SAFE MOTHERHOOD IN FRANCOPHONE AFRICA

Patricia Daly
Michael Azebê
Boniface Nasah
Safe Motherhood in Francophone Africa:
Some Improvement But Not Enough

by

Patricia Daly
Michael Azefor
Boniface Nasah
Abstract

Women of Sub-Saharan Africa face the highest risk of maternal mortality and morbidity of any region in the world. At least 150,000 African women will die of pregnancy-related complications every year in Africa, and the number of maternal deaths continues to rise each year in many countries. The population of women of child-bearing age is now larger than it was in 1989, and the number of women who die each year from pregnancy-related causes has increased even though there may have been a slight decline in the risks of pregnancy.

In 1989 representatives from the Governments of the French-speaking countries of Sub-Saharan Africa and international organizations participated in the Niamey Conference on Safe Motherhood and made a commitment to decrease maternal mortality by 50 percent by the end of the century. The result of the Niamey Conference was the "Appel de Niamey" -- a solemn call for Governments to make the reduction of maternal mortality a multi-sectoral national priority, develop action plans to implement safe motherhood programs, establish national committees on safe motherhood, and undertake a total mobilization of efforts in each country to reduce maternal mortality by 50 percent by the year 2000.

Since that time the Bank has maintained contact with the African technical experts who played a major role in the work of the Niamey Conference and has used them to review safe motherhood activities in the region. This paper reflects their recommendations for strengthening safe motherhood programs. Programs succeed best when there is substantial political commitment and policies which support an integrated package of services, including community-based family planning, health and nutrition services and appropriate allocation of resources. The report calls for the participation of every country, and within each country, the many government sectors, NGOs, community and women's groups, and health care providers. While there has been some progress in the countries of French-speaking Africa, the challenge remains to get safe motherhood programs rapidly in place at the country level.
I. INTRODUCTION

In 1989 representatives from the Governments of the French-speaking countries of Sub-Saharan Africa and international organizations participated in the Niamey Conference on Safe Motherhood and made a commitment to decrease maternal mortality by 50 percent by the end of the century. At this meeting, Mr. Edward Jaycox, Regional Vice President of the World Bank, called upon the participants to educate African leaders and the public about the unacceptably high levels of maternal mortality and morbidity in Sub-Saharan Africa. The result of the Niamey Conference was the "Appel de Niamey" -- a solemn call for Governments to make the reduction of maternal mortality a multi-sectoral national priority, develop action plans to implement safe motherhood programs, establish national committees on safe motherhood and undertake a total mobilization of efforts in each country to reduce maternal mortality by 50 percent by the year 2000. Several initiatives have been started in many countries and some progress has been made in reducing the current unacceptably high levels of maternal mortality and morbidity.

The pace of progress is uneven among and within the countries of Sub-Saharan Africa. The problems are immense:

◇ Women of Sub-Saharan Africa face the highest risk of maternal mortality and morbidity of any region of the world. Of all human development indicators, maternal mortality rates represent the greatest disparity between industrialized and Sub-Saharan Africa countries. At least 42,000 women in French-speaking countries of Sub-Saharan Africa will die of pregnancy-related complications this year. For every woman that dies, at least 15 others who survive will suffer chronic illness or physical impairment that will remain with them for the rest of their lives.

◇ Women form the backbone of African economies. They produce most of the food necessary for a household, cook for the family, fetch water, clean the house and care for the children, the sick and the elderly at home. The death of a woman results in both economic and social hardship for the family and community. At least 7 million pregnancies worldwide result in stillbirths or infant deaths as a result of maternal illness. Among infants who survive the death of the mother, fewer than 10 percent live beyond their first birthday (Koenig and others 1988; Chen and others 1974).

◇ HIV infection poses a further threat to health in Africa. Studies on HIV infection suggest that as many as 3.5 million women are already infected. Women between the ages of 15 and 35 years are most vulnerable. Data from Rwanda show that the younger the age of first pregnancy or first sexual intercourse the higher the incidence of HIV infection: over 25 percent of young women pregnant at age 17 or younger are infected and about 17 percent of those who initiate sexual intercourse before age 17 are infected (Chao 1991). In a study in Bujumbura, Burundi 24 percent of the women between age 24 and 34 years are HIV positive. Studies in Abidjan, Côte d'Ivoire indicate that among pregnant women with sexually transmitted diseases (STDs), HIV infection rates range from 11.6 percent to 17.8 percent (unpublished data).

◇ Adolescent pregnancy is an exploding problem in Sub-Saharan Africa. Young women under age 20 in Africa are more likely to have a child than those in other regions. For example, by age 18 more than 40 percent of the women in Côte d'Ivoire, Mali and Senegal have given birth already (Senderwitz 1993; Population Reference Bureau 1992). In Mali, 1 in 5 adolescent women will have a birth in a given year. Most of the births to teenagers are first births and women having their first child carry higher risk of serious medical complications. Babies who are first births face a higher infant mortality rate than higher order births and this risk is even
greater for teenage mothers. Adolescent childbearing imposes a heavy burden on each country's health care system as these young mothers also need antenatal, maternal and child health services.

* A large proportion of pregnancies, both within and outside a marital union, are unintended. The collapse of traditional socialization systems has led to an alarming increase in the number of women resorting to induced abortions to deal with unwanted pregnancies. Studies in Sub-Saharan African countries found that adolescents represented between 39-72 percent of all women presenting with abortion-related complications (Center for Population Options 1992). They are not alone in seeking abortions: women in all phases of their reproductive life-cycle experience unwanted pregnancies and seek abortions (Senderwitz 1993).

**What Is Safe Motherhood?**

Efforts to reduce maternal mortality and morbidity levels are a top priority, not only because of the scale of preventable suffering, but also because prenatal care and delivery services are among the most cost-effective interventions available to governments to improve adult and child health, according to the *World Development Report 1993: Investing in Health*.

Safe motherhood is achieved through a concerted set of interventions designed to reduce maternal mortality and morbidity and to improve the reproductive health status of women. This goal is formally set forth in the Safe Motherhood Initiative, which the Bank co-sponsored with other international agencies in an effort to achieve a worldwide 50 percent reduction of 1987 maternal mortality levels by year 2000. Healthy mothers result in fewer infant and child deaths, improved infant and child health and nutrition status, and usually generate higher incomes for the family and, subsequently, higher productivity in the community.

Safe Motherhood is achieved through a program of inter-linked steps which strive to provide: family planning services to prevent unwanted pregnancies; safe abortions, where legal, and efficient management and treatment of complications of unsafe abortions; prenatal and delivery care at the community level with quick access to first-referral services for complications; and postpartum care, including family planning services, promotion of breastfeeding, immunization and nutrition services. Safe motherhood services must be integrated into the health delivery system and the necessary inputs -- drugs, equipment, facilities, and properly trained staff -- supplied.

The root causes of a woman's death begin before her birth, are perpetuated during childhood and adolescence and continue later in life. Experience in both industrialized and developing countries has shown that safe motherhood is inextricably linked to the social, cultural and economic environment in which women live. Therefore, while strengthening medical services is the core strategy, safe motherhood efforts should also promote a comprehensive approach which includes education and income-generating opportunities for women.
Maternal mortality and morbidity can be reduced through improved access to family planning, appropriate delivery practices by trained birth attendants, and appropriate strategies to reduce the incidence of unsafe abortion. No matter how effective the community-based maternity care, some women will die from complications if not delivered or treated in a referral center. This requires efficient interaction between the community-based health post, the local health center, and the district hospitals.

**What Have We Learned?**

Experience demonstrates that community-based approaches, including family planning and training and deployment of nurses and midwives, have helped reduce maternal mortality in high-mortality settings. Community and facility-based services need to be linked and supported by training, effective logistic and supply management. An information, education and communications strategy is essential to promote awareness of the problems and effect behavior change of women, their families and health providers.

In Africa, over 60 percent of women deliver with a family member, a traditional birth attendant, or even by themselves. In Rwanda, only 18 percent of all deliveries are attended by trained personnel. Although traditional birth attendants (TBAs) still have an important role during childbirth in Africa, studies have evaluated their contribution to reducing maternal morbidity and mortality have shown variable results: in Benin and Eastern Nigeria, trained traditional birth attendants with back-up support from health personnel have contributed to a reduction in maternal mortality, while in the Gambia trained traditional birth attendants without skilled back-up support did not decrease maternal mortality (Greenwood 1991).

In resource-poor countries, expanding family planning services and cost-effective prenatal interventions, training midwives, and strengthening obstetrical services at district hospitals will be a priority. A woman's survival and well-being depends primarily on early detection of actual complications or disease and appropriate management of care. This requires trained health providers with midwifery skills in the community; TBAs trained to use appropriate and safe delivery practices and to recognize women with demonstrated risk factors or danger signs and refer them for obstetric care; and an informed community.

Safe motherhood also requires strong national and local political support. From the onset, policy-makers and decision-makers must demonstrate strong political commitment and encourage opinion leaders and potential program beneficiaries, both women and men, to focus constantly on efforts to improve safe motherhood.

Upgrading the quality and coverage of safe motherhood services will have the largest payoffs in averting deaths and reducing disability in women and children. According to the *World Development Report* 1993, prenatal care and delivery services are among the most cost-effective interventions available to governments to improve adult and child health. The costs for a substantial reduction in maternal morbidity and mortality are approximately the equivalent of $2 per capita per year, with half of that for maternal health and half for family planning (Tinker and others, 1993). The costs of not providing safe motherhood services will be a continued drain on the public health budget. The introduction of appropriate technology could reduce these costs sharply. For example, in Kenyatta National Hospital, Nairobi, substantial health care resources were being used to manage...
incomplete abortions. After introduction of the manual vacuum aspiration technique, clients and providers benefitted from shorter hospital stays and costs have been reduced from 23 to 66 percent.

II. SAFE MOTHERHOOD IN FRANCOPHONE AFRICA

The Regional Resource Group of Experts on Safe Motherhood

After the 1989 Niamey Safe Motherhood Conference, the Bank and other donors foresaw the need to coordinate safe motherhood efforts and to monitor progress towards attaining these safe motherhood goals. In this spirit, the Bank has maintained contact with the African technical experts who played a major role in the work of the Niamey Conference and has used them as a consultative group to review safe motherhood activities in the countries of the Region. This group represents specialists from various countries who have pioneered safe motherhood in francophone Africa since before 1987. In doing so, they have gained experience that is valuable to programs in the region. Composed of experts from francophone Africa, this group met for the second time in Bujumbura, Burundi in April 1993 to review the status of maternal health and family planning programs currently being implemented in francophone countries of the Region.

The objectives of this meeting were: to review the progress to date in implementing the recommendations of the Niamey Safe Motherhood Conference, particularly in Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Côte D’Ivoire, Madagascar, Mali, Niger, Rwanda, Senegal and Zaire; to identify the constraints and barriers to strengthening and expanding family planning services and prenatal, delivery and postpartum care; and, to identify priority measures and reforms in each country that will contribute to strengthening safe motherhood programs.

Principles of Safe Motherhood

♦ Safe Motherhood strategies should be integral parts of the national health policy and should depend on demonstrated leadership and commitment.

The policies and strategies for improving women’s health were framed by a set of guiding principles. According to World Bank participants, Michael Azefor, Senior Population and Health Specialist, AFIPH, and Patricia Daly, Public Health Consultant, PHN, the core concern in the development and implementation of a safe motherhood program is that it be an integral part of a country’s primary health care and overall public and private health system. They stressed the role policymakers and planners must play in building commitment at the national level and in mobilizing decision-makers, opinion leaders, and potential program beneficiaries, both women and men, to make programs succeed. Safe motherhood also requires local flexibility in planning combined with demonstrated national and local political support. Where this valued constituency is in place, such as in Senegal, safe motherhood is a priority program.

♦ Investments in needs assessment and research are important to building consensus and effective delivery systems.

Successful strategies to achieve safe motherhood depend on demonstrated leadership and political commitment at the national level. Achieving national consensus on approaches to safe motherhood requires a better understanding of the demographic, epidemiological and socio-cultural situation with respect to women’s health. Governments should conduct research on practices related to family
planning, adolescent sexual activity, abortion, childbearing practices and newborn care. Women and specific vulnerable groups, such as adolescents, unmarried women, women in urban slums, refugees, etc., need to be asked about their needs and this information needs to be used to adapt programs to these special needs.

◇ Health education and communication strategies are needed to strengthen public involvement in safe motherhood.

This qualitative and quantitative research can be used to convince policymakers of the importance of safe motherhood and to persuade governments to allocate resources for these programs. A constituency to support safe motherhood can then be built through discussions with government officials, legislators, women's associations, local interest groups, professional health associations and community groups. Organizational processes can be modified to establish safe motherhood committees at the national and local levels composed of these groups. These groups can then persuade government officials to translate their commitment to national and local budgetary support for programs and to generate community interest and demand for safe motherhood services.

◇ Program quality requires training, supervision and logistical support systems.

During the planning and implementation of safe motherhood programs, it is important to recognize that the components of the safe motherhood system are inter-related. Program strategies need to ensure that the health care system has the capacity to provide maternity care services and that health staff are appropriately trained and supported to provide these services. Quality of care must be improved at both the community as well as the first-referral level if there is to be a substantial reduction in maternal mortality. The development of one component without the simultaneous development -- or carefully designed phasing -- of related components could increase costs and diminish effectiveness. Services must be based on established norms and procedures and must be acceptable and perceived to be important by the client. For example, standard treatment practices, such as the partogram that has been shown to be effective in preventing prolonged labor, in reducing operative intervention, and in improving neonatal outcome should be used. Support systems to guarantee timely and periodic supervision as well as adequate supplies of medicine and equipment are essential. For example, ensuring the collection and availability of safe, reliable blood for transfusion poses particular problems at health care facilities in many parts of Africa, where blood and blood products need to be refrigerated or frozen until needed. "Walking blood banks" may enhance availability. These are individuals in the community who are identified as blood donors, ready to donate directly to a patient in need -- with the blood "stored" at body temperature in the donor until the moment of need. This intervention does not automatically overcome the risks of infection, which still need to be addressed. The responsibilities of each level of care have to be clearly defined, staff appropriately trained, and norms, skills and procedures for the maintenance of buildings, equipment, and vehicles established and carefully monitored.

◇ Monitoring and evaluation must provide input for program decision-makers.

The effectiveness of inputs to safe motherhood can also be better monitored by policymakers and health providers. Where possible, gender-based data should be gathered. Governments and donors need to invest in the local research capacity of individuals and institutions and be willing to provide support to those institutions in their developmental stage. In addition, analysis of health outcomes from the perspective of the health provider and the household should be a priority of
African governments. The effective use of service statistics and research data should be emphasized at the district and facility level, particularly by those directly responsible for clinical and management decisions. Reporting should be limited to data which are routinely needed by decision-makers to assess the approach and effectiveness of program delivery and to monitor programs.

Decentralization can improve the efficiency and responsiveness of safe motherhood services.

In Africa, political upheavals have had negative impact on the health care system, in general, and on services to mothers and children, in particular. In countries where there have been stronger initiatives in effective decentralization, the negative impact of such upheavals are reduced as local authorities take initiatives to ensure a minimum level of care. Increasing interest in decentralization among most governments is encouraging for safe motherhood. However, each country should recognize that a satisfactory level of investment, training and organization of decentralized units are prerequisites for success. Decentralization should also involve the sharing of budget planning and execution powers between the center and decentralized units. Though government decentralization and devolution can increase efficiency where there is adequate capacity and accountability at the district level, these actions can result in problems if taken too hastily. In some countries, such as Zaire and Madagascar, the pathway to better health may involve a rethinking and planning of the health care system. In other countries, such as Benin, Côte d'Ivoire, and Senegal, the path is likely to be one of building on the experiences to date and strengthening family planning and maternity care services within the overall health care system.

African governments and donors must work together to build local capacity to manage the health sector.

In Africa, aid contributes an average of 15 percent of national health spending (World Bank 1993). In most of the francophone African countries, however, external assistance accounts for all investments in the health sector. All too often, donor assistance drives the development program of a country and in many instances does not reflect the priorities of the country nor the capacity of a government to sustain these programs. Many donors have responded to this low capacity to sustain programs by sharply increasing technical assistance personnel who substitute for weak health ministries and have paid inadequate attention to the local capacity to plan or manage the program.

African policymakers need to develop their own national health policies and strategies to direct donor assistance and examine opportunities for collaboration in program development and co-financing of safe motherhood activities. While African policymakers need to take the lead in preparing health strategies, donor agencies need to seek greater beneficiary input in setting their priorities and allocating funding. Countries that show a willingness to plan and manage health and population sector programs and to improve access to health services for women should be candidates for aid.

Empowering women is essential to improving their health and that of their families.

Finally, African governments need to foster an enabling environment for women. In many parts of Africa, women perform an estimated 60-80 percent of all agricultural labor and female-headed households are becoming increasingly more common. Studies have shown that increasing female education and literacy positively impacts children's chances of surviving. The central role played by women in food preparation, nutrition, household tasks, home finances, and fertility choice has
a powerful influence on the health of household members. Removing gender discrimination can boost women's earnings and financial security. In addition, women need to be healthy themselves so as to fulfill their roles as mothers and household managers.

**Building Local and Regional Capacity for Safe Motherhood**

**Local and Regional Research Capacity:** Boniface Nasah, M.D., Director of the Regional Centre for Training and Research in Family Health in Rwanda, underlined the important role of African research institutions in research and training for programs to reduce maternal morbidity and mortality as well as the promotion of women's health. Previous workshops at the Regional Training Center in Kigali identified the need for countries to determine their research priorities in health and family planning, including the importance of socio-cultural and formative research in these areas. Several countries, including Côte d'Ivoire, Cameroon, Rwanda and Burkina Faso, have already held national workshops defining their national priorities for family planning and maternal health. Dr. Nasah stated that donor support to African research institutions could strengthen the capacity of these institutions to conduct their own training and research programs. Support of regional institutions may be the most effective way to build local or regional capacity for safe motherhood research and program management. This institutional development strategy is strongly endorsed by the World Bank. Mr. Edward Jaycox, World Bank Regional Vice President for Africa, recently called for greater effort to build local capacity and reduce Africa's dependence on "expatriate technical-assistance managed" programs. African institutions must be strengthened and used for training and retraining policymakers and providers in the health sector and managers and donor agencies need to be flexible in supporting these research institutions in their early stages of development.

**Greater Use of Professional Associations:** Another important priority area is to strengthen the collaboration with health professional associations and to elicit their participation in safe motherhood through training, research, and improvements in the quality of services. Professional associations, in particular the African Society of Gynecology and Obstetrics and the national midwifery associations, can undertake a variety of activities either with their own financial resources or through raising support from international associations. The professional associations need to be full partners in the development of safe motherhood policies and strategies and in developing quality assurance tools and training programs. Gaining their support and participation in the development, monitoring, and evaluation of safe motherhood programs can influence health policies and strategies and the effectiveness of these programs.

**Strengthen Regional Information Dissemination:** Better health requires that African policymakers determine health sector priorities and seek ways to use resources more effectively. Equally important is for developing countries to play a larger role in establishing international priorities. In order to do this, developing countries need to strengthen their resource base. Dr. Sambe Duale, Research Manager of the Project to Support Analysis and Research in Africa (SARA), described this USAID-financed project which aims to increase the utilization of research analysis and information dissemination in support of improved health, nutrition, education and family planning policies, strategies and programs in Sub-Saharan Africa. Dr. Duale described several ways this regional approach can promote research: (i) cross-country, cross-sectoral, and comparative analyses on important issues; (ii) economies of scale in analyzing issues common to many African countries; (iii) translation of research findings into policy and program recommendation and guidelines for African leaders and other decision makers; and (iv) innovative dissemination of information, including analytical tools to help decision-makers understand the policy and program implications.
of data. The program will develop links with African research institutions to strengthen the capacity of these institutions and to ensure African participation in both the research and dissemination of results.

**Strategies for Managing Risks Associated with Pregnancy**

For women in Sub-Saharan Africa, the risks of complications in pregnancy are much higher. A significant number of African women possess one or more of the broad characteristics which are frequently used to define maternal risk, such as those women who get pregnant under age 15 or over age 40, have multiple pregnancies or previous complications, or have other health problems such as malaria, hypertension, stunted growth or malnourishment. However, because recent studies have focused on different and varying outcomes of maternal mortality, others perinatal or infant mortality, it is difficult to conclude on the predictive value of "risk factors" for maternal mortality in developing countries.

Because of the issues of access and availability to health services in Africa, some African health and family planning professionals still see the risk approach as an evolving process and have identified it as an important area for continued research in Africa. The socioeconomic status of most women in Africa and the barriers to access to care create an environment in which it is important to screen women for early indications of complications and to refer them to trained health providers. In Africa, the lack, or poor management, of transportation to the first-referral center, shortages of and inadequately trained health personnel, poorly equipped and maintained health facilities, and flaws in the patient management system, all serve to create barriers to appropriate and timely obstetric care. While it is essential to reduce these problems, the Group considers it a priority to carry out further research on risk assessment in the African environment in order to develop guidelines for health providers to screen women for the most common and important complications.

**III. SAFE MOTHERHOOD ACTIVITIES IN SELECTED COUNTRIES**

Participants at the meeting presented status reports describing the needs and priorities of many of the francophone Sub-Saharan African countries. Drawing upon the information in these reports and the experience of the group, practical, realistic recommendations for action were developed. These country findings are summarized below.

**Benin:** High maternal mortality and fertility contribute jointly to the poor health status of women and children in Benin where only a third of all deliveries are attended by trained personnel. Hospital data indicate that over half of all maternal deaths are due to hemorrhage. The ability of the health system to deal effectively with these problems was hindered during the 1970s and 1980s by an over-centralized management system, poor infrastructure and acute shortage of drugs, supplies, equipment and appropriately trained personnel at the service delivery level.

A comprehensive reform of the health system initiated in 1987 gives high priority to improving basic health services, including maternal health and family planning services. Key components of this program include early detection and management of high-risk pregnancies, improved prenatal, labor and delivery care, and the creation of trained teams of health providers to manage the identification, referral and treatment of pregnancy-related complications. The program will also develop norms and standards for care and provide supplemental training for midwives in each
district. The reforms have initiated an effective essential drugs procurement and distribution system that has reduced the shortage of supplies and drugs.

Delays in the implementation of the proposed safe motherhood program, a major component of the project, result from inadequate political commitment and a highly centralized and inefficiently managed health ministry. The group recommended that political authorities at the national and local levels, MOH officials, and local associations support a more aggressive family planning and maternal health program which could reduce the country's high maternal mortality and fertility levels. The Group also recommended that the Government establish a coordination mechanism for integrating safe motherhood services into the family planning and maternal and child health (FP/MCH) program.

**Burkina Faso:** Maternal mortality remains high in Burkina Faso with maternal mortality rates ranging from 350 to 650 per 100,000 live births. Less than 23 percent of the deliveries take place in a health facility and less than 30 percent of deliveries are assisted by a trained attendant. According to Mme. Josephine Ouedrago even those women who recognize the need to go to a health facility for antenatal care are often treated rudely and forced to wait for long periods of time before they are seen. Often women wait only to be told that there is no blood or drugs are lacking.

The Government of Burkina Faso has developed an integrated family planning and maternal health program with the aim of reducing maternal mortality rates by 5 percent. The program will establish a continuum of care from the community to the district-level hospital which will be based on clearly defined national norms and standards.

Research is an important part of the safe motherhood agenda. A community-based maternal mortality study as well as a study examining the role of community health workers as agents to promote family planning and maternal health services are presently ongoing. A national committee on women's reproductive health has been established to determine the priorities in this area for the country.

**Burundi:** Burundi is the second most densely populated country in Africa. Persistently high fertility is reflected in the youthful structure of the population; 46.5 percent of the population is under age 15. Although the government has recently given high priority to slowing the population growth, contraceptive prevalence still remains at only 1.6 percent. Burundi's national health policy, which is firmly grounded in the principle of primary health care, aims to provide basic health care to all thereby: (i) increasing overall life expectancy; (ii) reducing morbidity and mortality of infants and children; and (iii) reducing maternal mortality and morbidity. Government studies estimate maternal mortality rate to be 300 per 100,000 live births.

A site visit to the Kigama Health Center in the Province of Muramvya allowed the Group to examine first hand some of the difficulties faced by the health system in Burundi. Health services in Burundi suffer from poor infrastructure and a lack of drugs, supplies and equipment and trained health personnel. Referral systems are weak and norms and standards for the monitoring and assurance of quality care are only now being formulated.

The national health policy places more emphasis on the major systemic concerns in the health sector, including: (i) decentralizing planning, programming and administration of health services to improve efficiency and responsiveness; (ii) according managerial autonomy to health facilities; (iii) strengthening family planning services; and (iv) involving communities in the financing and
management of health services. The Government’s population policy is to reduce the rate of population growth through the national FP/MCH program.

A review of recent data on fertility showed a relatively delayed age of marriage (23 years for girls), and indications of low abortion rates among girls below this age, yet an extremely high fertility rate for Burundian women. The data suggest that delayed age of first marriage is not a sufficient measure for reducing fertility. The Group proposed that research be undertaken to examine the socio-cultural factors influencing fertility practices, traditional contraceptive methods and management of unwanted pregnancies. Using the results of this research, program strategies integrating women’s reproductive health into the service delivery system can be developed.

Cameroon: The maternal mortality ratio in the Cameroon is estimated as 420 per 100,000 live births. Access to health care is limited for most of the predominantly rural population, with one physician for every 17,466 people. Contraceptive prevalence is approximately 5 percent. More than 21 percent of the female population is between the ages 10 and 19, and early marriage and pregnancy are the norm. Teenagers account for more than 21 percent of all annual births, and nearly 18 percent of teenage pregnancies end in induced abortion, which is legally restricted and usually unsafe. The total fertility rate is six, and the average age for grand multiparity is 27 seriously affecting maternal depletion. Teenage pregnancy and grand multiparity account for 67 percent of complications in labor and the puerperium. (Leke 1991; Nasah and others 1991).

The Central Maternity, University Hospital Center and 18 private maternities in Yaounde have adopted the risk approach, which requires that all pregnant women be screened for risk factors during the prenatal, intrapartum and postpartum periods. Those identified as being at high risk receive special surveillance and care. Studies have shown that inadequate care of hospitalized mothers contributed to 54 percent of all deaths. In addition to ensuring that all women at high risk receive appropriate surveillance, all women in labor in the teaching hospitals are monitored using the partogram, which can be used to detect intrapartum risk.

Dr. Robert Leke of the Central Hospital of Yaounde and Mme. Simone Dormont of the Centre International de l’Enfance in Paris presented the results of a research project conducted in one province of Cameroon. The study found that females under age 20 account for 21 percent of the births and that there is a low frequency of abortions in this age group. It was recommended that this study be expanded to one or two other provinces so that the results can be extrapolated to a national level. A review of the national program indicates that the lack of a central coordinating body responsible for safe motherhood has resulted in the fragmentation and diffusion of maternity services. It is recommended that program management and service delivery for safe motherhood services be decentralized to the program level and that norms and standards for safe motherhood services be strengthened to improve the quality of care. Professional associations, in particular the National Association for Obstetrician-Gynecologists, must be more actively involved in safe motherhood activities at the national and local levels. To encourage this involvement, the group agreed to invite representatives from the relevant medical professional associations to participate at the next meeting of this Group which is scheduled to be held in Cameroon.

Côte d’Ivoire: Despite considerable progress over the years in improving the health care system, health conditions in the Côte d’Ivoire are not significantly better than many poorer African countries. Life expectancy remains at 53 years and infant and maternal mortality are high. A recent maternal mortality study conducted in Abidjan found maternal mortality rates in three first-level
referral centers in Abidjan to be abnormally high in 1992. (Hospital maternal mortality rates of 2548, 2979 and 888 were recorded in Cocody, Treichville and Yopougon, respectively.)

Although there exists a public health care network linking primary health care services provided at the community level with first-level referral care, this pyramid of services does not function effectively. Hospital tertiary care has been favored over primary health care and first-referral services. Lack of finances and poor management of available resources have further aggravated the system. There is an oversupply of specialists in some fields and an acute shortage of primary health care providers for family planning and maternal and child health care. Patient care practice standards are unacceptably low and not based on established norms and clinical guidelines. Although there is no national safe motherhood strategy, political interest and commitment for reducing maternal mortality and morbidity and reducing the population growth is more evident. Two local NGOs, Association Ivoirienne pour la Maternité Sans Risques and l'Association Ivoirienne pour le Bien Être Familiale, have integrated safe motherhood services into their programming strategy in the urban areas.

The Group recommends that a dialogue be opened with the Government, through the formal mechanism of this Group, to sensitize government officials to the high levels of maternal mortality and morbidity in the country and the need to take urgent action. In addition, the Group proposes sending a mission to Abidjan to assist the Government in organizing a national workshop to develop a program to manage emergency obstetric care at the first-referral level facilities both in Abidjan and elsewhere in the country.

Madagascar: In 1976 Madagascar was one of the first countries to adopt a primary health care strategy which emphasized basic preventive health services. Despite this stated priority to health care, however, budgetary allocations to the MOH were low and conditions of the health system have progressively deteriorated. Maternal mortality in Madagascar is estimated in the range of 250-400 deaths per 100,000 live births. The major causes of maternal mortality are reported to be postpartum complications (29 percent), abortions (16 percent) and hemorrhage (7 percent). Access to quality prenatal and delivery care is limited. Accessibility and availability of family planning services is also low; contraceptive prevalence is estimated at less than 3 percent.

A substantial amount of induced abortion is reported in Madagascar. One hospital-based study in Antananarivo found that over 15 percent of all maternal deaths were attributable to unsafe abortion. A study in the rural areas reported that 30 percent of maternal deaths are attributable to complications from unsafe abortion. In another survey in the capital area, 36 percent of the women of childbearing age who were not pregnant reported that they would seek an abortion should they become pregnant. There is an urgent need to make safe and effective methods of contraception available and to improve early treatment and referral of complications for unsafe abortion and other emergency obstetric services.

In 1987, UNFPA sponsored a three-year safe motherhood project which emphasized family planning and maternity care services in the rural areas. The project trained family planning providers but did not successfully integrate these services into MCH activities. The lessons learned from this pilot safe motherhood project have encouraged the Government to pursue an integrated package of family planning and MCH services by the MOH.
At present, the Government of Madagascar is giving priority to rehabilitating the public health sector to deliver basic health services. Through a World Bank loan, the Government will reform its health service delivery system based on the health district approach.

Although reducing maternal morbidity and mortality and moderating fertility levels are priorities of the Government, insufficient human resources and health infrastructure severely limit the capacity of the system to provide services. In order to assure that safe motherhood becomes an integrated part of this system, the Group proposes sharing technical expertise on safe motherhood with the government and assisting them to develop a national safe motherhood program.

Mali: Quality family planning and maternity care is not readily accessible in Mali. Only 1 percent of women of reproductive age use a modern contraceptive method and 38 percent of women received prenatal care. Childbearing is high among teenage women, with almost one-half of all women under the age of 19 giving birth (Population Reference Bureau 1992). This means that on average, one in five adolescent women will have a birth in a given year. A 1987 report by the Ministry of Health estimated the maternal mortality rate to be between 1,750 and 2,900.

Although the health system has been plagued with a lack of finances and poor management of available resources, the country’s network of district-based health centers now provides access to care for 45 percent of the population and this is expected to increase. There is an insufficient supply of health manpower and existing staff are not adequately prepared to provide obstetric services. There is an oversupply of providers in Bamako and an acute shortage of primary health care providers at the periphery. Health services are not fully utilized because of the poor quality of health care. Faced with long waits, staff who are not responsive to clients needs and a shortage of drugs, Malians are forced to use more expensive private clinics, where they exist, or traditional healers for care.

In recent years, the Government has given increased priority to the promotion of primary health and, particularly, strengthening family planning and maternal and child health care. There is now greater collaboration between the public and private sectors, NGOs and donors to integrate FP/MCH services and to develop an IEC program to promote these services. Community-based and referral-level facilities are being enhanced to increase both the coverage and quality of health services.

Even though the FP/MCH program is now providing in-service training in safe motherhood, much remains to be done to reduce maternal mortality and morbidity in the country. Several of the constraints which are blocking the development of a safe motherhood program are: (i) lack of involvement of obstetrician/gynecologists in safe motherhood; (ii) lack of national research on maternal mortality and morbidity; (iii) limited collaboration with private clinics in providing safe motherhood services; (iv) poor understanding of and knowledge about adolescent fertility and abortion in the country; and (v) recent political instability which has disrupted the Ministry of Health.

Improving women’s health status in Mali means that policy-makers, health care providers and clients must focus both on the household’s capacity for self-care and community-based and referral level health services. The Group suggested the following recommendations to strengthen safe motherhood:

(i) There is a need to develop national norms and standards for delivering family planning and maternity care services.
(ii) The complexity of health manpower issues in Africa coupled with the need for services to be available in the community necessitate that Mali promote the concept of district health teams. District health teams can influence decision-making, set local standards, and monitor performance and, thereby, have an important role to play in guaranteeing an essential package of services.

(iii) Health professional associations and local NGOs need to be involved in the planning, implementation and monitoring of safe motherhood activities.

(iv) Training programs should be revised to adapt medical curricula to public health needs and reorient in-service FP/MCH training to focus on safe motherhood interventions.

(v) The Government, donors and regional institutions need to invest in the long-term development of the research capacity in safe motherhood and women’s health in Mali.

Senegal: Studies in Senegal estimate the maternal mortality rate to be 933 deaths per 100,000 live births. Most births in Senegal take place at home and, as a result, it is estimated that three out of four maternal deaths are not registered. Many women die in route to a health facility or, once they reach the facility, obstetric care may be delayed due to the absence of qualified medical personnel or the lack of drugs and supplies. Because of these problems, Mrs. Thérèse King, former Minister of Health of Senegal, told the Group that the Government of Senegal has chosen a proactive strategy which mobilizes both human and financial resources to reduce the levels of maternal mortality in the country.

The Government of Senegal has established a national safe motherhood program and coordinating body to ensure the implementation of program activities. The safe motherhood program emphasizes educating women and providers at the periphery about family planning and promotion of healthy pregnancies. At the level of the health center, the program will improve services for family planning, prenatal and delivery care and the screening, management and referral of high-risk pregnancies. Emergency referral systems will be strengthened by encouraging local communities to organize to provide these services. At the first-referral level, district hospitals are being upgraded to provide emergency obstetrical services.

At present, the safe motherhood program is being implemented in the Region of Tambacounda and provides a range of family planning, prenatal, delivery and postpartum services at all levels of the health pyramid. The Government plans to expand this program to a second region as funds permit. The Senegal program offers some excellent learning opportunities for other countries and the Group is encouraging site visits from neighboring countries.

Zaire: Dr. Alexis Ntabona, of the School of Public Health in Zaire and Dr. Sambe Duale described some of the maternal health problems and the constraints to improving family planning and maternal health services in Zaire. Women in Zaire suffer a disproportionate amount of health problems due to problems associated with pregnancy, infertility, STDs, and AIDS. Maternal mortality rates are estimated to be above 800 per 100,000 live births. The increasing incidence of STDs and HIV seroprevalence, estimated to vary from 6 to 8 percent in Kinshasa, and AIDS adds another dimension to the problems facing women.

In Zaire, the government’s share of health expenditures is less than 5 percent (World Bank 1993). Most services are delivered in collaboration with NGOs and religious missions. At the
district level, 50 percent of 306 health zones established between 1982-86 are being managed by, or in close collaboration with, NGO assistance. Unfortunately, broader societal conditions, such as political instability and financial mismanagement, have disrupted the health system. Today there is neither a national safe motherhood program nor a national coordinating body for safe motherhood in Zaire.

The political situation in Zaire has resulted in a lack of central coordination of health services and fragmentation of services delivered at the district level. Until the current political situation is improved, sector specialists, both within and outside of Zaire, should be encouraged (and supported) to use this opportunity to generate dialogue with beneficiaries, professional associations, and health providers on approaches for integrating safe motherhood services into the FP/MCH program.

IV. SPECIAL ISSUES: ADOLESCENT FERTILITY AND UNSAFE ABORTION

In Sub-Saharan Africa, adolescents make up 19 percent of the total population and are part of the group at greatest risk of maternal mortality and morbidity. Many female adolescents have had some sexual experience: some studies even suggest that more than one-half of women aged 15-19 had experienced sexual intercourse (Senderwitz 1993). A majority of these women will have had a birth by age 20 and an unknown number will have terminated their pregnancies through unsafe abortion. The result is that in some countries births to mothers under 20 years old account for close to 20 percent of total birth.

The rates of sexual intercourse vary greatly among countries according to premarital and marital social norms. In some countries, such as Mali where 76 percent of women under age 20 had sexual intercourse, the majority (99 percent) of these teenagers are married by the time their babies were born. In other societies, such as Kenya and Botswana, sexual intercourse takes place prior to marriage and most girls remain single after childbirth. Burundi is the only country in an eleven country DHS study of Sub-Saharan Africa where teenage childbearing is relatively uncommon (Population Reference Bureau 1992).

In some African societies adolescents are sexually active within culturally approved unions, which may take place outside of marriage, but conform to norms of many traditional African societies that approve of early marriage and childbirth. Today's adolescents in contemporary Africa are also facing vast pressures: increased opportunities for sexual activity because of urbanization, higher female enrollment in secondary schools, changes in the family structure, peer pressure, availability of drugs and alcohol, and media influence. A young girl may provide sexual favors to an older man, commonly known as the "sugar daddy," in return for material favors or in the role of the younger wife. These girls are often ignorant or fearful of seeking family planning counseling and STD treatment and control.

The health risks of teenage childbearing for both mother and child are serious, including pre-eclamptic toxemia, anemia, malnutrition, cephalic disproportion, obstetric fistulae, obstructed labor, low birth weight and perinatal mortality. However, most adolescents do not protect themselves against unwanted pregnancies; more than 30 percent of currently married teenagers in 8 of the 11 Sub-Saharan African countries looked at in the DHS study have an unmet need for family planning (Population Reference Bureau 1992). The social costs of teenage pregnancies are also high: teenage girls who are pregnant are threatened with school expulsion and ostracism by their families and often seek to terminate their pregnancies.
It is often difficult for adolescents to find appropriate family planning and reproductive health services because: (i) few teenagers are knowledgeable about sexual behavior; (ii) few services are designed to meet the needs of adolescents at a cost affordable to them; (iii) health providers are not trained to provide counseling and services to adolescents; and (iv) government policies and legislation often work at odds with promoting family planning and reproductive health services and education programs for adolescents.

African governments must do much more to promote legal and social change regarding adolescent fertility and to implement programs that are tailored to the fertility and reproductive health needs of adolescents. Family life education in schools and communities can help teenagers make informed choices about sexual behavior and family planning services should be available for those sexually-active adolescents. Some suggestions offered by the Group to reduce adolescent fertility rates are:

◊ Promote policies aimed at increasing the age of marriage, delaying childbearing, and increasing female enrollment in secondary schools.

◊ Provide more reproductive health programs aimed at increasing the knowledge and changing the reproductive behavior patterns of adolescents.

◊ Provide family planning counseling and services to adolescents, regardless of age and marital status.

◊ Provide family planning and maternal health services to adolescents in a multiservice center which is attractive to teenagers and serves their health and social needs.

◊ Design service delivery strategies in collaboration with adolescents who are the expected beneficiaries.

◊ Encourage wider public discussion of adolescent health needs and educate the public and adolescents, both males and females, about the advantages of delaying the first birth and marriage, staying in school, and practicing safe sex to avoid pregnancy and STDs, including HIV.

Misinformation or lack of knowledge about the socio-cultural factors surrounding adolescent fertility is widespread in most African countries. Promising approaches to delivering services and changing behavior through health education programs will need to be examined in each country.

Unsafe abortion is another cause of maternal mortality. Reliable data on abortion in Africa is lacking and the hospital-based data which is available is likely to underestimate the extent of the problem since information does not reflect those clandestine abortions which occur without any complication. Recent data from a study in Kenya estimated that there were approximately 75,000 abortions in Kenya in 1990. Extrapolating this to Sub-Saharan Africa suggests that there was an estimated 1.5 million abortions in the region (Rogo 1991). In Ethiopia and Nigeria, almost 50 percent of the maternal deaths result from complications due to abortion. In Kenyatta National Hospital in Nairobi, approximately 100,000 beds each year, or 27 beds each day, are occupied by patients with complications related to unsafe abortion. Treatment for abortion-related complications can consume significant resources.
Although adolescents account for a disproportionate number of abortion complications given their greater tendency to obtain an unsafe abortion and their delay in obtaining the procedures, they are not alone in seeking abortions: women in all phases of their reproductive life-cycle experience unwanted pregnancies and seek abortions (Senderwitz 1993). Dr. Colette Dehlot, from the Nairobi Office of the Population Council, reported on a knowledge, attitude and practice study among Masai women who have obtained unsafe abortions which found that no matter the age or marital status, when confronted with an unwanted pregnancy, the first reaction for all women is to seek an abortion.

The vast majority of women in Africa do not have access to safe abortion. Where abortion services are not available or because women seek anonymity or do not have the money to pay for services, they abort themselves or resort to unsafe abortion by people who have no medical training. Women often delay seeking treatment for complications of illegal abortion for fear of revealing the abortion or due to the lack of access to health services. Even where abortion is legal, such as in Zambia, problems with access continue. A 1988 study using data from the University Teaching Hospital in Lusaka showed that, for every one abortion performed legally, twenty-five abortion-related complications were treated.

A KAP study on health personnel which was also reported on by Dr. Colette Dehlot found that clandestine and unsafe abortion is practiced by both health professionals, including physicians and nurses, as well as traditional healers and non-medical personnel who work in health centers. Often, these abortions take place outside of clinic hours and are done to supplement their monthly income (Phillipps 1991). Many are performed under unsanitary conditions, using elementary techniques and inadequate instruments — all of which may lead to severe complications.

Throughout francophone Africa, there are examples of government legislation and policies which create barriers to improving women’s social status. The majority of countries maintain former colonial laws prohibiting abortion unless the mother’s life is in danger and restricting the sale of contraceptives to married women who have their husband’s approval. In many francophone African countries, the 1920 French law prohibiting the sale and distribution of contraceptives is still in existence. Access to family planning services for adolescents and single women is severely limited.

The recognition of abortion as a severe health problem in Sub-Saharan Africa is just beginning, however, there are a few examples of successful programs: in Kenyatta National Hospital, Nairobi, manual vacuum aspiration technique has been introduced to terminate pregnancies in the first trimester. After introduction of the manual vacuum aspiration technique, clients and providers have benefitted from shorter hospital stays, better results, and costs that have been reduced by 23 to 66 percent. Both Botswana and Burundi have family life education projects which focus on adolescents. The program in Burundi is a sexual education program conducted in the secondary schools. The objective of the Botswana program is to provide education, counseling and family planning services to boys.

Reducing unsafe abortion should be a priority for achieving safe motherhood. The economic and social costs of unsafe abortion in Africa are tremendous. Unfortunately, however, the problem has not been given the attention it deserves in Africa. Legalizing abortion, as in Zambia, is insufficient to improve women’s health where access to health services is limited. African governments need to document and recognize the extent of the problem of unsafe abortion and to focus resources on improving access to and quality of family planning services as well as services to manage the complications from unsafe abortion. This requires: (i) training health providers to ensure technical
V. SUMMARY: THE PROBLEM OF EXCESSIVE MATERNAL MORBIDITY AND MORTALITY IS INCREASING AND DEMONSTRATED POLITICAL COMMITMENT TO SAFE MOTHERHOOD IS LACKING.

The number of maternal deaths continues to rise each year in many countries in Sub-Saharan Africa. The population of women of childbearing age is now larger than it was in 1989, and the number of women who die each year from pregnancy-related causes has increased even though there may have been a slight decline in pregnancy risks. Yet, in spite of this fact, the Regional Resource Group of Experts on Safe Motherhood for Francophone African countries believes that there is cause for hope in the progress of the francophone African countries toward reducing maternal mortality by half by the year 2000. There is now more recognition and support for safe motherhood at the international, regional and country level, some governments have developed strategies and programs aimed at reducing the level of maternal mortality and morbidity and, in some instances, community
activities to promote safe motherhood have been initiated. There is cause for hope but much remains to be done.

The Group recognizes that although individual circumstances require each country to determine their own priorities and strategies, certain critical factors, essential to improving and expanding maternal health and family planning, are not receiving appropriate and urgent attention. These include:

**Inadequate political commitment at national level.** Evidence from statements and activities of political leaders do not reflect a sense of national priority in addressing maternal and women's health issues. The apparent lack of demonstrated political commitment in this area is most reflected in the limited or, in some cases non-existent, allocations in the government's budget for non-wage operating expenses that are needed at the level of health facilities to effectively prevent and manage high risk pregnancies. Few countries have established or rendered effective mechanisms for coordinating strategies and programs on safe motherhood. Even in countries where substantial work has been done to develop programs that will improve maternal and women's health, the lack, or ineffective operation, of coordination mechanisms contributes to duplication of efforts by various donors acting bilaterally and independently with the government. The positive effects of strong country commitment are almost universally recognized as one of the main factors behind program success.

**Over-centralization of decision-making processes within health ministries.** The efficiency and responsiveness of services to community needs for improving maternal and women's health are being hampered by an over-centralization of decision-making within the central units of health ministries. Resistance to decentralization of the crucial planning, management and supervision functions for family planning, maternity care and other priority health programs constitutes a major obstacle in Francophone African countries toward reduction of high levels of maternal morbidity and mortality. Experience in Africa, as well from other regions of the world, demonstrate that where the day-to-day management of primary care centers is decentralized to the local level and local accountability for services exist, services have improved.

**The need for a national policy and strategic framework for safe motherhood activities.** External donor interest in assisting African countries in strengthening services that promote safe motherhood have inadvertently hindered effective progress because donors have often worked in isolation without much real coordination of efforts and strategies. This has sometimes led to conflicting goals, duplication of efforts and results which are not commensurate to expended effort and resources. Agencies supporting safe motherhood activities must work within the context of national programs to avoid fragmentation of programs and misappropriation of scarce resources.

**Training of health providers.** The Group stressed the need for revising and streamlining basic and in-service training for physicians, nurses and midwives to ensure the content and technical skills for providing care that promotes safe motherhood and ensures better women's health status.

**Inadequate involvement of professional bodies in safe motherhood activities.** Safe Motherhood programs will be more effective if representatives of the health professions --physicians, surgeons, midwives, and nurses -- whose roles are critical for tackling safe motherhood problems, are involved in planning and implementation.
Monitoring performance and progress. An adequate monitoring and evaluation system is an integral part of program implementation and essential to building appropriate modifications into ongoing programs and determining whether they achieve their objectives. Countries should give greater priority to the development of service statistics and monitoring and evaluation of FP/MCH services. A better empirical statistical base is necessary for improved sector analysis, better socio-cultural and epidemiological studies and better evaluation of cost-effective approaches to safe motherhood. Service statistic data should enable countries to evaluate appropriateness of facilities, equipment, staff and operational strategies for managing obstetrical complications and effectiveness and quality of care, as well as provide feedback mechanisms for program managers.

Health education and communication strategies. Improved health education and communication strategies are needed to ensure the involvement of beneficiaries in program development and implementation. The absence of coordinated health education and communication strategies has tended to send mixed messages, excluded adolescents and single adult women and men, and neglected the involvement of community-based groups in the development of IEC messages for promoting safe motherhood. There is growing evidence that involving beneficiaries in program development and implementation contributes to better results.

Many African countries now recognize that access to family planning can improve women's health and stem rapid population growth which jeopardizes economic growth and development. However, current rates of population growth are slowly stretching to their limit existing skeletal health, education, housing and transport systems. This could contribute to a poorer quality of life and further environmental degradation even for countries that have developed otherwise effective economic growth strategies.

Although all pregnancies carry some health risks to the mother and child, family planning services can help to reduce the health risks from mistimed and unwanted pregnancies, particularly among adolescents. There is a need for increased government effort to promote female secondary education and to expand family planning services to all women, regardless of age or marital status. Another issue deserving more attention is the growing problem of unsafe abortions which currently result in the death of so many African women, a large proportion of whom are under the age of 20. With respect to maternity care, the priorities which emerge from research and program assessment are prevention at the community level (hygiene and nutrition education) and early detection, transport and referral of complicated cases to facility-based obstetric services.

This report signals the World Bank's willingness to support countries committed to safe motherhood and to work in concert with other donors to assist countries that accord a priority to improving women's health status. The Bank will continue to support investments in the health infrastructure and to strengthen the public and private sector capacity to provide family planning and maternal health services.

Safe Motherhood in Africa will require continued technical, human and financial resources. The Resource Group for Safe Motherhood in Francophone Africa calls for the participation of every country and within each country the many government sectors, NGOs, community and women's groups, and health care providers. The Group will continue advocacy and research efforts to mobilize government participation and to monitor program activities. Halving maternal deaths by the year 2000 is a concrete, achievable goal, provided sufficient commitment, resources and effort are dedicated to it.
REFERENCES


<table>
<thead>
<tr>
<th>No.</th>
<th>Title</th>
<th>Author</th>
<th>Date</th>
<th>Contact for paper</th>
</tr>
</thead>
<tbody>
<tr>
<td>HROWP1</td>
<td>Social Development is Economic Development</td>
<td>Nancy Birdsall</td>
<td>March 1993</td>
<td>L. Malca 37720</td>
</tr>
<tr>
<td>HROWP2</td>
<td>Factors Affecting Achievement in Primary Education: A Review of the Literature for Latin America and the Caribbean</td>
<td>Eduardo Velez, Ernesto Schiefelbein, Jorge Valenzuela</td>
<td>April 1993</td>
<td>B. Washington-Diallo 30997</td>
</tr>
<tr>
<td>HROWP3</td>
<td>Social Policy and Fertility Transitions</td>
<td>Thomas W. Merrick</td>
<td>May 1993</td>
<td>O. Nadora 35558</td>
</tr>
<tr>
<td>HROWP4</td>
<td>Poverty, Social Sector Development and the Role of the World Bank</td>
<td>Norman L. Hicks</td>
<td>May 1993</td>
<td>J. Abner 38875</td>
</tr>
<tr>
<td>HROWP5</td>
<td>Incorporating Nutrition into Bank-Assisted Social Funds</td>
<td>F. James Levinson</td>
<td>June 1993</td>
<td>O. Nadora 35558</td>
</tr>
<tr>
<td>HROWP6</td>
<td>Global Indicators of Nutritional Risk (II)</td>
<td>Rae Galloway</td>
<td>June 1993</td>
<td>O. Nadora 35558</td>
</tr>
<tr>
<td>HROWP7</td>
<td>Making Nutrition Improvements at Low Cost Through Parasite Control</td>
<td>Donald A.P. Bundy, Joy Miller Del Rosso</td>
<td>July 1993</td>
<td>O. Nadora 35558</td>
</tr>
<tr>
<td>HROWP8</td>
<td>Municipal and Private Sector Response to Decentralization and School Choice: The Case of Chile, 1981-1990</td>
<td>Donald R. Winkler, Taryn Rounds</td>
<td>August 1993</td>
<td>E. De Castro 89121</td>
</tr>
<tr>
<td>HROWP9</td>
<td>Poverty and Structural Adjustment: The African Case</td>
<td>Ishrat Hussain</td>
<td>September 1993</td>
<td>M. Youssef 34614</td>
</tr>
<tr>
<td>HROWP10</td>
<td>Protecting Poor Jamaicans from Currency Devaluation</td>
<td>Margaret E. Grosh, Judy L. Baker</td>
<td>September 1993</td>
<td>M.E. Quintero 37792, M. Rodríguez 30407</td>
</tr>
<tr>
<td>HROWP11</td>
<td>Operational Education Indicators</td>
<td>George Psacharopoulos</td>
<td>September 1993</td>
<td>L. Malca 37720</td>
</tr>
<tr>
<td>HROWP12</td>
<td>The Relationship Between the State and the Voluntary Sector</td>
<td>John Clark</td>
<td>October 1993</td>
<td>P. Phillip 31779</td>
</tr>
<tr>
<td>HROWP13</td>
<td>Obstacles to Women’s Access: Issues and Options for More Effective Interventions to Improve Women’s Health</td>
<td>Joseph Kutzin</td>
<td>October 1993</td>
<td>O. Shoffner 37023</td>
</tr>
<tr>
<td>HROWP14</td>
<td>Labor Markets and Market-Oriented Reforms in Socialist Economies</td>
<td>Arvil V. Adams</td>
<td>October 1993</td>
<td>S. Khan 33851</td>
</tr>
<tr>
<td>Title</td>
<td>Author</td>
<td>Date</td>
<td>Contact for paper</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>---------------------</td>
<td>-----------------</td>
<td>------------------</td>
<td></td>
</tr>
<tr>
<td>Reproductive Tract Infections, HIV/AIDS and Women's Health</td>
<td>May T.H. Post</td>
<td>October 1993</td>
<td>O. Shoffner</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>37023</td>
<td></td>
</tr>
<tr>
<td>Job Security and Labor Market Adjustment in Developing Countries</td>
<td>Ricardo D. Paredes</td>
<td>November 1993</td>
<td>S. Khan</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>33651</td>
<td></td>
</tr>
<tr>
<td>The Effects of Wage Indexation on Adjustment, Inflation and Equity</td>
<td>Luis A. Riveros</td>
<td>November 1993</td>
<td>S. Khan</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>33651</td>
<td></td>
</tr>
<tr>
<td>Popular Participation in Economic Theory and Practice</td>
<td>Philip R. Gerson</td>
<td>December 1993</td>
<td>L. Malca</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>37720</td>
<td></td>
</tr>
<tr>
<td>Economic Returns from Investments in Research and Training</td>
<td>Edwin Mansfield</td>
<td>January 1994</td>
<td>I. Dione</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>31447</td>
<td></td>
</tr>
<tr>
<td>Participation, Markets and Democracy</td>
<td>Deepak Lal</td>
<td>January 1994</td>
<td>L. Malca</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>37720</td>
<td></td>
</tr>
<tr>
<td>Safe Motherhood in Francophone Africa</td>
<td>Patricia Jaly</td>
<td>January 1994</td>
<td>O. Shoffner</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Michael Azefor</td>
<td></td>
<td>37023</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Boniface Nasah</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>