 for primary health care as a whole in many countries. In the poorest countries, a start can be made with services costing less than $1 per capita. Many countries already have health facilities that could be upgraded to deal more effectively with maternal health. And many communities would willingly contribute time and resources to help preserve maternal health and family wellbeing. Private expenditures on health care in poorer countries demonstrate willingness to pay if the investment will produce results. Investments in "safe motherhood" are indeed productive. Thus, even though governments face stringent budget constraints, a safe motherhood initiative makes sense.

Rationale

5. The Bank is taking the lead in drawing the attention of countries and donors to this problem by organizing a Safe Motherhood Conference to launch an initiative to improve maternal health and family planning services. The follow-up will include substantial increases in Safe Motherhood efforts in Bank-financed projects, aimed at 20 projects with major components in five years. These projects would be based on the broad strategy outlined above and elaborated in the program strategy paper (attached). But operational research is needed to tailor this strategy to country circumstances and to answer more refined but crucial technical questions, such as:

a) How can pregnancy risk screening be made more efficient? i.e., how best to identify and refer in large scale programs, the 20% of pregnant women who will have 80% of the complications of childbirth? How to reduce numbers of false positives and false negatives? How to make risk screening cost-effective, affordable and sustainable?

b) What are the costs and impact of safe motherhood strategies, such as assuring availability of blood transfusions and caesarean section capability, family planning, maternity villages, etc. under varying country conditions?

c) What difference (to families, the health system, the economy) does maternal morbidity make?

WHO, the World Bank, and other agencies all agree on the need for operational research and intend to support program initiatives which will provided sites for it.

Proposal

6. That the Bank join WHO and UNDP in catalyzing the creation of a Safe Motherhood Fund for supporting operational research projects to strengthen country programs. The Fund would provide funds and technical assistance to governments, NGOs and research institutions wishing to undertake Safe Motherhood operational research projects. Criteria for funding would

include commitment of the government concerned to act on the results of the study, feasibility and affordability of the proposed approach, and probability of major short-term impact, in addition to the merits of project design and competence of the researchers. This proposal is strongly backed by WHO, UNDP and other members of the conference planning committee.

Options for Organizational Arrangements

7. The Fund would be organized to reflect its international character clearly and to attract support from a number of multi-lateral and bilateral donors. WHO is the logical agency to execute the Fund and is enthusiastic about the prospect. It would work in partnership with the World Bank, UNFPA and other sponsoring agencies. It would utilize organizations with proven operational research expertise, e.g. the Population Council, London School of Hygiene and Tropical Medicine, Family Health International, and would seek advice from the World Bank, UNFPA and other sponsors and from appropriate technical groups, e.g. the Subcommittee on Maternal Mortality of FIGO (International Federation of Obstetricians and Gynecologists).

8. There are two promising organizational options under which WHO could operate as executing agency:

a) WHO program model, similar to the Diarrhoeal Diseases Control Programme; or
b) UNDP project model, with WHO as executing agency.

In either case, there would be no need to create any additional structure. The Fund would be executed by the Family Health Division of WHO with links to the Human Reproduction Programme to which the Bank will contribute support for contraceptive research. Both are under the same assistant director general, and good working relationships between the two already exist. Both work on safe motherhood, from the maternal health and family planning standpoints, respectively.

Resource Requirements

8. The Fund would support about 20 operational research projects in the first three years at a cost of $100,000 - $300,000 each. It should be given a minimum 6-year mandate to begin with and assured funds for the first three.

Proposed Budget for Three Years

20 research projects at $200,000 each	$ 4,000,000
Technical assistance, supervisory visits	$ 650,000
Administration	$ 350,000
	$ 5,000,000

Funding for six years would imply a budget of $10 million.

Bank Contribution

9. The Bank would provide $1 million, over the first three years, subject to contributions from other donors of $4 million. Thus the Bank's contribution would be 20 percent higher than the 12-15% for CGIAR and TDR. The higher proportion of Bank support is justified by the leadership role proposed (and taken so far in organizing the Safe Motherhood Initiative) and the lower resource requirements for the Fund. The Bank should contribute $500,000, $250,000, $250,000 in FY88, FY89 and FY90, respectively.

Expected Outcome

10. Strong consensus exists on the need for this operational research program. Very little operational research on this topic is being conducted. The research questions are well known, they can be tested with known methodologies, and competent and interested researchers exist in many developing countries. The main question, as with all research, is the extent to which the findings will be applied. Here the probabilities look promising, because many governments are anxious to improve maternal health and are seeking guidance regarding how best to do it. Moreover, real momentum is building in many countries to give higher priority to this neglected area. The same is true of donors, including the Bank, so that the Safe Motherhood initiative is generating unusual support and enthusiasm. The chances thus appear excellent that research findings will affect the major investments that are and will increasingly be made to reduce maternal deaths. Given the straightforward and practical nature of the operational research questions, lead time until operational pay off should be less than in many areas of population and health research. Three years' work will yield a good deal of urgently needed information.

11. Next Steps

i. Obtain management approval to explore further with developing countries, WHO and other donors.
ii. Secure donor pledges.
iii. Announce creation of the Fund in the Nairobi Conference Declaration.

BHerz/ARMeasham/rmf
11/26/86

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION
OFFICE MEMORANDUM

DATE: December 19, 1986

TO: DISTRIBUTION

FROM: Stephen M. Denning, Acting Director, PHN

EXTENSION: 61670

SUBJECT: Safe Motherhood Fund for Operation Research

1. Attached is a proposal for a Safe Motherhood Fund for operational research to support development of country programs and projects to reduce maternal mortality and morbidity. Bank management has approved the proposal and is allocating $500,000 for this purpose in the Special Programs category of the FY88 budget.

2. Your comments on this proposal are solicited, both on the substance and on possible organizational arrangements. Comments received by January 16, 1987 would be especially helpful. Please direct them to Tony Measham, Room N440.

DISTRIBUTION:

Messrs. North o/r, Hodgkinson, Berg, Liese, Measham, Sai, Schebeck
Mesdames Birdsall, Herz, Husain, Sanyal

ARMeasham/tc

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION
OFFICE MEMORANDUM

DATE: December 10, 1986

TO: Mr. Ernest Stern, Senior Vice President, Operations (through Mr. S. Shahid Husain, Vice President, Operations Policy)

FROM: John D. North, Director, PHND and Hans-Eberhard Köpp, Director, PPD

EXTENSION: 61571

SUBJECT: Proposal for a Safe Motherhood Fund for Operational Research

1. The more detailed proposal you requested for the Safe Motherhood Fund for Operational Research is attached. Please let us know if you would like to have additional information.

Attachment: Proposal
Annex

BHerz/ARMeasham/rmf

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Recommendation

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Background

1. Governments throughout the world have adopted the goal of "Health for All by the Year 2000". Many countries have made rapid strides toward that goal, particularly by improving child health. Yet maternal mortality and morbidity still threaten the health and well being of women, at the height of their productivity and family responsibility, in much of the developing world. In poorer countries, women often run 200 times more risk of dying in pregnancy than do women in developed countries. In fact, approximately 500,000 women in the developing world die each year from causes related to pregnancy. The result is not only tragedy for those women. At least that many infants and young children do not long survive their mothers. And for the women who survive, many millions suffer lasting ill health and disability.

2. This need not happen. Basic maternal health services, in conjunction with development programs to strengthen women's opportunities, can reduce the toll of maternal mortality and morbidity by half or more at affordable cost in many poorer countries within a decade. Some countries in Latin America (e.g. Costa Rica) and Asia (e.g. China, Sri Lanka) have succeeded in reducing maternal mortality very substantially in the past ten or twenty years at affordable cost, proving we have the means to do the job. The key is to make each pregnancy and childbirth safer and to encourage healthy spacing of pregnancies.

3. A three-pronged approach is required:

a) Better community-based health care (relying on non-physican health workers) to screen pregnant women, identify those at high risk, and refer them for help; to provide prenatal care and ensure safe delivery for women at less risk; and to provide family life education and family planning;

b) Adequate first referral level facilities--hospitals and health centers--to take care of complicated deliveries and obstetrical emergencies and provide surgical family planning methods;

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The implementation of each measure would of course depend on resource availability in particular cases.

4. These maternal health services would normally be built into government and NGO-sponsored programs of primary health care. (Programs outside the health sector and private health care also can help.) Their cost can be kept to less than $2 per capita per annum--compared to about $10 for primary health care as a whole in many countries. In the poorest countries, a start can be made with services costing less than $1 per capita. Many countries already have health facilities that could be upgraded to deal more effectively with maternal health. And many communities would willingly contribute time and resources to help preserve maternal health and family wellbeing. Private expenditures on health care in poorer countries demonstrate willingness to pay if the investment will produce results. Investments in "safe motherhood" are indeed productive. Thus, even though governments face stringent budget constraints, a safe motherhood initiative makes sense.

Rationale

5. The Bank is taking the lead in drawing the attention of countries and donors to this problem by organizing a Safe Motherhood Conference to launch an initiative to improve maternal health and family planning services. The follow-up will include substantial increases in Safe Motherhood efforts in Bank-financed projects, aimed at 20 projects with major components in five years. These projects would be based on the broad strategy outlined above and elaborated in the program strategy paper (attached). But operational research is needed to tailor this strategy to country circumstances and to answer more refined but crucial technical questions, such as:

a) How can pregnancy risk screening be made more efficient? i.e., how best to identify and refer in large scale programs, the 20% of pregnant women who will have 80% of the complications of childbirth? How to reduce numbers of false positives and false negatives? How to make risk screening cost-effective, affordable and sustainable?

b) What are the costs and impact of safe motherhood strategies, such as assuring availability of blood transfusions and caesarean section capability, family planning, maternity villages, etc. under varying country conditions?

c) What difference (to families, the health system, the economy) does maternal morbidity make?

WHO, the World Bank, and other agencies all agree on the need for operational research and intend to support program initiatives which will provided sites for it.

Proposal

6. That the Bank join WHO and UNDP in catalyzing the creation of a Safe Motherhood Fund for supporting operational research projects to strengthen country programs. The Fund would provide funds and technical assistance to governments, NGOs and research institutions wishing to undertake Safe Motherhood operational research projects. Criteria for funding would

include commitment of the government concerned to act on the results of the study, feasibility and affordability of the proposed approach, and probability of major short-term impact, in addition to the merits of project design and competence of the researchers. This proposal is strongly backed by WHO, UNDP and other members of the conference planning committee.

Options for Organizational Arrangements

7. The Fund would be organized to reflect its international character clearly and to attract support from a number of multi-lateral and bilateral donors. WHO is the logical agency to execute the Fund and is enthusiastic about the prospect. It would work in partnership with the World Bank, UNFPA and other sponsoring agencies. It would utilize organizations with proven operational research expertise, e.g. the Population Council, London School of Hygiene and Tropical Medicine, Family Health International, and would seek advice from the World Bank, UNFPA and other sponsors and from appropriate technical groups, e.g. the Subcommittee on Maternal Mortality of FIGO (International Federation of Obstetricians and Gynecologists).

8. There are two promising organizational options under which WHO could operate as executing agency:

a) WHO program model, similar to the Diarrhoeal Diseases Control Programme; or
b) UNDP project model, with WHO as executing agency.

In either case, there would be no need to create any additional structure. The Fund would be executed by the Family Health Division of WHO with links to the Human Reproduction Programme to which the Bank will contribute support for contraceptive research. Both are under the same assistant director general, and good working relationships between the two already exist. Both work on safe motherhood, from the maternal health and family planning standpoints, respectively.

Resource Requirements

8. The Fund would support about 20 operational research projects in the first three years at a cost of $100,000 - $300,000 each. It should be given a minimum 6-year mandate to begin with and assured funds for the first three.

Proposed Budget for Three Years

20 research projects at $200,000 each	$ 4,000,000
Technical assistance, supervisory visits	$ 650,000
Administration	$ 350,000
	$ 5,000,000

Funding for six years would imply a budget of $10 million.

Bank Contribution

9. The Bank would provide $1 million, over the first three years, subject to contributions from other donors of $4 million. Thus the Bank's contribution would be 20 percent higher than the 12-15% for CGIAR and TDR. The higher proportion of Bank support is justified by the leadership role proposed (and taken so far in organizing the Safe Motherhood Initiative) and the lower resource requirements for the Fund. The Bank should contribute $500,000, $250,000, $250,000 in FY88, FY89 and FY90, respectively.

Expected Outcome

10. Strong consensus exists on the need for this operational research program. Very little operational research on this topic is being conducted. The research questions are well known, they can be tested with known methodologies, and competent and interested researchers exist in many developing countries. The main question, as with all research, is the extent to which the findings will be applied. Here the probabilities look promising, because many governments are anxious to improve maternal health and are seeking guidance regarding how best to do it. Moreover, real momentum is building in many countries to give higher priority to this neglected area. The same is true of donors, including the Bank, so that the Safe Motherhood initiative is generating unusual support and enthusiasm. The chances thus appear excellent that research findings will affect the major investments that are and will increasingly be made to reduce maternal deaths. Given the straightforward and practical nature of the operational research questions, lead time until operational pay off should be less than in many areas of population and health research. Three years' work will yield a good deal of urgently needed information.

11. Next Steps

i. Obtain management approval to explore further with developing countries, WHO and other donors.
ii. Secure donor pledges.
iii. Announce creation of the Fund in the Nairobi Conference Declaration.

BHerz/ARMeasham/rmf
11/26/86

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION
OFFICE MEMORANDUM

DATE: December 10, 1986

TO: Mr. Ernest Stern, Senior Vice President, Operations (through Mr. S. Shahid Husain, Vice President, Operations Policy)

FROM: John D. North, Director, PHND and Hans-Eberhard Köpp, Director, PPD

EXTENSION: 61571

SUBJECT: Proposal for a Safe Motherhood Fund for Operational Research

1. The more detailed proposal you requested for the Safe Motherhood Fund for Operational Research is attached. Please let us know if you would like to have additional information.

Attachment: Proposal
Annex

BHerz/ARMeasham/rmf

Proposal for the Establishment of a Safe Motherhood Fund for Operational Research

Recommendation

It is recommended that the Bank take the lead in establishing a Safe Motherhood Fund under WHO, for operational research to support development of country programs and projects to reduce maternal mortality and morbidity. An initial Bank contribution of $1 million is recommended, representing 20% of the proposed three year budget of $5 million.

Background

1. Governments throughout the world have adopted the goal of "Health for All by the Year 2000". Many countries have made rapid strides toward that goal, particularly by improving child health. Yet maternal mortality and morbidity still threaten the health and well being of women, at the height of their productivity and family responsibility, in much of the developing world. In poorer countries, women often run 200 times more risk of dying in pregnancy than do women in developed countries. In fact, approximately 500,000 women in the developing world die each year from causes related to pregnancy. The result is not only tragedy for those women. At least that many infants and young children do not long survive their mothers. And for the women who survive, many millions suffer lasting ill health and disability.

2. This need not happen. Basic maternal health services, in conjunction with development programs to strengthen women's opportunities, can reduce the toll of maternal mortality and morbidity by half or more at affordable cost in many poorer countries within a decade. Some countries in Latin America (e.g. Costa Rica) and Asia (e.g. China, Sri Lanka) have succeeded in reducing maternal mortality very substantially in the past ten or twenty years at affordable cost, proving we have the means to do the job. The key is to make each pregnancy and childbirth safer and to encourage healthy spacing of pregnancies.

3. A three-pronged approach is required:

a) Better community-based health care (relying on non-physican health workers) to screen pregnant women, identify those at high risk, and refer them for help; to provide prenatal care and ensure safe delivery for women at less risk; and to provide family life education and family planning;

b) Adequate first referral level facilities--hospitals and health centers--to take care of complicated deliveries and obstetrical emergencies and provide surgical family planning methods;

c) An "alarm and transport" system to get pregnant women from the community to the referral facilities in time.

The implementation of each measure would of course depend on resource availability in particular cases.

4. These maternal health services would normally be built into government and NGO-sponsored programs of primary health care. (Programs outside the health sector and private health care also can help.) Their cost can be kept to less than $2 per capita per annum--compared to about $10 for primary health care as a whole in many countries. In the poorest countries, a start can be made with services costing less than $1 per capita. Many countries already have health facilities that could be upgraded to deal more effectively with maternal health. And many communities would willingly contribute time and resources to help preserve maternal health and family wellbeing. Private expenditures on health care in poorer countries demonstrate willingness to pay if the investment will produce results. Investments in "safe motherhood" are indeed productive. Thus, even though governments face stringent budget constraints, a safe motherhood initiative makes sense.

Rationale

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BHerz/ARMeasham/rmf
11/26/86

SMFUND

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