Progress and Prospects
The Safe Motherhood Initiative
1987 - 1992

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By

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# TABLE OF CONTENTS

## Part I

1. **Introduction** .......................................................... 3

2. **Planning Safe Motherhood Programs** ........................................ 5  
   A. Health Service Priorities ........................................ 5  
   B. Implementing Safe Motherhood Programs: Assessing Constraints  
      and Possibilities .................................................. 8  
   C. Strategies for Strengthening Safe Motherhood Programs .......... 10

   A. Health Service Improvements ..................................... 12  
   B. Communications .................................................. 16  
   C. Research ........................................................... 17  
   D. Cooperation and Partnership ...................................... 19  
   E. Advocacy and Information ........................................ 20

4. **Summary and Discussion** ............................................... 22

## Part II

### Appendices

1. Case studies from the field: project and program descriptions by country 25
2. Directory of select international agencies ................................ 85
3. Update: regional and national Safe Motherhood workshops .......... 171

### References .............................................................. 177

### Safe Motherhood: Global Fact Sheet .................................... 181
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1. INTRODUCTION

In recent years, considerable attention has been focused on the tragic, unnecessary and inequitable toll pregnancy and childbirth exact on women in developing countries. Current estimates indicate that at least 500,000 women -- almost one every minute -- die annually from causes related to pregnancy and childbirth. Ninety-nine percent of these deaths are to women in developing countries.

Too many women die in the prime years of their lives. And these numbers do not capture the suffering of the far greater number of women who do not die but endure debilitating and sometimes permanent damage to their health as a result of their pregnancies. Nor do they convey the grief felt by women’s families, or the loss to their communities and societies. The discrepancy between maternal deaths in the developing and developed worlds is greater than for any other health indicator. Moreover, the most common direct causes of maternal death are preventable, at relatively low cost.

The justification for working toward safe motherhood is both humanitarian and economic. Women should not die from largely preventable causes. Families and societies should not lose so many of their most essential and productive members as a result. Throughout the world, women are the primary caretakers of children and managers of the household (collecting fuel and water, tending animals, cooking, cleaning, caring for young and old). In many areas, they are also the main producers of food and perform vital economic roles, contributing significantly to development. The loss of a mother also has severe adverse consequences for infants and young children, who too often die following their mother’s death, or suffer impaired health and development prospects. The productivity lost when women die in the prime of life saps families and societies of a vital resource.

In recognition of the problem, an international meeting was convened in Nairobi in 1987. During the Nairobi conference, high-level representatives from international agencies, national governments, academic institutions and non-governmental organizations made a commitment to undertake efforts to reduce the toll of reproductive ill-health by 50 percent by the year 2000. The main strategies outlined at that time included: increasing access to and use of family planning services; improving community-based maternity care services; providing adequate emergency obstetric care; and addressing the social and economic inequalities that contribute to women’s poor health status.

Since 1987, an ever-growing number of partners from the international development community, governments, and non-governmental organizations around the world have been planning and implementing activities designed to make motherhood safer. These include advocacy and information efforts, research projects and service delivery programs at the local, national, regional and international levels.
The content and scope of the activities vary considerably. This breadth of activity has prompted substantial debate over the relative merits of specific interventions, and related discussion about the appropriate scope of Safe Motherhood programs. At the heart of this dialogue lies a question: how far should we venture from the event of a maternal death? Is the Initiative primarily concerned with preventing pregnancy-related deaths, or is it also attempting to improve women’s reproductive health more generally? Is it also trying to bring about further improvements in infant and child health? Finally, should women’s status issues, which influence women’s health and access to appropriate services be included? The threat of death bears its own imperative for intervention, but averting maternal deaths, ensuring that women lead healthy reproductive lives improving women’s status and ensuring the health and survival of their children are not necessarily synonymous. Each implies different optimal intervention strategies.

Part I of this paper will describe the activities undertaken as part of the Safe Motherhood Initiative at the local, national, regional and international levels, and the issues and questions raised during its first five years. Following a review of proposed program priorities and related discussions, the paper will briefly summarize the different types of activities that have been launched, highlighting any evaluative findings available.

Part II contains three appendices, which are intended to serve as a directory. The first contains summary descriptions of select local and national Safe Motherhood programs, and other efforts which, while not formally linked to the Safe Motherhood Initiative, address many of the same concerns. The second contains brief descriptions of the Safe Motherhood activities of various international agencies. The last provides an overview of the regional and national Safe Motherhood Initiative conferences and workshops held over the last five years, and lists the countries that were represented.
2. PLANNING SAFE MOTHERHOOD PROGRAMS

Setting priorities for Safe Motherhood programs and designing the right strategies to achieve them can be viewed as a process of diagnosis, appraisal and prescription: what is the nature and extent of the problem? what are the best strategies? what resources are available in a given setting to implement such strategies? Based on the answers to these questions, what strategies are feasible for the setting in question? Despite continuing debate about the scope of the Initiative, advocates agree that preventing maternal deaths is its core objective. There is growing consensus that reproductive morbidity, some but not all of which results from the same factors that lead to maternal deaths, deserves more emphasis in the Safe Motherhood Initiative.

A. Health Service Priorities

A maternal death is the worst possible outcome of a complex set of interactions among social and biological factors. In many areas of the world, poverty and discrimination compound the particular health risks women face in pregnancy, limiting their access to the resources they need to improve their health, and to appropriate and timely care when their health is in jeopardy. As such, it has been suggested that both direct health sector interventions and socio-economic change are needed to bring about the largest and most sustainable reductions in maternal mortality and morbidity.

Much more is known, however, about the direct and immediate medical causes of maternal deaths, and the magnitude of their contribution to overall maternal mortality. The five major medical causes of maternal mortality are the same all over the world: hemorrhage, infection, obstructed labor, pregnancy-related hypertension, and unsafe abortion. In the developing world, these factors account for over 75 percent of maternal deaths. The imperative to address these causes has guided much of the work undertaken within the Initiative to date.

A recently developed analytical framework describes the factors and events that affect pregnancy outcomes and the mechanisms through which these factors lead to maternal deaths or disabilities. The model groups different factors according to their relative influence on the outcomes of pregnancy, particularly those that lead to disability or death (Maine, 1991).

By definition, a sequence of three things must happen for a maternal death to occur: a woman must become pregnant, she must develop complications, and those complications must lead to her death. These are the proximate determinants of maternal death.
All other behavioral and social factors thought to influence maternal health are grouped as either intermediate or distant determinants, depending upon their estimated degree of influence on maternal outcomes. Distant determinants (e.g., socio-economic and cultural factors) operate by affecting intermediate determinants (e.g., health status, reproductive status, health care behavior, and access to health services), which in turn affect the proximate determinants described above.

To prevent maternal deaths and ill-health, any proposed intervention must eventually have an impact upon one of the three proximate determinants, i.e. by preventing pregnancy, by preventing the development of complications and by treating complications when they arise. The more directly interventions influence these three factors, the more immediate the impact upon maternal mortality.

It has been proposed that family planning, safe abortion services and essential emergency obstetric care are the most important interventions to ensure such reductions in maternal mortality. However, while it is widely agreed that these interventions should be given high priority within Safe Motherhood programs, they are not sufficient in and of themselves. Firstly, people must know the services exist, must believe in their effectiveness and must use them. Maternal deaths can and do occur within very short distances of a well-stocked hospital or a well-staffed clinic. Efforts to ensure that women know more about their own health conditions and problems, and when and where to seek care, can help prevent such loss of life, and ensure that services are utilized. Prenatal and post-partum care, for example, can help improve women's access to and use of appropriate care for delivery and family planning services respectively.

Secondly, there are conditions (e.g., anemia, malaria and sexually transmitted diseases) that are associated with poor reproductive health and outcomes, and which require health services not provided through family planning, care for the complications of abortion or emergency obstetric care. Identifying and treating problems as early as possible can prevent significant reproductive morbidity and, in some cases, help prevent the onset of more serious complications. Both prenatal care and post-partum care can help prevent certain direct obstetric complications from arising or progressing, and are important elements of Safe Motherhood programs. The roles of each component of an ideal Safe Motherhood program are outlined below.

**Family planning** can contribute immeasurably to reducing the risk of pregnancy-related mortality, primarily by reducing the overall number of pregnancies. Simply put, if fewer pregnancies occur, there are fewer opportunities for complications to develop. Family planning should also reduce the number of unwanted pregnancies, many of which may otherwise end in unsafe abortion. It has been shown that providing family planning services to all women who wish to avoid or delay their next birth but are not using
contraceptives could reduce the number of maternal deaths by over 30 percent. The impact of family planning is further illustrated by comparing the relationship between maternal mortality and fertility levels in different countries. No country with a low fertility rate (less than three births per woman) has a high maternal mortality ratio (over 150 deaths per 100,000 live births)(Koblinsky and Huque, 1991).

**Abortion care.** It is estimated that up to half of all pregnancy-related deaths in developing countries result from the complications of unsafe abortion. Many women who want contraceptives do not have access to them. While family planning can help prevent unwanted pregnancies and thus prevent some abortions, it is not the only answer. Contraceptives sometimes fail. In most parts of the world, access to abortion is legally restricted. Nonetheless, women all over the world risk their lives to end unintended pregnancies. Hundreds of thousands of lives could be saved if abortion procedures were performed safely by skilled and authorized providers, and if the complications of poorly performed abortions were properly treated.

**Emergency delivery care.** Adequate, timely care for emergencies during delivery is key to reducing maternal mortality. Studies have shown that most women who suffer pregnancy-related complications cannot be identified with certainty before the complications develop. With proper care from trained personnel, most of the complications that do develop (hemorrhage, infection, obstructed labor and hypertensive disorders of pregnancy) can be treated or prevented from progressing to a more serious and potentially fatal phase. Since it is difficult to target emergency services only to those who will need them, it is important that emergency delivery care be made available to all women. Solutions to transportation and communications barriers for women far from facilities are essential to making this care accessible.

**Pre-natal care** may be the first or main point of contact between many women in developing countries and the health sector. Pre-natal care can offer effective prevention, detection and treatment of some complications, or conditions that may exacerbate complications. These include detection and treatment of chronic anemia, and certain infections especially sexually transmitted diseases; detection and referral of hypertensive disorders of pregnancy; and prediction of women’s risk of some obstetric complications, especially cephalo pelvic disproportion (Rooney and Graham, 1991). It provides an important opportunity for health education -- both specific to pregnancy, and more broadly. Women can learn about their own health needs and how to identify warning signs of complications of pregnancy (e.g., edema, bleeding), and where to seek appropriate care if such signs appear. Finally, pre-natal care offers an opportunity for family planning counselling and nutrition education, and is also associated with better perinatal outcomes, such as fewer low birthweight babies. Without pre-natal care, women’s understanding of, access to and use of routine and emergency delivery services is likely to be less than optimal.
Ensuring that women have access to **appropriate care during labor and childbirth for normal deliveries** is also an important strategy for Safe Motherhood programs. Indeed, ensuring adequate routine care for normal deliveries is as important as ensuring adequate emergency obstetric care, and could do much to reduce the incidence of maternal deaths. Early identification and management of problems by trained providers can help prevent the progression of some complications and ensure access to emergency care when necessary. Improving hygienic delivery and decreasing dangerous delivery practices will help many women have safe deliveries. As with pre-natal care, routine delivery care can reduce maternal mortality both directly and by increasing women's access to additional care when complications develop.

**Post-partum care** is the final element in this package of reproductive services for women. It offers an important opportunity to monitor the health of both mother and infant, and is timely and appropriate for discussing the benefits of child spacing, and providing family planning services. It is also key to the identification and treatment of post-partum infections, which many times go undetected even among women who deliver in health facilities, as they often do not develop until after the women have returned home. Through education on breastfeeding, nutrition and other health interventions (e.g., immunizations), post-partum care provides additional benefits for both mothers and infants.

Taken together, these health services (pre-natal care, family planning, routine and emergency delivery care, safe abortion services, and post-partum care) constitute an ideal continuum of care necessary for bringing about a sustainable reduction in maternal mortality and some additional improvements in maternal health.

**B. Implementing Safe Motherhood programs: Assessing constraints and possibilities**

Although policy makers may understand the basic health interventions required to reduce maternal mortality, they must answer the following question: how can these critical elements be made available in different settings?

In addition to reproductive health needs, the design and implementation of an effective Safe Motherhood program will vary according to the broader characteristics and resources of the setting in question. Decisions about program design are based on political and legal context, cultural appropriateness, an appraisal of the existing health infrastructure, the skill levels of health personnel and related resource constraints. These factors can be grouped into five areas:

1. **Political commitment.** Existing health and development policies and priorities, and the commitment of national and political leaders to the goals of the Safe Motherhood Initiative, will influence the possibilities for program implementation. If decision-makers
do not understand the need for or assign priority to maternal health improvements, Safe Motherhood program planners must seek to change their perspectives.

2. Legal context. Safe Motherhood efforts may be affected by legislation and regulations which affect women’s role in society and access to health services. For example, laws that restrict the provision of family planning services, and other customs which restrict a woman from leaving her home without the permission of her husband, may prevent women from receiving the care they need in a timely fashion. Adolescent pregnancy is a growing problem, but in many settings, adolescents have limited access to reproductive health services, especially family planning.

3. Community knowledge, attitudes and practices. Prevailing attitudes and cultural practices affect women’s knowledge of their reproductive health needs and their willingness/ability to seek appropriate care. Planners and health professionals must understand these perceptions and incorporate them into the program design if community members are to participate -- and participate successfully. Community members do not necessarily share the same perceptions of maternal health problems as those determined by epidemiologists and health planners. For example, in some areas, customs pressure young adolescent girls into marriage before their bodies are fully mature. Efforts to change such practices will require substantial outreach and education within the community about the consequences of adolescent pregnancy for the girls themselves, their infants and families. Finally, since decisions about a woman’s health are often not hers alone or hers at all, the perception of those who influence her access to health care and other resources must also be determined and considered in program design.

4. The scope and quality of the existing health service delivery system. An appraisal of the type of health services provided, by whom and for whom will help planners determine what types of improvements are possible. Such an assessment should review all aspects of service delivery including: numbers and skills of personnel; location, range and quality of services; allocation of equipment and supplies; and quality of linkages or communication between different levels of the health care system.

5. Costs. In order to maximize the benefit of scarce health resources, the cost of interventions and associated inputs (e.g., personnel, equipment, supplies, training, vehicles, etc.) should be considered in the design of Safe Motherhood programs. Solid data on Safe Motherhood program costs is scarce. Nonetheless, costing highlights an important planning concept -- optimization, or ensuring the most efficient use of available resources given limited resources and competing demands. Planners must balance the needs of Safe Motherhood programs against other health and development goals (Forgy, Measham and Tinker, 1991).

These factors will vary substantially from country to country, and within countries. However, such an appraisal should provide a better understanding of the terrain upon
which a Safe Motherhood program will be built, and an inventory of the building blocks available for the effort.

C. Strategies for Strengthening Safe Motherhood Programs

Based on the discussions above, an ideal Safe Motherhood program seeking to bring about immediate reductions in maternal mortality and morbidity includes an informed and participatory community with access to a continuum of services such that women in need can receive appropriate care at any point in pregnancy, labor, delivery and the post-partum period. In many situations, however, ensuring access to this ideal continuum may be a distant possibility, given a scarcity of resources and other constraints. A particular configuration of economic, social, political, demographic and infrastructural considerations may preclude some options, and favor others. For example, in remote settings where fertility is high, skilled health professionals are not readily accessible, and resources are scarce, it may be difficult to provide obstetric services. Expanding community-based family planning services may be the most cost-effective and feasible intervention in such settings.

A review of current Safe Motherhood efforts suggests that in most settings planners have limited ability to implement the full spectrum of maternal care components. As a result of these constraints, many countries are emphasizing four strategies in their Safe Motherhood programs.

1. **Communications efforts** can perform several important functions for the Safe Motherhood Initiative. They can motivate people to adopt more healthful behaviors. They can improve knowledge of related issues and appropriate responses, e.g., knowledge of reproductive functions (especially danger signs during pregnancy) and where to seek care. Communications strategies can also promote program, policy and service changes/improvements to users, health personnel and policy-makers (Griffiths, 1991). They can also draw attention to other factors which influence women’s health, such as education, control of income/resources, laws, and social and cultural practices (e.g., age at marriage and workload) which govern the lives of girls and women.

2. **Improving the referral system at and between all levels of care** will help to provide an integrated system of care from community to hospital-level. It includes improving transport options to ensure that women reach facilities in a timely fashion, as well as improving communication and collaboration between different types of health providers, and between the community and care providers.

3. **Improving the skills of providers at all levels** helps ensure that women receive high quality and appropriate care. This can be accomplished through revisions in basic training curricula at health training institutions, and through upgrading the skills of existing providers. In many settings it may also mean training and equipping non-medical personnel to provide services commonly reserved for medical staff, since there
are too few medical staff to provide these services, particularly in the areas where they are most needed. Such delegation must be done carefully; tasks must be assigned only to those with the right skills, and staff must receive adequate training, re-training, supervision and support to ensure that tasks are performed correctly.

4. Upgrading and equipping health facilities and providers. This approach is often combined with staff training programs, and is important to ensuring that providers at all levels have the equipment and supplies necessary to perform assigned tasks in a proper fashion.

The components of care and strategies discussed above are the core building blocks for efforts to reduce the number of pregnancy-related deaths and morbidities. The struggle to reduce maternal death and improve reproductive health takes place in many developing countries. The following section -- an overview of select activities in different countries -- spotlights many of the strategies and issues discussed above.

Since the launching of the Safe Motherhood Initiative in 1987, governmental and non-governmental organizations alike have undertaken a wide range of activities to reduce maternal mortality and improve maternal health. The following section provides a brief sampling of current projects and strategies, many of which are described more fully in Appendix I.

A. Health Service Improvements

Many of the Safe Motherhood projects planned or underway aim to improve the health service delivery system, and the quality of care women receive during pregnancy and delivery.

Health provider improvements can range from increasing numbers, to improving the quality and range of their skills, utilizing more appropriate types of personnel, to a better distribution of health workers.

- As part of Indonesia's national effort to lower maternal mortality, the Ministry of Health is revising its policy regarding the training of midwives, in order to improve their availability and skill, and enable them to become a primary source of family planning and maternal and child health care at the village level. The quality of their training will be strengthened, and teaching materials and equipment improved. Certification and examination procedures for these workers and accreditation standards for nurse midwifery training schools will be made more rigorous. The project aims to more equitably deploy and increase the effectiveness of about 16,000 community midwives.

- An essential part of the home-based maternity care project in Matlab, Bangladesh, is its efficient chain of referral and transport, maintained by posting professional midwives at the community level to assist traditional birth attendants (TBAs), should complications arise during pregnancy and delivery. The midwives can provide immediate treatment, or accompany women to the district hospital when needed. Each midwife is supported by a locally recruited village man who accompanies her, especially at night, transmits messages, carries equipment and a lantern, and assists in transporting the patient by stretcher or boat. The program also includes prenatal home visits by midwives. This allows midwives to build a relationship with and gain the trust of the women and their families earlier in the pregnancy, to screen the women for signs of potential complications and provide them with information.
• In Ghana, a "Life Saving Skills" (LSS) training program to provide midwives with the skills to perform emergency obstetric techniques is being conducted by the Ghana Registered Midwives Association (GRMA), in collaboration with the American College of Nurse Midwives. A total of 120 midwives were selected to participate in the initial phase of the hands-on training program: 60 from the private sector, and 60 from the public sector. Distance from appropriate care is an important contributing factor in maternal deaths; as such, all of those selected for the program practice at least two hours away from the nearest referral center. Several hospitals in different regions of the country were used as training sites. An obstetrician staffed the program at each training facility, to both train and supervise the midwives, and to support and advocate an expanded role for midwives within the medical/hospital community. The success of the initial training has prompted the Ministry of Health to extend the program by establishing two more LSS training sites, and by building the improved Life Saving Skills component into the curriculum at one of the country’s midwifery schools.

• A recent government-sponsored project in El Salvador is training additional community health promoters and birth attendants, to allow more equitable distribution of health workers around the country. The project aims to improve the delivery of adequate primary health care and referral services for 80 of the country’s most disadvantaged municipalities. The project’s goal is to deploy one health promoter per 1,500 inhabitants, and one trained birth attendant per community.

• In Togo, in an effort to increase the effectiveness of the existing health care network, a government-sponsored Safe Motherhood project is introducing an enhanced package of maternal health services, including family planning. Traditional birth attendant training will be expanded and community health workers will be trained and provided with basic drugs and contraceptives. Rural Basic Health Units (BHUs) and Maternal and Child Health (MCH) centers will receive additional female paramedical staff, and health staff will be trained and provided with contraceptive supplies to make family planning services available in all health facilities.

Emergency care, including effective referral and transportation systems are critical components of Safe Motherhood programs.

• The Quetzaltenango Project in rural Guatemala is in the process of developing a pictorial maternity card depicting a select number of the most prevalent and dangerous situations. Traditional birth attendants (TBAs) will be able to send patients to health facilities and alert health staff using this card. Health staff can also use the card to alert the TBAs to additional
problems encountered, enabling joint patient management. To improve relationships between providers at different levels of the health system and the functioning of the referral system, and to identify training needs and discuss the problems TBAs confront, regular meetings will be held between TBAs and district health staff.

- The effectiveness and responsiveness of Grenada’s referral system for pre-eclampsia, ante-partum hemorrhage, gestational diabetes, and malpresentation has been essential to their having achieved and maintained low maternal mortality. A well-established referral system is in place to provide obstetric consultations to those with prenatal or intrapartum complications, including reliable communications and emergency transportation systems. Grenada’s national maternal health program also sponsors weekly prenatal clinics at satellite health stations. Each patient is given a personal prenatal care record on her first visit. She is asked to present it at each visit during pregnancy, and to take it to the maternity unit or hospital when delivery is imminent to ensure effective and continuous care throughout pregnancy.

- In Senegal, the government has started a program to strengthen the emergency referral system. They use local committees responsible for maternal and child health care in the community, and have instituted an information system to follow women who were referred to a higher level of care. The program will also strengthen emergency obstetric services and provide more resources for family planning and surgical obstetric care services at district hospitals.

Family planning programs are important in many settings.

- The Bangladesh Women’s Health Coalition (BWHC) aims to improve women’s reproductive health by providing women with the information and services they need to make their own family planning choices. All staff are trained to provide family planning information, and the counselor and client discuss the woman’s knowledge of family planning, her thoughts about what she wants, and the appropriateness of a method for her particular situation. BWHC offers a choice of family planning methods including the pill, injectables, IUDs, and barrier methods. BWHC does not perform sterilization procedures, but it will recommend the nearest appropriate facility. BWHC also provides menstrual regulation (MR) services as part of its comprehensive program of women’s health care. MR can be used for diagnostic purposes or to eliminate the possibility of an unwanted pregnancy, but the procedure is performed only if no more than 10 weeks have passed since a woman’s last menstrual period.
Approximately 95,000 MR procedures a year are reported in Bangladesh, with most performed in government hospitals and health and family planning clinics.

- In Malawi, a pilot community-based contraceptive distribution program is being extended to all districts as part of the country’s national Safe Motherhood program. Community health workers are now equipped with supplies of contraceptives, and trained in family planning services and counseling. The skills of Basic Health Unit (BHU) and Maternal and Child Health (MCH) staff are also being upgraded. BHU and MCH staff will be provided with contraceptive supplies to make family planning services available in all health facilities. Through the project’s "strengthening of basic programs" component, the number of women Health Surveillance Assistants (HSAs), Enrolled Nurse Midwives (ENMs), and Community Health Nurses (CHNs) will be increased to promote woman-to-woman contact, and raise women’s consciousness about safe motherhood, birth spacing, and maternal and child nutrition.

- The decline in Brazil’s population growth rate over the past three decades is due to a dramatic decline in fertility, from a Total Fertility Rate (TFR) of 6.3 in the 1950s, to about 3.3 today. The fertility decline is due in part to rapidly increasing contraceptive prevalence rates; about 66 percent of married women in Brazil now use contraceptives. Nonetheless, access to a broad range of contraceptives is quite limited. Almost 80 percent of users rely on one of two methods, sterilization or the pill. In response to this situation, a large-scale health program has been launched in Northeast Brazil, including an expanded family planning component. Information and education on family planning is provided, screening for sexually transmitted diseases is conducted, and a wider range of contraceptive methods are being offered.

- Women’s savings groups, combined with family planning motivation and supplies and services, have been shown to be an effective strategy for raising contraceptive prevalence in rural Bangladesh. In 1982, Save the Children’s Women’s Program (SAVE) introduced savings groups on an experimental basis in 13 villages in rural Bangladesh. Preliminary results show that contraceptive use, both ever and current, is higher among members of savings groups than among non-members. These results obtain in spite of the fact that members and non-members of savings groups have equal access to family planning motivation and services offered by SAVE.
Prenatal coverage is another major aim of Safe Motherhood programs.

- Through 10 community MCH centers, the Maternal and Child Welfare Association of Pakistan (MCWAP) provides comprehensive Family Planning/Maternal and Child Health (MCH) services in poor areas of Lahore, Pakistan. Staffed by a trained Lady Health Visitor (LHV), a trained dai (traditional birth attendant), and one or two dai-trainees, these centers provide prenatal, delivery, and postpartum care, as well as contraceptives, and child health services. The program emphasizes identifying and enrolling women in the early stages of pregnancy and bringing them to centers for prenatal care, monitoring, and follow-up. The centers also sponsor related community projects including classes on nutrition, and breast-feeding.

- As part of Tunisia's national plan, prenatal care is being expanded. All physicians and female health staff employed in Basic Health Center facilities and outreach services receive training in gynecological screening and prenatal care. Mobile clinics and outreach teams will increase coverage of prenatal care, principally through home visits.

Abortion care is also an essential Safe Motherhood priority.

- Hospitals are often overwhelmed by women seeking treatment for the complications of unsafe abortions. Kenyatta National Hospital in Nairobi, Kenya is no exception. Until the late 1980s, the method used for treating incomplete abortion (sharp curettage, or D&C) required an operating theater, general anaesthesia and a period of recovery in the hospital. In the last decade, improved technology has reduced mortality due to the complications of unsafe abortion. One of these techniques, Manual Vacuum Aspiration (MVA), was introduced in Kenya in 1987. Considered a safer procedure than methods used before its introduction, MVA is used for the treatment of incomplete abortions without the use of general anaesthesia, and can be provided safely on an outpatient basis. Patients usually feel well enough to be discharged within hours of treatment.

B. Communications

Information, education, and communication (IEC) efforts are essential to the effectiveness of all Safe Motherhood interventions. Advocacy to influence policy-makers, training of health care workers, and educating women about their health are all important ways to inform and motivate people around the issue of maternal health. Such efforts also can secure vital community participation.
The MotherCare Reproductive Health Project in Cochabamba, Bolivia is developing its IEC interventions on the basis of comprehensive quantitative and qualitative research findings. Educational messages and materials for health professionals, media campaigns, and other strategies for reaching women and their families with critical reproductive health information are now being considered. Once materials and campaigns are developed, public sector and NGO health care providers will receive training to improve their reproductive health education and counseling skills.

As part of a postpartum program in Sfax, Tunisia, the link between the mother’s health and that of the infant is stressed from the day of delivery. By linking a follow-up visit to a day of traditional significance (the fortieth-day after birth), the program has been tremendously successful in ensuring that women return for this critical post-partum visit. The fortieth-day consultation is also promoted through the use of audio cassettes routinely played in the maternity ward. These tapes contain ten minutes of popular traditional music and eight minutes of information about the importance of breast feeding, basic childcare practices, and the fortieth-day visit.

In eastern Nigeria, several local women’s groups have formed a regional Safe Motherhood network. The effort began after group members attended seminars and a national conference held in 1990. These women are working together to design and implement community-based health education and training programs.

In Tanzania, UNICEF is supporting a pilot Safe Motherhood project, which includes advocacy and information seminars from the village to the district levels to raise awareness about the magnitude and causes of maternal mortality and encourage countries to address these causes. Both health-related and underlying issues, such as women’s workload, legal reform and nutrition of girls, will be addressed.

C. Research

Research is important to understanding the nature and extent of women’s reproductive health problem and to assess the effectiveness of interventions and programs. Research efforts related to maternal health are underway in many countries. Those listed below are only a small sample.

Epidemiological

Community-level studies to gather information on the magnitude and causes of maternal mortality have been carried out in Guinea and Ecuador with assistance...
from WHO. Preliminary findings confirm that abortion is a leading cause of maternal mortality in Guinea, and that hypertensive disorders of pregnancy and hemorrhage are the leading causes in Ecuador.

- In Egypt, research was undertaken by the Population Council to shed light on the prevalence of reproductive morbidity and women’s perceptions of these problems, as well as perceptions of local health services. All women (500) in a small rural village were interviewed and given clinical examinations and tests to identify their reproductive health problems. The findings of the study were used to sensitize the traditional medical community about the serious reproductive health problems women face, and how women perceive their own health problems and the formal health care delivery system.

Operational

- A multi-year operational research program is being conducted by Columbia University’s Prevention of Maternal Mortality Program (PMM) in conjunction with eleven multi-disciplinary teams from Universities in West Africa (seven in Nigeria, two in Ghana, and two in Sierra Leone). The purpose of the program is to assess the causes of maternal mortality in select communities, and develop interventions to reduce maternal deaths in those areas. To date, the PMM teams have conducted initial needs assessments and have begun small projects to increase the availability of emergency obstetric services.

- WHO is examining the effectiveness of a variety of interventions. For example, a study in Colombia is assessing the impact of maternity waiting homes; studies in Malaysia, and Thailand are evaluating the effectiveness of the partograph; and continuing education and training programs for traditional birth attendants are being evaluated in Bangladesh and India.

Methodological

- The Maternal and Child Epidemiology Unit at the London School of Hygiene and Tropical Medicine has undertaken a multi-year program to evaluate existing methods of measuring maternal health in developing countries, and to test new methods in collaboration with research partners in developing countries, including Nigeria, Bangladesh, Honduras, and Egypt.

- The Population Council, IPAS and WHO sponsored a seminar on methodological issues in abortion research in 1989. The seminar gathered together service providers and prominent social scientists from around the world who are involved in abortion research. The purpose of the seminar was to discuss the difficulties inherent in the study of abortion, review and appraise various methodological approaches used to study the topic, and suggest new and innovative research
approaches that could be applied. The proceedings of the meetings have been widely disseminated.

D. Cooperation and Partnerships

At all levels -- international, regional, national and local -- one of the distinctive features of the Safe Motherhood Initiative is the way in which partnerships have been formed to support and develop program efforts. In light of the magnitude and multiple causes of maternal mortality and morbidity, Safe Motherhood advocates have stressed the need for multi-faceted, inter-sectoral program approaches. While governments clearly have a major responsibility for developing programs and instituting policy reforms to make motherhood safer, women’s groups and NGOs play a key role. They are an important complement to often restricted government resources, and often more responsive to community needs, sensitive to local customs, innovative, and cost-effective. In many settings, they may be the most effective -- if not the only -- fora through which women can voice their needs and develop appropriate responses. Examples of partnerships include the following:

- In Tanzania, the national Safe Motherhood strategy has been developed by a national Task Force that includes representatives from UMATI (the national family planning association), UWT (the women’s organization of Tanzania), the Red Cross, the Tanzania Media Women’s Association, the Christian Medical Board of Tanzania, associations of lawyers and other professionals, and representatives from the Ministry of Health and Ministry of Community Development, Women and Children, and as international agencies including UNFPA, UNICEF and WHO. The strategy includes an expansion of maternal health services by the government, community awareness seminars, and the production and distribution of community health educational materials by several of the NGOs involved.

- The recently completed Central America Safe Motherhood meeting involved representatives from nine Central American and Caribbean countries. Participants, including five national Ministers of Health, 30 parliamentarians, women’s rights organizations, health and family planning professionals, and journalists, worked together for five days to develop multi-sectoral regional and national plans to combat maternal mortality in the region. Recommendations addressed the need to develop national reproductive health plans, a more forthright recognition of the magnitude and consequences of abortion as a public health problem, and the need to incorporate sex education into the formal and informal educational systems.
Representatives from the Inter-agency group for Safe Motherhood, seven international agencies actively involved in Safe Motherhood activities, meet semi-annually to exchange ideas, develop cooperative strategies and to ensure appropriate resource allocations for Safe Motherhood efforts.

Following the Niamey Safe Motherhood conference in 1989, the Regional Resource Group on Safe Motherhood, composed of African experts in maternal health, was formed to promote and strengthen Safe Motherhood programs in sub-Saharan Francophone Africa. With representatives from seven Francophone countries, the group is available to assist African governments and international organizations to formulate programs for maternal health, and to assist governments and local organizations to develop and initiate appropriate and integrated Safe Motherhood activities.

E. Advocacy and Information

The purpose of advocacy is to bring the issue of Safe Motherhood to the attention of policy-makers and the public, and to mobilize them to action. As general awareness increases as to the dimensions of the problem, individuals and organizations, both within and outside the health professions will be motivated to examine the causes of and find solutions to the problem of maternal mortality. Sharing information is also an important way of maintaining momentum and continually increasing the number of people informed about Safe Motherhood.

Conferences and Workshops

At the regional and national levels, almost 90 countries have already participated in advocacy and program development workshops since 1987. Most recently, activities were launched for the Latin America and the Caribbean region through a Central American conference in Guatemala in January 1992. Such activities have been pivotal starting points for the development of the national and local plans and strategies discussed in this paper (see Appendix I for case studies and Appendix III for a list of all national and regional Safe Motherhood conferences).

Publications

- Since the Safe Motherhood Initiative was launched, many of the international organizations involved in the Initiative have published, and continue to publish a variety of related materials. These include:
  - a kit of resource materials describing innovative programs for planners and managers, four Safe Motherhood videos, factsheets, and various national and regional conference reports produced by FCI;
  - an ongoing series of reports on issues related to maternal health published by the World Bank;
  - topical papers from the Population Council’s Ebert program;
  - a Safe Motherhood chart book, additional reports and materials from Columbia University’s Prevention of Maternal Mortality Program;
  - several reports from the Maternal and Child Epidemiology Unit of the London School of Medicine and Tropical Hygiene; and
  - a variety of materials from the MotherCare Project.

For copies of these and other materials, please find contact information in Appendix II, which is a directory of organizations involved in Safe Motherhood-related activities.
4. SUMMARY and DISCUSSION

The Safe Motherhood Initiative rests on humanitarian and economic imperatives. Women should not die from preventable causes. Society, the economy and families should not lose needed members in the prime of life.

The major direct causes of maternal death are known, and cost-effective interventions to address them exist. Family planning, abortion services, routine and emergency delivery care, prenatal and postpartum services comprise the ideal continuum of care. Access to these services is limited by resources and other constraints that vary from setting to setting. Social, economic, legal and political realities will affect the design of Safe Motherhood programs and influence their ability to achieve or approximate the ideal.

The efforts undertaken to date reflect a range of strategies, and provide some useful lessons for future efforts. For example:

- Increasing access to family planning is critical and cost-effective;
- Training providers at all levels of the health system to improve care and increase communication and cooperation between different levels increases women’s access to appropriate care;
- Partnerships are a critical and creative way to address important problems (e.g., transportation) that influence women’s ability to receive appropriate care;
- Communications strategies expand peoples understanding of the issues and enhance their use of appropriate care.

The number of people and organizations active on behalf of the Safe Motherhood Initiative continues to grow. But even as its efforts to reduce maternal mortality and morbidity expand, questions remain about whether this focus is broad enough for the Safe Motherhood Initiative, given the many other problems that plague women’s reproductive lives.

Proponents of a strict mortality-focus believe that momentum will be dissipated and opportunity lost if the spotlight does not remain on maternal death. Preventing death has an urgency that summons support and commitment, while broader goals may not. Indeed, it was the growing awareness of the appalling toll of maternal death that initially galvanized world attention in the mid-1980s and continues to expand the Initiative’s constituency today.

But some say maternal death is only the most blatant manifestation of the general neglect of women’s health concerns which in turn, reflects broader and widespread discrimination against women. They caution that the narrow focus on mortality can obscure the full extent of the harm and disability that many more women suffer as a result of their sexual and reproductive functions. Indeed, the focus on one outcome -- death -- leaves out the four other "D’s: disease, disability, discomfort and
dissatisfaction," which may be of far greater concern to women than maternal death (Graham and Campbell, 1991). Status issues and chronic ill-health may determine many of these morbidities, but they are not always addressed in efforts that stress immediate reductions in maternal mortality. Given the numbers of women affected by reproductive morbidities, shouldn't the Safe Motherhood Initiative more actively seek to alleviate some of this suffering?

The mortality focus of the Safe Motherhood Initiative tends to stress a particular time interval in a woman’s reproductive life -- namely, pregnancy, delivery and the puerperium. The concern is that such a focus maintains and perpetuates an over-identification of women with their reproductive function. The Initiative may make pregnancy, delivery and motherhood safer, but it does not adequately question social mores and traditions that largely limit a woman’s worth to her reproductive role.

In response to concerns about whether the Initiative poorly serves women by focusing on mothers, the pragmatic rationale for Safe Motherhood -- both the label and the programs -- appears to hold. First, most women in the world will become pregnant, if not mothers. They need care. Second, safe pregnancy and childbirth practices and improved maternal health are indisputably desirable and politically safe goals for virtually all health officials. Moreover, Safe Motherhood has proven an effective vehicle for discussing and developing strategies to address sensitive topics such as abortion, harmful traditional practices, and sexually transmitted diseases.

The question has also arisen as to how far the Safe Motherhood Initiative should venture beyond maternal health initiatives into "non-health" areas such as education and the law to achieve its objectives. Since 1987, many active on behalf of the Safe Motherhood Initiative have stressed the connection between maternal-ill health and the socio-economic conditions in which women live. Socio-cultural, economic and educational practices that discriminate against women have an adverse impact upon their health and welfare. This fact has helped to broaden the Safe Motherhood constituency to include agencies outside the health sector. And, while changes in some of these sectors (increasing educational access and attainment of girls, for example) may have no immediate impact on maternal mortality rates, they are expected to have an indirect impact through empowering and enabling more women to utilize health services or improve their own health. Involving a broad constituency in Safe Motherhood efforts has benefits for Safe Motherhood programs and other health and development initiatives. It encourages others to recognize the potential impact of their efforts to improve reproductive health, while illustrating to them the importance of Safe Motherhood -- i.e., healthy women -- to their own development goals.

Finally, monitoring the progress and impact of Safe Motherhood programs is critical, and should help provide important feedback on the success of different interventions. A concerted effort to improve our information base will enable us to move forward in determining program scope, goals and configuration of interventions, and thus guide
future program developments. Baseline data on maternal mortality levels is generally of poor quality in many settings. It is also difficult to monitor the large number of women required for calculating a maternal mortality rate or ratio. Both make it difficult to measure program effectiveness in reducing maternal mortality. This is true for mortality-related information, but it is even more true for morbidity, for which data sources often do not exist at all. More information on the scope and nature of maternal morbidity, and broader aspects of women’s reproductive health, would assist in efforts to ensure that these issues receive the attention they deserve.

There are a number of efforts underway to expand and improve data bases or improve the utilization of existing data. Practical considerations have led to proposals for measurement techniques, such as the “Sisterhood Method” and a spectrum of process indicators linked to maternal outcomes. These include proposals to measure health service indicators, such as percentage of different health personnel trained in emergency obstetrical procedures, percentage of communities with effective transport capabilities for referral, etc. (Koblinsky, 1992). Efforts also are aimed at developing improved morbidity and health-status measurement techniques.

Clarifying the goals and content of Safe Motherhood programs has been a constant theme over the past few years. Sustainable improvements in women’s reproductive health require immediate efforts to reduce maternal mortality and related morbidity, and long-term efforts to address the broader reproductive health problems women face. The Safe Motherhood Initiative should strive to address the immediate concerns of today’s women while laying the foundation for the safer reproductive lives of the next generation.
APPENDIX I: CASE STUDIES FROM THE FIELD

<table>
<thead>
<tr>
<th>Country</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>27</td>
</tr>
<tr>
<td>Bolivia</td>
<td>36</td>
</tr>
<tr>
<td>Botswana</td>
<td>38</td>
</tr>
<tr>
<td>Brazil</td>
<td>40</td>
</tr>
<tr>
<td>El Salvador</td>
<td>42</td>
</tr>
<tr>
<td>Gambia</td>
<td>43</td>
</tr>
<tr>
<td>Ghana</td>
<td>45</td>
</tr>
<tr>
<td>Grenada</td>
<td>47</td>
</tr>
<tr>
<td>Guatemala</td>
<td>50</td>
</tr>
<tr>
<td>India</td>
<td>53</td>
</tr>
<tr>
<td>Indonesia</td>
<td>56</td>
</tr>
<tr>
<td>Kenya</td>
<td>58</td>
</tr>
<tr>
<td>Malawi</td>
<td>59</td>
</tr>
<tr>
<td>Namibia</td>
<td>60</td>
</tr>
<tr>
<td>Nigeria</td>
<td>62</td>
</tr>
<tr>
<td>Pakistan</td>
<td>64</td>
</tr>
<tr>
<td>Peru</td>
<td>67</td>
</tr>
<tr>
<td>Senegal</td>
<td>68</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>70</td>
</tr>
<tr>
<td>Tanzania</td>
<td>71</td>
</tr>
<tr>
<td>Tunisia</td>
<td>73</td>
</tr>
<tr>
<td>Turkey</td>
<td>75</td>
</tr>
<tr>
<td>Uganda</td>
<td>76</td>
</tr>
<tr>
<td>Francophone Africa Regional Plan</td>
<td>79</td>
</tr>
<tr>
<td>Latin America Regional Plan</td>
<td>82</td>
</tr>
</tbody>
</table>
BANGLADESH

Safe Motherhood in Bangladesh

After the 1987 Safe Motherhood Conference held in Nairobi, the Government of Bangladesh formed a Maternal Health Care Sub-committee. In 1988, the government initiated an extensive assessment of maternal health services, in collaboration with WHO, UNICEF, and NORAD. This assessment revealed a number of gaps and constraints as well as insight into sociocultural influences in maternal health. Even though the Government of Bangladesh had been investing in the institutionalization of family planning (FP) and maternal and child health (MCH) care programs for 16 years, the maternal mortality ratio (MMR) remained high at 700 per 100,000 births. In order to evaluate these findings and to develop effective strategies, a National Maternal Health Care Workshop was held in February 1989. The workshop brought together professionals from all spheres of maternal health care, relevant ministries, non-governmental organizations, and international agencies. Recommendations were in the following five areas: management support for maternal health services; logistics and referral for maternal health care; training for maternal health personnel; information, education, and motivation; and the role of non-governmental organizations (NGOs).

Following the Workshop, a National Safe Motherhood Plan of Action was developed, to be carried out by the National MCH Coordination Committee. The goal of the national plan is to reduce maternal and neonatal morbidity and mortality, and to develop an effective, comprehensive maternal and neonatal health care program for replication throughout the country. This plan is national in scope and requires coordination between NGOs, local communities, and the government at the regional and district levels. Several district projects have now been launched, including the three listed below.

- As a "medium-term activity," the committee proposed a four year "Maternal and Neonatal Health Care Project" to be implemented from 1992-1995 in four districts, with a view to eventual extension to all Bangladesh districts. The project emphasizes improved management of personnel, logistics, and the referral system. All medical officers will be trained in obstetrics and gynecology.

- The government's MCH Committee has implemented a five-year Safe Motherhood project 1992-1996. The project aims to promote Safe Motherhood by strengthening general health service delivery by increasing the range of maternal and neonatal health services, and improving nursing and medical education. In support of the project's initial plans, the project will assist in reinforcing information systems, improving family planning and health management, expanding communications programs, supporting NGO activities, and developing innovative projects. In addition, as mentioned above, an initiative has been launched to begin specialized training for medical officers at the
Primary Health Care level. Nearly 800 doctors will be trained in essential Obstetric Functions in order to provide emergency obstetric services and handle complicated cases at the sub-district level. Finally, the project will support the further development of three women's programs and the National Nutrition Council, in anticipation of a substantial increase in nutrition programming.

- In collaboration with the United Nations Population Fund (UNFPA) the government also intends to undertake a specific project to provide adequate care for mothers and children through the renovation of Maternal and Child Welfare Centers (MCWCs) in Rajshahi Division, which has the highest population growth rate in the country. The Directorate of Family Planning, on behalf of the Government of Bangladesh, will implement the project.

The long-range objectives of this project are to assist the government in achieving its national family planning objective: contraceptive prevalence rate of 50 percent by 1995. The government plans to strengthen the integration of MCH/FP services to reduce maternal mortality to 450 per 100,000 live births and infant mortality to 80 per 1,000 live births, increase prenatal and postpartum coverage by 30 percent, and expand immunization to reach 85 percent of all children under two years of age.

The project’s immediate objective is to revitalize 14 MCWCs in Rajshahi, to link the MCWCs to lower level service points and providers as special MCH centers equipped to manage high-risk pregnancies and emergency obstetric and gynecological cases, and to provide field level, practical training opportunities for medical interns, nurses, and paramedical personnel.

The project will begin with improvement and expansion of the physical facilities, arrangements for supply of equipment and drugs, and technical and administrative training of personnel. Education and motivation of the community and the institution of proper record keeping and reporting procedures and supervision mechanisms will also be undertaken. Service delivery and referral linkages will be created and a practical training site and appropriate curricula will be developed for interning doctors, nurses, and paramedics.

The project coordinating committee identified a need for additional TBA training because ninety percent of all deliveries in the region are performed by TBAs. It is felt that an additional political commitment to Safe Motherhood and to women's issues in general must be made to facilitate further progress.
Reproductive Health in Bangladesh: Bangladesh Women's Health Coalition

There are forty-five million girls and women in Bangladesh, most of whom live in conditions of relentless poverty. A work day of 14-16 hours is common; in addition to caring for her husband, children, and in-laws, as well as performing household tasks, a woman often takes on other work to earn much needed money. Young girls usually care for younger siblings and manage the house; they have no time to go to school.

After a girl reaches puberty, she is protected from encounters with any man who is not a family member. Early marriage is the norm and social pressures force most women to have many children quickly. Nonetheless, girls and women have limited access to modern health services, which are unavailable, out of reach, or too expensive. In addition, most doctors are men, and it is usually unacceptable for women to be examined by male doctors except in cases of emergency, when it is often too late. At any one time, approximately five million women in Bangladesh are pregnant, 13 million are at risk of becoming pregnant and, of these, no more than 25 to 30 percent use modern contraception.

Since 1971, the Government of Bangladesh, in collaboration with local, national, and international non-governmental organizations (NGOs), has sought to provide contraceptive services, especially in rural areas. Reversible contraceptive methods (pills and injectables), condoms and foam, as well as female and male sterilization, are offered through NGO and government clinics and field programs. In addition, a large social marketing program sells condoms, foam, and pills at subsidized prices through a nationwide network of small shops.

Little care is available for most pregnant women, although governmental and non-governmental programs do provide tetanus vaccinations, nutrition information, and health education in some areas. The majority of women give birth at home, attended only by relatives or an untrained traditional birth attendant (TBA). Approximately 24,000 women die in childbirth every year. Within one year, 95 percent of the children born to these women are also dead.

Every year, an estimated 750,000 Bangladeshi women have abortions, generally under dangerous clandestine circumstances. At least 7,500 women die each year of the complications of unsafe abortion, and several thousand others are left sterile or seriously ill. Induced abortion is legally restricted in Bangladesh, and only the major teaching hospitals are equipped to provide abortions after ten weeks gestation. However, the Government of Bangladesh does provide menstrual regulation (MR) services for women who fear they may have an unwanted pregnancy. The practice of MR (both reported and unreported) saves between 100,000 to 160,000 women in Bangladesh from the dangers of unsafe abortion each year.
Bangladesh Women’s Health Coalition (BWHC) was founded in 1980 to address some of these maternal and women’s health problems. From one urban clinic focusing on the provision of MR services, BWHC has grown to include seven multi-service clinics in urban and rural areas. In 1989-1990, BWHC clinics served approximately 97,000 women and children, providing counseling, contraception, menstrual regulation, basic children’s and women’s health care, prenatal care, immunization, and referral to hospitals and clinics for other gynecological and obstetric care, including sterilization. BWHC’s guiding premise is that informed choice is as essential to a reproductive health program as are medical safety and access to contraceptives. While BWHC was originally founded to provide MR, its sensitivity to the needs of its clientele quickly led to the delivery of more comprehensive services for women and their children. In 1989-1990, 25 percent of the services provided by BWHC were related to family planning, including MR, 38 percent to women’s gynecological, obstetrical, and health problems, and 37 percent to children’s health and immunization. The basic health care services for women and children offered at all BWHC clinics include treatment for such illnesses as dysentery, scabies, upper respiratory tract diseases, eye infections, and anemia.

No matter what the reason for their original visit, at BWHC, all women learn about and have access to the full range of BWHC services. A minimal registration fee is charged at all clinics. Two clinics charge fees for services on a sliding scale basis. Since February 1990, nominal service fees have also been instituted in other clinics to facilitate BWHC’s move toward self-sufficiency. Paying for services also seems to increase clients’ self-respect. However, no one is ever turned away because she cannot pay.

Each BWHC clinic is staffed by two or three paramedics (Family Welfare Visitors), a project coordinator or administrator, a counselor, a nurse’s aide who dispenses medicine, two attendants, and two guards. All staff members, except the guards, are trained to provide health and family planning information to clients. They are supervised by full-time physicians, who also provide all maternal and child health services except immunizations. Two clinics have full time counselors on staff. At the other five clinics, the project coordinators serve as counselors, and interpersonal skills are valued highly.

At BWHC, counseling is an important component in the delivery of all services. The aim is to put the client at ease and encourage her to ask questions as well as to share information with her. A conscious effort is made to overcome the class barriers that exist between the counselors and most of their clients, and to avoid patronizing clients. Women are counseled in as much privacy as possible. When all the woman’s particulars have been noted, she and her counselor discuss her knowledge of family planning, her thoughts about what she wants, and the appropriateness of particular methods for her situation. BWHC offers a choice of family planning methods including the pill, injectable, IUD, and barrier methods. Counselors discuss all these methods, and sterilization, with their clients.
Following initial screening by a receptionist, clients are directed to the appropriate staff. In the three clinics where there are resident female doctors, women with gynecological problems are treated by physicians. At the other four clinics, women are examined by paramedics, who work under the supervision of a male doctor. BWHC has established working relationships with a variety of health providers, including government hospitals and private physicians, and a BWHC registration card, with a doctor’s comments, is honored by these providers.

The maintenance of accurate and accessible records is a vital component to the provision of high quality care, by facilitating continuity of care and appropriate patient management. Data collection, however, must be selective in order to avoid needless, burdensome paperwork. Each mother is given numbered registration card to keep. The registration card records the name and address of the mother and the names of all her children. There is space on the reverse side to note the dates of follow up visits for individual family members. One sign-in registration book is maintained for all clients visiting a clinic; if a client has lost or forgotten her registration card, the book serves as a backup. The core of the data collection system is a family file, which contains service summary sheets and health, family planning, and prenatal forms. It is opened at the first visit and is kept at the clinic.

Another important element in BWHC’s success has been the development of advisory committees to help establish and maintain good rapport with the local community. Every year the Coalition provides free clinical training in family planning service delivery for Female Health Visitors enrolled in government training programs and in-service refresher programs. Overall policy is the responsibility of an executive council of six prominent Bangladeshi women committed to issues of women’s development, including a social scientist, a professor of gynecology, a lawyer, a researcher, and an educator. (Kay et al., 1991)

Matlab: Posting Trained Midwives in Rural Bangladesh/The Matlab Maternity Care Project

The Matlab district of Bangladesh is located 40 miles southeast of Dhaka, the country’s capital, in the rural, flood-prone Ganges-Meghna delta region. Eighty five percent of the area’s 200,000 people are Moslem, and the active practice of Purdah is the norm. Women’s mobility is limited to the household compound and they have minimal exposure to adult men other than relatives. Female literacy is only 17 percent. Women are virtually invisible in labor statistics, though their multiple responsibilities include childcare, maintenance of the physical household structure, and food processing and preparation. Female children receive less food and health care within the family than their brothers, and are often chronically undernourished.
Nearly 80 percent of women are married by age 20. Suicide and homicide are common outcomes of illegitimate pregnancies. Talking about reproductive issues is considered inappropriate, limiting access to care when problems arise. Matters related to the female genital tract are associated with shame, though women may exchange experiences freely among themselves, particularly within their compound.

Walking and rickshaws, when available, serve as the main modes of transport to health facilities, even in emergencies. Transport by boat is also common, but boats are often not available, particularly after dark. Night travel is further limited by lack of electricity, and taboos associated with women leaving home at night, when pregnant. Twenty-five percent of all adult female mortality is due to direct complications of pregnancy and childbirth.

Since 1966, the International Center for Diarrhoeal Disease, Bangladesh, has operated a rigorous demographic surveillance system in Matlab. In the late 1970s, the area was divided into an intervention area, where a maternal and child health and family planning (MCH-FP) project was implemented, and a control area, which receives government health services. Female Village Health Workers (FVHWs) provide a full range of contraceptive methods through home-based delivery, monitor and manage adverse effects, provide a range of child health services, and refer women and children to MCH-FP outposts staffed by paramedics or to the Central Matlab clinic, when necessary. While contraceptive prevalence rates have increased from eight in 1977 to 56 percent in 1989. The provision of family planning services in the area is responsible for a reduction in the number of pregnancies and, consequently, a 57 percent reduction in the number of pregnancy-related deaths. The risk women face once pregnant, however, remains high, as reflected in a maternal mortality ratio (MMR) of 550 per 100,000 live births. In addition, unsafe, induced abortion, remains a primary cause of death. As part of the MCH-FP project, the FVHWs also provide women with safe delivery kits and iron tablets, and area traditional birth attendants (TBAs) are trained in hygienic delivery practices. While these interventions have helped to reduce neonatal mortality, which was their primary objective, their impact on maternal mortality has been limited.

A retrospective study of maternal mortality in Matlab found that the main causes of death, in order of importance, are unsafe induced abortion, postpartum hemorrhage (PPH), toxemia, obstructed labor, and postpartum sepsis. Ninety-five percent of all deliveries, and 80 percent of all deaths, occur at home. Most deaths occur during or within 48 hours of labor and delivery. The results of this study, and the failure of the MCH-FP project to improve maternal outcomes, prompted the development of a home-based maternity care project. Professional nurse-midwives were posted at the community level in an effort to ensure timely intervention in complicated pregnancies and deliveries and a functioning referral system. Access to emergency obstetric surgery and blood transfusion in the area is limited to the government district hospital, one hour away. Prior to the introduction of the program, the Matlab clinic had no emergency obstetric capacity. The nearby Chandpur Red Crescent Hospital remains better equipped, but has no surgical capacity either.
The Matlab MCH-FP area was divided into a control and intervention district, comparable in terms of socioeconomic, demographic, and specific health indicators. One nurse-midwife was posted at each health outpost, serving a population of approximately 20,000. The midwives, who had received three years of standard government nursing training and one year of midwifery training, were given a brief orientation but no project-specific training. All were from a rural background and had experience working in traditional communities. They were equipped with a standard midwifery kit, as well as with antibiotics, heavy sedatives, infusions and plasma expanders, and pitocin, to be administered intra-nasally. The focus was on supplementing rather than supplanting, the work of TBAs, who would remain responsible for managing deliveries as far as possible. The midwives were responsible for making prenatal visits to establish rapport with pregnant women, provide information, detect and manage prenatal problems, and screen for potential future complications; encouraging labor calls and attending as many deliveries as possible; providing immediate treatment for complications in labor and delivery when possible; organizing referral and accompanying the patient to the Central Matlab clinic, when necessary; and visiting new mothers as soon as possible after delivery. There were about 1,600 pregnancies a year in the intervention area, or an average of about 33 per month, per midwife.

The aim was to ensure that the complications that arose received appropriate intervention as early as possible, to prevent progression to a severe stage, given the limitations of existing services to cope with severe complications. Examples of feasible timely interventions the midwives could effectively carry out include early administration of anti-eclamptic drugs; complete evacuation of the uterus in case of a retained or torn placenta; vaginal packing in cases of PPH; stitching of vaginal tears; infusion of plasma-expanders in cases of hemorrhagic shock; and administration of antibiotics to prevent severe infections.

Each midwife was supported by a locally recruited village man who accompanied her, especially at night, transmitted messages, carried equipment and a lantern, assisted in transporting the patient by stretcher or boat, and motivated male members of the community. The midwives were also supported by the installation of a maternity clinic at Matlab, with limited emergency obstetric capacity, and at which female physicians were always available. Clinic physicians supervised the midwives, evaluated and managed referrals for which they were equipped to cope (e.g., Dilation and Curettage, management of pre-eclampsia/eclampsia) and ensured timely referral of cases in need of transfusion and surgery to the district hospital. The project was not able to ensure quality of services at the district hospital level.

A communications strategy which aimed to orient the TBAs, familiarize them with the referral system and care facilities, including visits to these facilities, and introduce the midwives was also implemented. Efforts were also made to inform and motivate women and their families. This element of the program was helped enormously by the results of an anthropological study which shed light on family level decision-making dynamics:
while women are involved in decision-making regarding health and health care, they do not make decisions independently. When complications occur, decision-making roles shift, and the mother-in-law, elder sister-in-law, or husband take charge. Another study found that there was often conflict between young mothers and older family women with regard to appropriate health behavior. As is often found, the mother-in-law tends to be the gatekeeper.

Outcomes were measured by comparing maternal mortality ratios in the control and intervention districts during three years prior to and three years following the implementation of the project. The mortality difference between the two areas prior to implementation was not statistically significant. During the three years after the program was implemented, the difference between the two areas was statistically significant, and the ratio in the intervention area had fallen by 68 percent. In short, the introduction of the maternity care program had a substantial impact on maternal mortality.

The causes of death that were reduced by the program were, in order of importance, the complications of unsafe abortion, PPH, postpartum sepsis, and eclampsia. Other causes of adult female mortality were constant over the project period. Although abortion was not a specific focus of the program, the decrease in abortion-related mortality may have been related to earlier intervention in complications by the midwives. In addition, the midwives may have successfully discouraged some women from resorting to dangerous traditional abortion procedures.

Of the 4,884 registered pregnancies, 44 percent were visited at home at least once. Fifteen percent of the pregnant women requested attendance during labor. In nine percent of cases, the midwife herself delivered the baby, and in four percent she attended the delivery but allowed the TBA or a female paramedic to perform the delivery. In two percent of cases, the midwife was on her way. Nineteen percent of the women attended by midwives were referred to the Matlab clinic. Of the 1,712 women visited postpartum, three percent were referred to the clinic.

Some reviewers have questioned the relationship between the small proportion of deliveries attended by the midwives and the reduction in mortality. Although it is not possible to determine exactly which of the home deliveries they performed and which of the patients they referred would have died in their absence, it is legitimate to accept that the averted deaths were drawn from the patients attended or referred by the midwives.

Research was conducted to identify the factors that differentiated women who requested midwife attendance from those who delivered alone or with a TBA. Attended women were more often of lower parity, and were more often primigravidae. Women who lived closer to the midwife's residence, women who had received prenatal care from the midwife, women with poor obstetric histories, women with pathologic signs during pregnancy (e.g., vaginal bleeding), and women who experienced complications during labor were also more likely to be attended. Contrary to what was expected, users and non-users did not differ significantly in terms of socioeconomic status.
The low proportion of requests for attendance may be related to distance or to the rarity of complications. In addition, it is possible that the reluctance of family decision-makers (husbands, mothers-in-law) to call for external assistance was greater than expected. Many would not call until complications had already arisen. Others would be hesitant to call for fear of referral to the district hospital, based on negative past experience and a common perception that quality of care at the facility is poor. (Measham, 1992)
BOLIVIA

MotherCare Reproductive Health Project in Cochabamba

In Cochabamba, Bolivia's third largest city, underutilization of all types of reproductive health care, and other potentially dangerous behaviors related to pregnancy and childbirth, may be the most serious obstacles to improved maternal and neonatal health.

Despite the rapid growth of the medical profession, a large proportion of births in and around the city still take place at home, attended by an untrained birth attendant, who is usually a family member. Even when pregnant women do seek formal prenatal or delivery care, the quality of this care, in both government and non-governmental organization (NGO) facilities, is likely to be poor. Clinic providers typically lack basic equipment, rarely perform or request laboratory exams due to lack of facilities or cost, do not apply risk screening criteria, infrequently refer clients to higher levels of care when problems are detected, have a poor understanding of the importance of proper nutrition during pregnancy and lactation, and provide little problem-specific counseling or education to their clients. Services are also provided by private physicians, but the quality of this care is also questionable, and the cost to the client considerable.

Access to family planning services is extremely limited and, as a result, unwanted pregnancy and induced abortion are common. Abortion-related complications are among the principal causes of maternal death and disability; the Cochabamba maternity hospital reported that 20 percent of the deaths occurring in the facility over a 10 year period were related to abortion complications.

While government policy was recently revised to incorporate family planning as an integral part of maternal health care, public sector services remain inadequate, and are not likely to improve dramatically in the short term.

In response to these problems, the MotherCare Project of John Snow Inc. developed a three year project in urban/periurban Cochabamba. The project aims to reduce maternal and neonatal morbidity and mortality by increasing recognition of problems during pregnancy, delivery, and the neonatal period among women and their families, and by encouraging them to seek medical attention in response to such problems. The project seeks to increase utilization of prenatal, postpartum, and trained delivery care, in part by improving the quality of such care, and by creating a functioning referral system for those experiencing problems. A third goal of the project is to increase the availability of contraceptive services and information to women who wish to postpone or limit childbearing.

The project has four principal components. The first entails initial investigations to provide baseline information on priority problems, to guide intervention design, and to ensure effective measurement of project outcomes. These investigations include a study
of health service costs and pricing alternatives, and studies of attitudes, practices, and perceptions of pregnancy, birth and the immediate postpartum period. Patterns of health service utilization (traditional, public, and private) will also be investigated.

Information, education, and communication (IEC) interventions will be developed on the basis of the study findings, using a social marketing approach. Educational promotional messages and materials for health professionals and media campaigns, and other strategies for reaching women and their families with critical reproductive health information, are now being considered. Once these materials and campaigns are developed, public sector and NGO health care providers will receive training to improve their health education and counseling skills around reproductive health topics.

MotherCare will work with other AID Cooperating Agencies and PAHO/UNFPA to develop and provide in-service training to Ministry of Health and NGO health providers on risk screening and referral for pregnant women, postpartum care and birth spacing methods, and counseling and IEC skills.

Through the project, MotherCare is providing assistance to four NGOs -- ME.DI.CO., PROMEFA, COMBASE, and CPCCM -- in an effort to provide women with better access to low-cost, comprehensive reproductive health care, including family planning services.

The project will be coordinated by a resident MotherCare Technical Advisor and the Director of the Unidad Sanitaria, with the participation of a number of local organizations. (MotherCare Project, John Snow, Inc., 1992)
Launching Safe Motherhood in Botswana

The regional Safe Motherhood conference for southern African countries, held in Harare in November 1990, aimed to sensitize politicians and other leaders about Safe Motherhood issues. Over 12 people from Botswana attended the conference, including representatives from the government, non-governmental organizations (NGOs), and donor agencies. Participants returned to Botswana eager to refine and implement the national Safe Motherhood plan of action they had drafted during the Harare conference.

The health infrastructure in Botswana is relatively sound, with 85% of the population within 15 kilometres of a health facility and adequate supplies of drugs and equipment at almost all facilities. Government commitment to the provision of quality health services is reflected in a very low infant mortality of 37 infant deaths per 1,000 live births, one of the lowest in Africa. Maternal mortality in Botswana, however, is estimated to be 200 deaths per 100,000 live births, with a range from 70-380 for various regions of the country, placing Botswana in the high maternal mortality category. While accurate baseline data on the dimensions and causes of maternal mortality are lacking, health officials believe that the high national rate must be due largely to inadequate care for the 25-35% of women who deliver at home. In addition, many women suffering from pregnancy-related complications arrive at health facilities too late for treatment to save their lives, largely because they do not recognize the onset of a complication or do not know what to do about the problem. Finally, both the health sector and the broader community are concerned about the high and growing rate of adolescent pregnancy, which rose from 15.6% in 1971 to 25% in 1984.

Since the Harare Safe Motherhood conference, Botswana has carried out a number of activities toward the development and promotion of a national Safe Motherhood plan. In November 1990, a conference was organized for members of parliament and the House of Chiefs to sensitize them about the issues involved. In October 1991, Safe Motherhood was a major topic of a workshop on "Information, Education and Communication for Health Development." And in March 1992, a national Safe Motherhood Task Group was formally established to define and implement a national strategy for reducing maternal mortality and improving women's health in Botswana. The Task Group includes government, NGO, and donor agency representatives, and is chaired by the Family Health Division of the Ministry of Health.

The draft strategy, which will be fleshed out and refined in the coming months with the assistance of Family Care International, focuses on training health workers to improve risk screening and the quality of care, especially by promoting sympathetic and humane treatment of women. The second major program component will be to educate and
mobilize the community with regard to Safe Motherhood, targeting women of reproductive age in particular. Major issues that will be addressed by the program include STD/AIDS prevention and teenage pregnancy. Additional research will be carried out to provide baseline data and pinpoint major target groups and issues for attention within the overall strategy. (Starrs, 1992)
Women's Reproductive Health in Brazil: A Basic Health Services Project for the Northeast

As a complement to the rapid socioeconomic change that has characterized Brazil in recent decades, fertility has declined, and women's educational levels and labor-force participation have increased. Brazilian women provide essential economic support for their families, either in conjunction with their spouse or as the sole supporter, and continue to have primary responsibility for the care and health of their children.

Women of reproductive age make up about a quarter of the Brazilian population, yet reproductive health needs are poorly met. While this reflects problems of the health care system in general, women are particularly vulnerable; they are disproportionately poor, and the severity of their health problems is often compounded by their poverty and limited access to services.

Reproductive health services in the public sector are weak, and the quality of care in the private sector is often inadequate. While contraceptive use is high in Brazil, contraceptive choice is very limited. Over 80 percent of all users rely on one of two methods: oral contraceptives or female sterilization. Unintended pregnancies and unsafe abortion are common. The lifetime induced abortion rate has been estimated at two per woman. Illegal and often unsafe abortion explains as much as 20 percent of maternal mortality in Brazil. Cervical cancer is the number one cause of cancer deaths among women. Although cost-effective technologies exist for controlling cervical cancer through regular screening and follow up, it is estimated that only two percent of Brazilian women have been screened by the public health system. The incidence of cervical cancer is inversely related to income. One in four women receive virtually no prenatal care, and the rate of cesarean deliveries, of which half are estimated to be unnecessary, is the highest in the world. Sexually transmitted diseases and other reproductive tract infections, about which extremely little information is available, also pose a growing threat to women's health and well-being.

In recognition of the importance of reproductive health and the gravity of related problems, the Ministry of Health created the Women's Health Program (PAISM) in 1984, to be carried out by the Public Health Network of the Ministry of Health and the State and Municipal Secretariats of Health. The PAISM program concept of comprehensive women's health services is promising, yet implementation of the program has been difficult and slow, in part due to broader problems in the public health system related to management and its curative bias, lack of training, and technical assistance.

Many of the measures needed to improve women's reproductive health in Brazil are neither technically complex nor costly. Health education, adequate prenatal care, provision of good quality contraceptive services, and screening for cervical and breast
cancer are cost-effective interventions that, while technically straightforward, require improved management and financing of basic preventive health care in order to be successfully implemented.

The Ministry of Health has recently launched a project in collaboration with the State Health Secretariats in 10 states of Northeast Brazil (Piauí, Rio Grande de Norte, Alagoas, Bahia, Ceará, Maranhão, Paraíba, Pernambuco, Sergipe, and Minas Gerais (Montes Claros region). The project is targeted mainly toward poor women and children, particularly in rural areas, and illustrates the PAISM approach. It has two main objectives: (a) to strengthen basic health services in selected low-income areas; and (b) to reinforce the implementation of sectoral reforms, including the decentralization of financial resources and administrative authority within the states.

The project has two major components. A Health Services Development component focuses on the delivery of a package of three basic health services: family planning and comprehensive care for women and children, a program of infectious disease control, and a program of ambulatory and hospital-based medical care. The objective is to improve women’s reproductive health by providing information, education and services related to prenatal care, breastfeeding, family planning, sexually transmitted diseases, breast and cervical cancer. Activities include prenatal, delivery, and postpartum care; screening and treatment for breast and cervical cancers and sexually transmitted diseases; and broadening the range of contraceptive methods.

In addition, an Institutional Development component seeks to improve the administration and delivery of basic services and promote the decentralization of the public health network. Related civil works, furniture, equipment, drugs, supplies, incremental operating and maintenance costs, technical assistance, special studies, information, education, and communication (IEC) activities, and training and supervision are financed by the project.
EL SALVADOR

Safe Motherhood in El Salvador

In El Salvador, a country of approximately five million people, the maternal mortality rate (MMR) is 140 per 100,000 live births, and only 56 percent of the population has access to adequate health services. To address this dire situation, the government designed a Health Services Rehabilitation Project geared toward improving primary health care services and expanding Safe Motherhood programs. The project’s main objective is to facilitate the delivery of improved social services to 80 of the country’s most disadvantaged principal municipalities. It is estimated that over 70 percent of those benefitting from improved primary health care services will be women and children under the age of five.

The Ministry of Health would like to increase the primary health care coverage in targeted municipalities, and develop adequate referral services to manage high-risk births and obstetric emergencies. The project plans to expand Primary Health Care (PHC) through outreach activities, which will be organized by trained health promoters and led by traditional birth attendants (TBAs). An additional 342 health promoters will be trained over a three-month period, and 275 more TBAs will be trained in an intensive two-week course. The project aims to place one health care promoter per 1,500 inhabitants, and one TBA per canton (community). Furthermore, there are plans to enhance the first aid services at primary health care facilities by financing equipment and training staff. The project also plans to strengthen the nutritional component of its health care services through educational activities and the provision of essential micronutrients such as iron, folic acid, iodine and vitamin A, to children and pregnant and lactating women.

The national health program will upgrade its maternal care referral system by posting qualified professionals to secondary level facilities and ensuring that they are available on a 24-hour basis. The quality of emergency obstetric care will be improved by training staff and purchasing appropriate equipment at the primary and secondary levels. Qualified doctors, nurses, anesthesiologists, and blood bank technicians will be posted at each health facility covered by the project. Primary and secondary health unit personnel, including nurses and assistants, will be trained in communications, the referral system, and emergency delivery techniques.
Safe Motherhood in the Gambia: Women in Development Project

The health status of women in the Gambia is among the poorest in the world. The maternal mortality ratio (MMR) is 1,000 per 100,000 live births, and in some of the country’s rural areas, maternal mortality is as high as 2,000-2,200 per 100,000 live births. Postpartum hemorrhage and infection are the leading causes of maternal mortality. Malnutrition is prevalent and has a significant effect on maternal mortality and morbidity levels. A high fertility rate (6.5 live births per woman) also contributes to maternal ill-health. Additional factors influencing the high MMR are the lack of an effective early warning system for high-risk pregnancies, inadequate access to prenatal care, lack of emergency transport, and a first-referral level inadequately equipped to deal with problematic and emergency cases.

In 1979, The Gambia officially adopted the Alma Alta objective of “Health for All by the Year 2000” and formulated a Primary Health Care (PHC) Action Plan, which proposed that by the year 2000, there would be village health services (VHS) run by the community in all villages whose population exceeds 400. A key component of the PHC Action Plan was the training of traditional birth attendants (TBAs) who, together with the Village Health Workers (VHWs), were to form the core of the village health services. An evaluation of the TBA training program component, complete with recommendations, was recently undertaken at the request of the government. According to this assessment, the TBAs were well-accepted and utilized by the community: 80 percent of the births from 1980 -1990 were found to have been delivered by TBAs. The study also found that the majority of the TBAs were utilized by the community because of the training the TBAs had received.

The evaluation also noted discrepancies between the knowledge and the actual performance of the TBAs. This was concluded to be mainly due to the lack of a collaborative working relationship and inadequate support and supervision of the trained TBAs by health personnel in the formal health system.

Some other relevant lessons learned from the evaluation were as follows:

- In-service training programs for health personnel working with TBAs should focus on effective communication, supervisory, and teaching skills.

- "Training of trainers" is a critical aspect of all TBA programs. Trainers should be nurse-midwives or others with strong obstetrical experience working at health centers and outreach clinics. Trainers should also be oriented to attending births in homes, rather than in institutional settings.
• Re-training or refresher courses for previously trained TBAs are equally important. Governments should program and budget at least one re-training course every one to two years.

• While training at major health centers is important in order to introduce this cadre to the modern expectations of safe obstetric practice, a good part of the training must also be done in villages where conditions are similar to those under which they will later practice.

These recommendations are being integrated into the ongoing Women in Development (WID) project initiated by the Government of the Gambia in 1987. The WID project aims to: (a) improve women’s productivity and income-earning potential; (b) improve women’s welfare and status; (c) strengthen government institutions to enable them to better deal with women’s issues; and (d) contribute to bringing about a change in Gambian society’s perception of the role of women.

The objectives of the Safe Motherhood and Family Planning component of this project are to reduce the current high maternal mortality rate and the incidence of malnutrition in the target villages, and improve the use of modern contraceptives nationwide. Strategies for achieving these objectives include: the training of TBAs, community health nurses (CHNs), and outreach health personnel to improve identification and management of at-risk mothers well before delivery; establishment of an "alarm" evacuation system to transfer high-risk pregnancies and emergencies to facilities where more sophisticated care can be provided; development of a nutrition education and micronutrient supplementation program; and the expansion of family planning services. The activities of this component would expand and strengthen the village-based health care system; they would complement the activities undertaken in the National Health Development Program and improve the link between village communities and the public health services, both with respect to the patient referral system and to staff supervision and support. A fund is also being established to be used by non-governmental organizations (NGOs), on a matching fund basis, to implement small projects to help women and children.
GHANA

Life Savings Skills for Midwives: A Preliminary Review of a Training Program in Ghana

Between 1989 and 1990, two studies were undertaken in the Accra region of Ghana to gain a better understanding of the direct medical causes of maternal mortality in the area, as well as insight into service and cultural factors that contribute to pregnancy-related deaths. Through interviews with private sector midwives, and a retrospective study of maternal mortality records from three hospitals, the researchers found that the major direct causes of maternal death were hemorrhage, infection, pregnancy-induced hypertension, and anemia (including sickle cell disease).

Based on the results of the studies, it was concluded that most neonatal deaths are indeed preventable, and it was proposed that midwives could intervene. A majority of the midwives in Ghana have been in practice for an average of 25 years, however, with no education in modern techniques that would permit them to identify problems, intervene, and effectively prevent a large number of maternal deaths. Yet they constitute a rich source of information about complex cultural beliefs, and could serve as a valuable link between formal health care providers and community-level practitioners, such as spiritualists and traditional birth attendants (TBAs).

Initially, a risk assessment/intervention tool was developed, focusing primarily on prevention and treatment of anemia and pregnancy-induced hypertension. Both public and private sector midwives were trained in its use. While it appeared to improve their ability to identify certain problems, such as anemia, it did not sufficiently improve their ability to prevent, recognize, and treat pregnancy-related hypertension, for example.

In 1990, a considerably more thorough "Life Savings Skills" training program for midwives was developed by the American College of Nurse Midwives (ACNM), and implemented in collaboration with the Ministry of Health and the Ghana Registered Midwives Association (GRMA).

A total of 120 midwives were selected to participate in the hands-on training program: 60 from the private sector and 60 from the public sector. Trainers selected midwives who practiced at least two hours away from a referral center, in recognition of the fact that distance from care is an important contributing factor in maternal deaths. Between five and 10 midwives participated at each training site, and each training session lasted two weeks. Prior to beginning the sessions, the trainers themselves completed a mandatory three-month review period during which they learned and practiced new skills.

Three hospitals in different regions of the country were used as training sites, selected based on volume of deliveries in order to permit substantial hands-on experience for the
trainees. In addition, the active participation of an obstetrician was considered critical, for both the training and supervision of the trainees, and as a supportive advocate for an expanded role for midwives. ACNM suggests that a trainer/trainee ratio of 1:3 be maintained, and that the trainer have a strong, up-to-date clinical background, to ensure program success.

The life saving skills taught in this two-week program included:

- prevention, early recognition, and treatment of sepsis;
- manual removal of the placenta;
- digital evacuation of products of conception (incomplete abortion);
- internal and external bimanual compression;
- management of labor with the partograph;
- active management of the third stage of labor;
- hydration or rehydration through IVs, ORS, and rectal or intraperitoneal infusions;
- repair of episiotomies and lacerations;
- prenatal risk assessment, with a focus on prevention and treatment of anemia, and early treatment and referral of pregnancy-induced hypertension;
- adult and infant CPR plus Heimlich maneuver;
- vacuum extraction;
- symphysiotomy.

A preliminary evaluation of the program was conducted in November 1991, with promising results. Project coordinators found that the trainees' skills in identifying and managing of complications have improved. Hygienic practices in most private sector maternities have improved substantially, and of the 24 trainees who were visited during the November evaluation, two had already successfully performed CPR in their communities. Finally, one of the government's 11 midwifery schools is integrating the Life Saving Skills (LSS) program into its curriculum. The Ministry of Health is eager to extend the program by establishing two more LSS sites and to begin training for 72 more public and private sector midwives. (ACNM, 1991)
GRENADA

Grenada: Achieving Safe Motherhood with Limited Resources

There were only six maternal deaths in Grenada between January 1, 1987 and December 31, 1988, among 5,803 births, implying a maternal mortality ratio (MMR) of 104 per 100,000 births. Indeed much of the Caribbean region has achieved a low level of maternal mortality, compared to most of the developing world, despite budgetary and geographical constraints.

In Grenada, health care is delivered through a network of seven primary health care centers, one in each of the parishes of Grenada and one in Carriacou. These centers deliver a broad range of primary care services and provide medications free of charge. There are 29 smaller visiting or satellite health stations that provide more limited health services, including weekly prenatal clinics and referral. Ambulance services are available at the General Hospital, at the one other hospital in Grenville and at the two health centers in Gouyave and Sauteurs. These health centers also have outpatient maternity units. Staffed by nurse-midwives, each unit delivers a small number of babies annually (50-60). The General Hospital in the town of St. George's has a 29-bed maternity unit, laboratory, blood bank, X-ray unit with ultrasound facilities, pharmacy, and two operating theaters, and delivers about 1,500-2,000 babies annually. The smaller district hospital at Grenville has a 14-bed maternity unit with X-ray and pharmacy facilities. About 575 midwife-attended deliveries are performed at the facility annually. Complicated cases are referred to St. George’s by ambulance.

A small 35-bed infirmary/hospital in Carriacou also provides limited services and referrals to St. George’s. Nurse-midwives at the maternity unit deliver about 100 babies annually. Women requiring caesarean sections and those with pre-eclampsia and other serious complications are transferred to St. George’s by air or sea.

Petite Martinique presents special problems for the delivery of maternity care, since only a small number of births occur there and the area can only be reached by boat. Women in labor normally hire a boat to carry them to Carriacou, and then hire a taxi for the 15 minute ride to the hospital. Costs for boat and taxi hires however, are significant.

Prenatal care is provided to most patients through a network of multipurpose health centers and smaller health stations throughout the country. Although it was not possible to estimate the coverage of prenatal care, clinic records show that most patients have their first prenatal visit during the fourth or fifth month of pregnancy, and that coverage for third trimester prenatal care is over 75 percent.

Each patient is given a personal prenatal care record on her first visit, which she is asked to present at each visit during pregnancy and to take to the maternity unit or hospital when delivery is imminent. Information from each visit is recorded on the card.
Health education is given strong emphasis in prenatal care, particularly for primigravidas. Health education methods include both individual counseling and group sessions, depending on the size of the clinic, the pattern of attendance, and the priorities of the nurse-midwife. The early recognition and reporting of problems is stressed, and women are informed about the treatment system, should complications arise.

Adequate laboratory services are essential to the diagnosis and treatment of maternal complications. Establishment and maintenance of laboratory facilities has been an ongoing challenge to the Grenadian health care system. Because laboratory facilities are located only at the General Hospital at St. George's, considerable time and effort is devoted to transporting blood and other laboratory samples to the hospital and obtaining test results. Each health station and center has a refrigerator and a weekly delivery of samples to the hospital, although the specific arrangements vary from parish to parish.

Maternity care in Grenada makes very sparing use of physician services, supplies, and equipment. Physician services are primarily reserved for complicated cases, caesarian and forceps deliveries, and a limited number of private patients. It was not possible to estimate the exact proportion of private and public maternity cases, but private deliveries are rare. Of the approximately 90 percent of births attended by nurse-midwives, less than one percent occurred in private facilities. Less than one percent of births were performed by general practitioners in private practice. In 1988, nine percent of vaginal deliveries at the General Hospital were performed by obstetricians. Many, perhaps most, of these deliveries were to private patients.

There are no practicing untrained midwives, presumably due to universal access to and acceptance of qualified nurse-midwives. Most births occur in medical facilities, but 10 percent of women deliver at home. The health service guarantees assistance at home deliveries when requested by the family. This service is performed by District Nurse-midwives who are stationed at health centers and stations throughout the country.

Normal deliveries are attended by nurse-midwives, and involve limited use of medications, interventions, and diagnostic tests. Most women receive no intravenous drip, no episiotomy, and no routine analgesics or anaesthesia. The only medication routinely given is oxytocin after the crowning of the head. Although normal deliveries are allowed to progress without intervention, midwives are trained to recognize early signs of intrapartum complications and to notify obstetric consultants for guidance in such cases. Grenadian nurse-midwives take considerable responsibility while acting on the basis of clear protocols for the management of life threatening complications. The quality of care in Grenada is largely an outcome of the skills, experience and training of nurse-midwives, who are graduates of a three year nursing school. Fully qualified staff nurses undertake an additional 10 month period of intensive midwifery training before they serve prenatal and maternity patients.
The effectiveness and responsiveness of the referral system for pre-eclampsia, antepartum hemorrhage, gestational diabetes and malpresentation is essential to the attainment and maintenance of low maternal mortality in Grenada. Most pregnancy-related complications appear to be detected early enough to ensure successful treatment. Potential cases of obstructed labor are referred to hospital on a urgent basis. Considerable effort has been made to reduce delays in performing Caesarian sections. Pre-eclampsia is detected in prenatal clinics and referrals are made for further treatment. A well-established and reliable referral system is maintained to provide obstetric consultations to those with prenatal or intrapartum complications, including an effective emergency transportation system. A referral from the district nurse-midwife or general practitioner is necessary prior to visiting an obstetrical consultant, unless the patient can pay for a private visit. Women who are referred for diagnosis of a suspected complication do not continue to receive care at the level to which they are referred unless the severity of the condition or its unresponsiveness to treatment require continuation of higher care.

Among the major strengths of the maternity care system in Grenada is the integration of all the various units of the system. Both face-to-face meetings and frequent telephone calls tend to reinforce interpersonal links among midwives, and health stations are visited frequently by a supervising public health nurse. (Laukaran, 1991)
GUATEMALA

A Rural Case Management Strategy in Guatemala: The Quetzaltenango Project

Maternal mortality estimates in Guatemala range from 100-144 (government estimates) to 1,000-1,700 (World Bank estimates) per 100,000 live births. Forty percent of the country's nine million people are illiterate, and more than two-thirds live in extreme poverty, in both rural and urban areas. Access to health care is limited, with hospital capacity for a maximum of 25 percent of all births, and 4.4 physicians per 10,000 population.

The health system, which is highly centralized, is divided into health regions, areas, and districts. The district chief is responsible for a network of health posts, which are staffed by rural health technicians and auxiliary nurses, who in turn are responsible for supervising traditional birth attendants (TBAs) on an informal basis. The supervising auxiliary nurses, whose training emphasizes the health needs of children under age five, have little training and practical experience in obstetrics. This reflects the heavy emphasis on child survival in recent decades and the limited programmatic attention to maternal mortality. Guatemala's 20,000 TBAs attend 60-70 percent of all births, but have little functional interaction with the referral system. Community organization and emergency transport are extremely limited.

The government recently initiated a decentralization policy, and the Instituto Nutricional de Centroamerica y Panama (INCAP) was asked to develop a "local health system" in the high priority highland districts of Quetzaltenango as a test-case, prior to country-wide implementation. As part of this effort, INCAP conducted an operational study to determine how high-risk pregnancies were perceived, detected, and managed at all levels of the health system. A maternal and neonatal health project has been developed on the basis of the study findings, in collaboration with the MotherCare Project of John Snow, Inc.

TBAs, who attend 90 percent of all births in Quetzaltenango, were found to have limited understanding of the concept of risk. They recognize certain situations as dangerous, but often attribute them to luck or divine will, and do not know how to prevent or manage problems. Their opinion of the formal health system, from which they receive little support, is low. Harmful practices are common, including the widespread and often inappropriate use of oxytocin to "give force to the labor." Community members were found to have some knowledge of high-risk situations and to perceive hospitals and doctors as the best source of care. But their opinion of these services is low, due to poor treatment, fear, lack of confidence, high cost, and long waiting times, and they are reluctant to use them. The formal health services do not use a risk screening and management approach, and lack institutional norms and basic screening equipment. The referral system is non-functional, as are information and registration systems for patient management.
The maternal mortality ratio (MMR) in the area was found to be 234 per 100,000 live births. Most deaths occurred in the area’s one hospital (57 percent), followed by deaths at home (37 percent), and deaths en route (six percent). Most were due to hemorrhage (41 percent), sepsis (35 percent), and eclampsia (16 percent). In the case of hemorrhage, 52 percent of women died within two-six hours, 74 percent within 24 hours, and 98 percent within 48 hours. In the case of sepsis, days elapse between the onset of complications and death. Seventy-one percent of the deaths that took place at home were attended by TBAs, who recognize problems or seek help too late, and have no knowledge of simple management techniques (e.g., external uterine massage in the case of postpartum hemorrhage).

The study was followed by a long program development process, which began with the presentation of findings to health personnel and the development of a collaborative plan of action. The program, which is now in the early implementation phase, aims to reduce maternal mortality according to the three main causes of death, accelerate the detection and referral of cases, and ensure appropriate management at all levels of the health system. The traditional risk approach is inappropriate in this context given the low absorptive capacity of the formal health system. Referring all first births alone would far exceed this capacity. Therefore, an approach based on a small number of actual, high-risk events, those which are associated with the greatest risk of mortality, has been adopted.

Strategies include TBA training and supervision, through a modular, participatory approach that builds on their own experience and is appropriate to the local culture; the establishment of new relationships between all levels of the health system, focusing on the TBAs as the critical link, and creating mutual respect among health cadres; increasing the assessment and problem-solving skills of medical and nursing staff; increasing the registration of births through a simple technique of TBA reporting; and ensuring that the information collected is used for improved decision making. Community education, using interpersonal media, will be undertaken to improve recognition of danger signs, health care seeking behavior, and compliance with referral. Outcome and process indicators in the four intervention districts will be compared with those in four comparable control districts.

TBA training materials are being revised based on specific, priority, risk events and the specific tasks the TBAs will need to perform to prevent death. A pictorial maternity card depicting these high-risk situations will be developed, which will be managed by the TBAs themselves. The TBA will be able to send patients to health facilities and alert health staff to risk situations using the card. Health staff can also use the card to alert the TBAs to additional problems encountered, facilitating joint patient management.

To improve relationships between levels of the health system and the functioning of the referral system, regular meetings will be held between TBAs and district health staff, to identify training needs and discuss the problems TBAs confront. TBAs have been taken
to visit the hospital, to familiarize themselves with the surroundings in which their patients will be attended, and to exchange points of view on management with hospital staff. The chief of obstetrics and gynecology is considering making it possible for the TBA to remain with the mother in hospital, as well as other changes to make the hospital environment more comfortable for women. Physicians were also taken to communities to gain a greater understanding of existing conditions, including transport and resource constraints.

The project aims to develop a replicable model, including norms, information and referral forms, and training materials. It will be promoted to facilitate replication throughout Guatemala, and possibly in other parts of Central America. (Measham, 1992)
Government of India Safe Motherhood Program

Maternal mortality in India is currently over 400 per 100,000 births and may actually be more than twice as high. At least 25 percent of the world’s maternal deaths occur in India. Infant mortality is also high, although the most recent estimate (80 per 1,000 live births) indicates an encouraging decline in recent years. In the context of the global objective of "Health for All by the Year 2,000," the Government of India has adopted goals that include a reduction in maternal mortality. Among the goals of the revised policy are a reduction in maternal mortality. To this end, the government has adopted a comprehensive maternal and child health (MCH) program, to be implemented in two segments from 1991-2000. Safe Motherhood is a central feature of the program, which, although national in scope, emphasizes districts where maternal and infant mortality rates are higher than the national average. The program has three primary objectives.

The program’s first objective is to enhance child survival by implementing a Universal Immunization Program (UIP), as well as through the strengthening of diarrhoea control programs and control of acute respiratory infections (ARI), prophylaxis against blindness and eye lesions due to vitamin A deficiencies, enhanced newborn care, and the active promotion of breastfeeding (this package of interventions will be called "UIP Plus").

The second objective is to increase the effectiveness of service delivery by improving training programs for family welfare workers, expanding information, education, and communications (IEC) activities, and strengthening existing center and state/district management information, supervision, planning, procurement, logistics, and maintenance systems. In addition, the government is revising the job descriptions and work routines of health staff and supervisors.

The program’s third objective is to reduce maternal mortality and morbidity. In order to realize these maternal health goals, a Safe Motherhood program will be implemented to improve maternity care and preventive programs for all women, with an emphasis on strengthening essential routine and emergency obstetric care at selected community health centers, and at district and subdistrict hospitals. The program, in cooperation with the Family Planning Division of the Ministry of Health, will also promote later marriage and childbirth for women, and birth spacing, as key elements of women’s health and well-being. Postpartum counseling, as well as social marketing of contraceptives through the private sector will complement this campaign. Anemia control and prophylaxis will also be important program components, as anemia affects as many as 85 percent of pregnant women, and 70 percent of all women in India. All pregnant women will be given 120 mg of iron and folic acid for 100 days, at a health clinic or during a home visit by a health worker. Those found to be anemic will be prescribed 180 mg of iron and folic acid and will be given appropriate dietary advice.
The program includes activities to increase awareness and action through Panchayats and women’s groups including Mahilla Mandals and private voluntary organizations (PVOs). Moreover, IEC programs are being designed specifically to address local customs which are dangerous to women’s survival. Local communities, through their representatives and/or with the assistance of PVOs, are being mobilized as an integral part of planning.

The program will help to sustain and develop MCH services during a period when the scale of publicly financed social services could be severely and negatively affected by government budgetary constraints. The project will also contribute to an ongoing government review of national MCH policy and adjustments in the content, targeting, and delivery of services. District-level evaluation of the "UIP Plus" and Safe Motherhood models is being undertaken, and the results will be used to improve expanded implementation.

In the long-term, the program should promote a more efficient and effective national family welfare program, which would lead to significant reductions in maternal, infant, and child morbidity, mortality, and disability, thereby enhancing the quality of life of India’s people, and the country’s development prospects. It is estimated that about 115 million lower-income women and about 190 million children in rural areas and urban slums will benefit directly from the program.

Family Welfare Area Project in Himachal Pradesh

In 1990, government health services in India began a five year “area” project in the Himalayan state of Himachal Pradesh, India. The population of the state is 5,100,000. The chief objectives of the project are to promote Safe Motherhood and reduce maternal mortality, through improvements in health services for women and family planning coverage, and to enhance child survival.

The project allocated funds for maternal care training, communications, and services. It involved traditional birth attendants (TBAs), many of whom are family members, and who conduct the bulk of home deliveries in the state. In order to enable district (population about 350,000) and block (population about 75,000) level health program managers to devise a practical plan for implementation, a “team problem solving" approach was utilized. This took the form of a six-day planning workshop at the Health Workers’ Training School at district headquarters. Three blocks from each district were chosen for participation in the workshop and allotted one of three problems related to maternal mortality in the block: lack of prenatal care; unsafe home deliveries; and lack of clean delivery kits in the district.
Each team was made up of two (general duty) medical officers who had overall responsibility for health services in their block, one male and two female health auxiliaries, a health educator, two village women of childbearing age, two members of village level voluntary women’s groups, and two TBAs. Program officers of the district affiliated themselves with individual teams during the workshop. A project officer of the United Nations Population Fund (UNFPA) and a program officer from a non-governmental foundation for Maternal and Child Health (MCH) care, both of whom were Indian nationals, participated as workshop facilitators.

Workshop sessions progressed from a review of available data on maternal-neonatal health status and services (gleaned from service records and two surveys), focus group discussions with village women and TBAs, problem analysis, strategy development and target setting, and culminated in the creation of a work plan and monitoring schedule. Nine focus group discussions were conducted in villages by the medical officers with illiterate TBAs and fertile childbearing women (in separate groups). This followed a three hour classroom briefing on focus group techniques, including mock situations, which increased the ability of middle level health program officers to ascertain local traditional values, practices, and nomenclature pertaining to maternal and neo-natal care. Traditional beliefs and practices were then categorized as being beneficial, harmful, or benign. The workshop devoted one and a half working days to field data collection and analysis. Detailed plans for training, communications activities, production of clean, disposable delivery kits by rural women’s groups, and ongoing training and reporting sessions for TBAs were outlined. A decision was made to develop and annually update a TBA registry based on information from key community members. Each team’s block-level plan was extrapolated to cover all three participating blocks.

Participants felt that this micro-level planning exercise facilitated the development of a more practical plan of action than would have been possible through more conventional approaches. It also gave local program managers a greater sense of involvement in the planning process. The participation of illiterate and semi-literate village women and TBAs led to a better understanding, on the part of health service personnel, of their perceptions and practices. (UNFPA, 1990)
Family Planning and Safe Motherhood in Indonesia

Maternal mortality is high in Indonesia, at 450 per 100,000 live births. These figures reflect women's inadequate access to quality care during pregnancy and delivery, and their poor nutritional condition, lack of access to education and employment opportunities, inadequate financial resources, and their status in Indonesian society.

A national Mothers' Welfare Symposium was held in June 1988 to draw attention to the issue of maternal well-being in Indonesia and generate national commitment to address the immediate and underlying causes of maternal mortality and morbidity. The symposium was followed by a national workshop in August 1988 at which the participants defined policy and program priorities, and outlined specific activities, which would build on existing programs and test pilot projects with the potential to bring about significant improvements in women's welfare.

Following the symposium, the Indonesian government launched a multi-sectoral, long-term program to improve the welfare of mothers in Indonesia. With a view to developing clear national strategies and a plan of action to achieve the maternal mortality reduction targets, the Ministry of Health undertook an assessment of the maternal health situation, including underlying sociocultural factors and the availability of relevant health care services and personnel. Numerous government sectors have developed policies that relate to the status of women in general and to the welfare of mothers specifically. Each of these sectors is contributing to the Mothers' Welfare Initiative by supporting appropriate activities as part of their program for the next five-year development plan.

- The health sector's maternal health policy is directed at improving the health status of mothers through efforts involving the individual and the family, and offering services at the community, first referral, and second referral levels. The government also devised a strategy to accelerate the training of midwives for deployment at the village level to ensure the availability of a midwife in almost all villages. More than 18,000 midwives will be trained by 1994.

- The family planning sector's efforts to provide approved and reliable contraceptives is directed toward ensuring that pregnancy takes place during the most appropriate time in a woman's life, in physical, emotional, and social terms.

- The information and communications sector disseminates information and ideas that help change attitudes and practices about reproductive behavior and the role of women in the economy and society, targeting women and men, formal and informal leaders, and other special groups.
• The education sector focuses on providing women with the basic literacy and numeracy skills they need for their current household and economic activities and expand their opportunities, through formal schooling, informal study groups, and non-formal education.

• The agriculture, industry, and human resources sectors cooperate in efforts to provide women with greater economic and income-generating opportunities in farming, home and small industry, and marketing, through training and credit programs and other support services.

• The cooperative sector supports women’s income generating activities through efforts to integrate them into credit and marketing programs.

• The family welfare movement is committed to improving the well-being of women and other family members through a range of activities in education, environment, household management, family planning, and health.

Each sector and program defined the objectives by which to evaluate its success. Specific targets include reducing the maternal mortality rate by 25 percent, reducing infant mortality to 50 per 1,000 live births, and reducing the total fertility rate to 2.8 by the end of 1994. Additional targets include improving awareness among women and community members of how to ensure a healthy pregnancy and better general health, where to obtain necessary health services; increasing education and literacy rates for girls and women; increasing the participation of women in the work force; and increasing wage levels for women.

These activities also involve the participation of representatives from the Ministry of Social Welfare, the Ministry of Health (DepKes), the Ministry of Women’s Affairs (UPW), the National Family Planning Coordinating Board (BKKBN), the People’s Welfare Movement, and the Indonesian Association of Obstetricians and Gynecologists (POGI). Other participants in the planning and implementation process include, but are not limited to the following: the Ministry of Home Affairs, the Ministry of Education, the Ministry of Information, the Ministry of Religious Affairs, the Ministry of Cooperatives, the Ministry of Agriculture, the Indonesian Doctors Association (IDI), the Indonesian Midwives Association (IBI), the Indonesian Planned Parenthood Association (PKBI), the Indonesian Women’s Congress (Kowani), Dharma Wanita, and other youth groups, women’s groups, and religious organizations.
Treating the Complications of Incomplete Abortions at Kenyatta National Hospital

Incomplete abortion is a major cause of maternal mortality in developing countries. Throughout the world, many women resort to illegally induced abortions to prevent an unwanted pregnancy and later present at hospitals with incomplete or septic abortions. Kenya is no exception; an estimated 30,000 cases present at public hospitals annually. Traditionally, these cases of incomplete abortion have been treated using dilation and curettage (D&C) for uterine evacuation. For the most part, these procedures have been performed in an operating room using general anaesthetic.

In 1987, a program was initiated at Kenyatta National Hospital (KNH) to treat incomplete abortion with Manual Vacuum Aspiration (MVA), a method of uterine evacuation using a vacuum syringe and flexible cannula. Prior to the introduction of MVA at KNH, women with incomplete abortion waited days to undergo treatment, bed occupancy for acute gynecology problems was over 300 percent, and staff members were tremendously overworked. The situation was similar at district hospitals. The MVA technology enables treatment of incomplete abortion on an outpatient basis, without general anaesthesia, thereby reducing congestion on the gynecology ward. Most importantly, MVA increases both the efficiency and quality of treatment for women suffering from incomplete abortion, as reflected by the results of studies conducted by the Kenya health system, which document enhanced safety and effectiveness. At KNH, MVA is now the preferred method for uterine evacuation and is routinely taught in the University of Nairobi Medical School. MVA training and service delivery has been extended to 17 district hospitals.

A study was conducted in 1991 to measure the costs associated with the treatment of incomplete abortion using MVA and D&C. The study also examined effects on the management of incomplete abortion, following the adoption of MVA into routine practice. The study found that MVA has generated cost savings in Kenyan hospitals, due primarily to the fact that patients can be treated quickly and their hospital stay reduced, since there is no need to wait for operating room space. The average cost per MVA patient -- including costs for hospital staff, drugs, supplies and overload -- was less than for D&C patients, even taking into account the need to purchase MVA equipment and associated supplies. Overall, the study demonstrated total cost reductions of up to 66.

This study suggests that the adoption of MVA in public hospitals could significantly reduce related costs to the Ministry of Health, reduce bed occupancy and pressure on operating theaters, and allow nursing staff to devote more time to other gynecological patients. Economically, it would also be of significant value to those women who can be treated and allowed to return home within a few hours, thereby reducing their own costs in terms of inpatient fees and possible loss of earnings and/or time away from family and domestic responsibilities. (IPAS, 1992; Johnson, B.R., 1992)
MALAWI

Safe Motherhood in Malawi

Since 1990, the Ministry of Health of Malawi has implemented two programs to expand and strengthen maternal and child health (MCH) services. These projects are being carried out through a collaborative effort involving Chitukuko Cha Amayi M'Malawi, or CCAM, (a women’s organization), the Ministries of Agriculture, Community Services, and Health, and the Ministry of Population, Health, and Nutrition. Both projects address a need for information and dialogue about family planning, health, and women-in-development issues on the national and local levels.

The first project began with a National Workshop on Safe Motherhood, Child Spacing, and Family Welfare in October 1990, to enable CCAM (the project’s implementing agency) to strengthen its involvement with family planning service providers in rural areas. The two-day workshop was held in Lilongwe for 40 health service providers from 12 districts, and was followed by 12 village-level workshops, each of which involved 30 participants. The project emphasized the health and economic benefits of child spacing, taking a broad intersectoral approach, and explored the relationships that exist among factors such as child spacing, economic security, health status, and family welfare. The workshop examined traditional attitudes and beliefs about reproduction, and sought to provide the basis for informed decision-making about child spacing by training service providers and village women to disseminate information. The distance of the health centers was noted as a specific problem and nutrition was discussed, especially in relation to religious and cultural beliefs concerning certain foods, and with regard to household food allocation. By coordinating this workshop, CCAM demonstrated the critical role that non-governmental organizations (NGOs) play in raising awareness about women’s health, and mobilizing support to tackle related problems. The workshop made use of visual aids and discussion groups, and discussed plans for future local-level workshop activities.

The Government of Malawi also undertook a second project, in June 1990, through its Ministry of Population, Health, and Nutrition. The goal of the project is to improve health sector quality, access, efficiency, and effectiveness through strengthening basic programs, increasing support services, and improving efficiency. As part of the plan, the number of female Health Surveillance Assistants (HSAs), Enrolled Nurse Midwives (ENMs), and Community Health Nurses (CHNs) will be increased to promote woman-to-woman contact. Specifically, the project calls for provision of a total of 3,500 HSA’s, two-thirds of whom will be women. A variety of media and communication campaigns will also be undertaken to help focus the attention of health staff on women’s health needs, and to raise women’s consciousness about Safe Motherhood. A pilot community-based contraceptive distribution program will also be extended to all districts. (Chidammodzi, 1991)
In November 1991, a three-day conference on Safe Motherhood was held in Namibia. Between 100-150 participants attended, including representatives from various ministries and non-governmental organizations (NGOs), as well as district level health personnel. The agenda included a range of topics related to maternal health, including women's socioeconomic status, family planning, adolescent pregnancy, and AIDS.

The organizers put considerable effort into an information, education, and communication (IEC) campaign around the conference. Some of the materials developed for this campaign will be adapted for further use as community-level educational materials. Conference materials included banners and posters with relevant messages (prenatal care, the importance of male involvement in women's health and family planning, and the risks of too many pregnancies, pregnancies among women who are too old or too young, and pregnancies spaced too closely together), and a booklet of basic Safe Motherhood messages, based on UNICEF's "Facts for Life."

The conference succeeded in drawing public attention to the issue, generating political commitment at the highest levels, and mobilizing governments, NGOs, and donor agencies. A national task force was established and will convene early in 1992 to prepare a plan of action. Four regional Safe Motherhood workshops have also been scheduled.

Safe Motherhood is already included as a major goal and strategy of Namibia's new Primary Health Care Policy (PHCP). The six components of the PHC strategy include: immunization; control of diarrheal diseases; Safe Motherhood; adolescent health; control of malaria, tuberculosis, and AIDS; and provision of essential drugs. Since PHC itself is a new concept/strategy in Namibia, Safe Motherhood activities will be integrated into programs from the onset. A key component of the PHC strategy involves training community health workers (previously non-existent in Namibia); Safe Motherhood topics will be included in the initial training curriculum, rather than integrated at a later date, requiring the retraining of workers, as has been necessary in other settings.

The Ministry of Health has identified the following objectives for its Safe Motherhood activities: increasing access to effective services during pregnancy, delivery, and the postpartum period; reducing mortality and morbidity associated with teenage pregnancy; increasing access to family planning information and services; increasing the public's access to information on women's health needs and status; and improving access to services for the prevention and management of malaria, STDs, anemia, and reproductive cancers.

There is still little reliable information on Namibia's maternal mortality levels. A Household Health and Nutrition Survey, using the sisterhood method of maternal mortality measurement, estimated the maternal mortality ratio (MMR) to be 371. The Ministry of Health is concerned about the accuracy of this figure for two reasons: the
survey did not cover the entire country, even though the population of Namibia is small; secondly, institutional data indicate a MMR of around 70, and 60-70 percent of deliveries take place in health institutions. If, however, both estimates are reasonably accurate, this implies that about 90 percent of maternal deaths occur in non-institutional deliveries, and that the MMR for these deliveries is well over 1,000 per 100,000 live births.

If the above figure is accurate, Safe Motherhood programs, and the general PHC strategy, face a major challenge. This challenge is compounded by the difficulties of reaching isolated communities which represent the majority of the population, and which have almost no tradition of community involvement. There are no existing structures or channels for reaching out to these communities with information or services. Almost all health services in Namibia are provided through hospitals. To make information and services available through community level structures will require a major investment in and reorientation of the system. Some funding is available for this purpose, however, and the road infrastructure throughout the country is in good condition. In addition, hospitals are in good condition; some facilities are even over-stocked with drugs and equipment.

The government in general, and the Ministry of Health/Family and Community Health Division in particular, are benefitting from lessons learned in other African countries in designing and implementing PHC and Safe Motherhood strategies. (Starrs, 1991)
NIGERIA

Safe Motherhood Activities in Primary Health Care Zone A Nigeria

Maternal mortality estimates for Nigeria are among the highest in the world. While the lack of reliable, comprehensive data makes it difficult to pinpoint the country’s actual maternal mortality rate, various hospital-based studies suggest that the rate lies anywhere from 800-1,500. Since most women in Nigeria deliver outside of hospitals, under sub-optimal conditions, these estimates may be low.

Many factors contribute to the high rates of maternal mortality and morbidity in Nigeria. Nigeria has a total fertility rate of 7, one of the highest in Africa and the world. Given the relationship between multiparity, maternal mortality and morbidity, and a very low contraceptive prevalence rate (estimated at five percent), it is not unreasonable to assume that many women die from complications associated with multiple pregnancies. It is also likely that many women suffer illness or die from having children too close together. Nigerian women also begin bearing children early in life: in 1982, the Nigerian Fertility Survey found that approximately 50 percent of all girls are married by the time they reach fifteen, and 80 percent of Nigerian women marry before they are twenty. The median age at first birth is 19.5. Nigerian women continue bearing children until the end of their reproductive years -- at both ends of the age spectrum, their risks are increased.

In 1990, additional attention was focussed on the issue of Safe Motherhood in Nigeria. Between March and June, special seminars were held in each of Nigeria’s four Primary Health Care Zones in preparation for a national Safe Motherhood Conference held later in the year. The zonal seminars were designed to elicit the views of local women on maternal health problems in their communities and to provide them with the opportunity to propose ways of improving the situation. More than 500 people, mostly women, participated in the seminars. Their comments and suggestions were documented, and were central to discussions at the national Safe Motherhood Conference, held later that year, and attended by policy-makers, leading national and local women’s organizations, and health providers. The comments, suggestions, and commitments to action from participants at one of the zonal seminars -- Zone A -- also served as the basis for planned local activities.

Following the Zone A Safe Motherhood seminar, held in Enugu in April 1990, several different groups of participants formed the Zone A Safe Motherhood network. With technical assistance from the University of Nigeria at Enugu, and Family Care International the network developed plans for a series of Safe Motherhood activities that includes:
• seminars and workshops in selected LGAs for community and religious leaders, women's organizations, TBAs and other local health workers to raise awareness about the problems of maternal mortality and morbidity, and to mobilize them to action;

• specialized "Life Savings Skills" training seminars, to improve the skills of midwives, especially those practicing far from referral centers;

• training programs for TBAs toward identification of problems, provision of family planning counseling, and to encourage cooperation with and referral to midwives when necessary;

• development of pregnancy monitoring programs at the village level. A pair of "Village Safe Motherhood Monitors" will be responsible for identifying all pregnant women in their village, maintaining records on the progress and outcome of the pregnancies, and encouraging women to seek prenatal care;

• development and use of various health education materials and media, including dramatizations of the social and medical causes of maternal mortality and morbidity for a variety of local audiences.

In a special effort to reach adolescents already out of school this project will include an innovative health education campaign for youth in Nigeria’s Primary Health Care Zone A. It will complement some of the more formal "family life education" efforts undertaken in schools, supported by the Ministry of Health, especially the school curricula developed by the Nigerian Educational and Research Council. There will be two main audiences for the health education materials planned for Zone A: young people of reproductive age, with an emphasis on "Tomorrow’s Mothers," and their families. The planned materials will be used in youth and church groups, traditional village "age grades," and other venues. (FCI, 1991)
PAKISTAN

Improving Maternal Health in Pakistan

In Pakistan, the maternal mortality ratio (MMR) is estimated to be around 600 per 100,000 live births. The causes of maternal mortality are complex and include the interaction of excessive/early/late and frequent childbearing, delivery complications, and post-delivery infections. High levels of anemia and malnutrition prevail, and women receive little or no prenatal care, deliver at home without trained attendants, and receive no postpartum care. The dearth of female health staff, inadequate quality of care, poor management and supervision, insufficient drugs and supplies, inadequate integration of the traditional birth attendant (TBA) or dai into the formal rural health services system, and the weakness of the referral system all contribute to the women’s limited use of facilities and the ineffectiveness of the health system.

The total fertility rate is estimated at 6.6 births per woman, which is among the highest in Asia. There is no evidence of a general fertility decline despite over thirty years of government-sponsored and donor-supported population programs. Contraceptive use remains below levels which would have a demographic impact. Knowledge of modern contraceptive methods, on the other hand, is widespread, and desired family size (4.1 children per mother) is lower than actual family size attained, suggesting an unmet need for contraceptive and family planning services. Abortion is illegal in Pakistan, except to save the life of the mother; although little is known about the extent of illegal abortion, associated complications are often encountered at health facilities, especially in urban areas.

The Islamic Republic of Pakistan’s Family Health Project is being implemented in the provinces of Sindh and North-West Frontier. At the village level, where few services presently exist, the project aims to introduce prenatal care, including high-risk pregnancy screening, supervised delivery, and postpartum care, through trained TBAs and female Community Health Workers. Services will include family planning and nutrition education.

The program will provide improved access to multiple maternal health services, including a quality referral system and emergency obstetric care. TBA training efforts will be expanded to create a link between the trained TBAs and the local primary health care facility. The curriculum and training plan will be evaluated with assistance from UNICEF and training activities will be implemented with the aid of Basic Health Unit (BHU)/Rural Health Centre (RHC) staff. The project plans to renovate 80 BHU Centres and MCH Centres, providing essential routine delivery equipment where none exists. Essential medication and minor equipment will be provided to 1,000 BHUs and MCH centers.

The project will build on training for health staff already begun by the Ministry of Population Welfare and, through an integrated series of orientation and technical
workshops, will introduce family planning services into all provincial government health facilities. Family planning will be integrated with all routine health services. Over half of the government facilities in both provinces will begin to offer family planning counseling by December 1993, and the remainder, by July 1995. This is part of a wider program to introduce a systematic training program designed to refresh and improve the skills of about 12,000 existing primary health care staff. The project will also increase the output of female paramedical staff (by 55 nurses and 60 Lady Health Visitors (LVHs) annually). Efforts will also be made to improve the retention of staff once posted.

The project will help the government achieve its objective of improving the health status of the population generally but with a special emphasis on high-risk and other under-privileged sections of the community. Service quality and effectiveness will be increased. Women will benefit substantially, through improved maternal health and family planning services. Some eighty percent of the total population of the two provinces (including nine million women of childbearing age) could potentially benefit. Service use is expected to increase with a doubling, to 35-50 percent, of pregnant women receiving some prenatal care and a doubling in the proportion of supervised deliveries.

Strengthening public health services, and particularly women’s health services may not receive sufficient priority from the male-dominated, traditionally-oriented health system. Further difficulties could arise from the administrative separation between health and population activities. This project will benefit from efforts to foster a strong commitment on the part of senior officials, reinforce key primary and maternal/child care aspects of the government’s health policy, and the involvement of local university departments of community members and NGOs.

**Maternal and Child Welfare Association of Pakistan: The Integrated Family Planning/Maternal and Child Health Project in Lahore**

The Maternal and Child Welfare Association of Pakistan (MCWAP) was established to create public awareness about the gravity of maternal and child health problems, and to develop good quality, community-based health services for mothers and children to supplement government efforts.

Between 1984 and 1985, MCWAP launched its first comprehensive Family Planning/Maternal and Child Health (FP/MCH) project in Lahore through 10 community Maternal Child Health centers, each serving an estimated 5,000-6,000 people. These centers provide contraceptive services, maternal health services (antenatal, delivery, and postpartum care), immunizations and child health services.

The LHVs are central to the work of the community MCH centers. These women, who are carefully selected, have completed 24 months of training at the Public Health Nursing School. They are assisted by a trained dai (an auxiliary midwife or TBA), and two dai trainees. Dais are selected by the District Health Officer, after which they
undergo one year of training as prescribed by the Pakistan Nursing Council. LHVs assist in delivery and postpartum care, and spend almost 50 percent of their time making home visits. They immunize mothers and children, and provide health education on family planning, breastfeeding and infant care. They also help to train dais, keep records, and prepare for monthly “peer-review” meetings, which involve all project staff.

A public health nurse provides support and supervision to the MCH centers through weekly visits. A medical doctor with MCH training is available as needed to take care of administrative and management tasks, and for clinical consultation. In addition, related community projects have been sponsored by the centers to respond to community requests. These include nutrition, health education, and craft classes. Furthermore members of the executive committee, consultants, professional experts and members of the community volunteer their time to motivate center teams and pass along their knowledge and skills.

When the program was launched, baseline community data was gathered through household surveys. Women and their families were then formally registered at the centers according to an initial classification scheme, which served to guide the center staff in their initial contact with community members.

A review of the project after five years showed a continuing decrease in maternal mortality and morbidity, and infant death rates in the selected communities, as well as increasing contraceptive use. MCWAP managers believe that the management framework of the project, which involves regular training, supervision and feedback for center staff, play an important role in maintaining the quality of the program.

There is more emphasis now than ever before on identifying women in the early stages of pregnancy and bringing them to the centers for antenatal care, monitoring, and follow-up. The accuracy of the community survey and family registration procedures has made the follow-up and monitoring of women during pregnancy a much simpler task. High-risk pregnant women are identified, and appropriate measures are taken. When a woman is referred to a hospital, her progress is nonetheless followed by MCWAP health center staff. (Awan, 1992)
PERU

Movimiento Manuela Ramos

Twenty years ago, a group of Peruvian women, determined to improve the status of women in their country, launched the Movimiento Manuela Ramos. The organization's various information, education, and communication (IEC), advocacy, and service projects address issues of women's empowerment, health care, income generation, and legal rights. Manuela Ramos has publicized the prevalence of violence against women, and has fought for women's reproductive rights, including the legalization of abortion. In 1990, the group helped bring about a modification of the penal code, waiving the penalty for abortion in cases of rape. Through lobbying and public information campaigns, the group was also instrumental to President Fujimori’s establishment of a national plan endorsing family planning.

In 1989, Manuela Ramos opened a community-based clinic in San Juan de Miraflores to provide health information and services to women living in the shantytowns of Lima. The clinic is open five days a week and is staffed by an obstetrix (a specially trained nurse) and 17 trained women’s health promoters from the community. These "promotoras" receive extensive initial and ongoing training, supervision, and a salary, resulting in high-quality services and low staff turnover. They provide a range of primary care services, including prenatal care, family planning counseling and services, (including IUD insertion), and treatment of sexually transmitted diseases.
SENEGAL

Plans for Safe Motherhood in Senegal

During the 1970s, studies at the Hopital Le Dantec in Dakar drew national attention to the high level of maternal mortality in Senegal. This concern, reinforced by national data on the high rate of population growth in Senegal, led to the adoption of a national population policy and to Senegal’s active participation in the International Safe Motherhood Conferences in Nairobi (1987), Paris (1988), and Niamey (1989). The Government of Senegal realized that tackling the problems of maternal mortality and morbidity would require intersectoral efforts. As a result, an interministerial committee was created to formulate national maternal mortality reduction strategies. This committee had a specific mandate to promote relevant research, develop a national program, and coordinate government, donor, and international non-governmental (NGO) activities aimed at promoting Safe Motherhood.

The Ministry of Public Health and the Ministry of Social Development collaborated with international and bilateral organizations and universities to develop the national strategy to reduce maternal mortality by 50 percent by the year 2000. Sectoral studies have been conducted and their results used to develop an integrated maternal and child health strategy that emphasizes community participation and affordable care for every individual and family; accords high priority to preventive care and early treatment; and defines the content of care including family planning and high-risk pregnancy management, at different levels of an integrated referral system.

At the community level, the program emphasizes educating women and families on the recognition of, and response to, danger signs during pregnancy, delivery, and postpartum; educating women and couples about family planning to reduce unwanted pregnancies; working with the community to improve access to emergency care; upgrading the skills of traditional birth attendants (“matrones”); and improving collaboration with ongoing national efforts to improve women’s socioeconomic status.

At the level of the health center or health post, the program focuses on improving prenatal and routine delivery care, screening for and management of high-risk pregnancies, providing family planning services, and improving postpartum care. In addition, the program aims to strengthen the emergency referral system by creating local committees responsible for the maternal and child care and by instituting an information system to track women who are referred to a higher level of care.

The program also aims to strengthen emergency obstetric services and enhance the ability of district hospitals to provide family planning and obstetrical surgical care.

The program will also involve increased supervision and monitoring at all levels of the health care system, operational research on the causes of maternal mortality, and
support to local women’s organizations. Basic and in-service training of medical and paramedical staff will also be conducted. The curricula of medical training institutions will be revised to ensure that staff adequately respond to women’s obstetrical needs and that mutual respect and teamwork are fostered among health care providers at different levels of the system. Finally, improved pharmaceutical procurement systems are being developed and staff are being redeployed to ensure greater coverage. (Azefor et al., 1991)
Maternal Health Care in Sri Lanka: A Brief History

Sri Lanka's maternal mortality rate (MMR) has gradually declined since 1881, due primarily to the long history and efforts of the Maternal and Public Health Services. The first prenatal clinic in Sri Lanka was established in 1921, and formal training of auxiliary midwives began in 1926. In subsequent decades, the Health Unit system was expanded to cover the entire country, and maternal and child health (MCH) services were established in every unit. Midwives, who were supervised by Medical Officers of Health, engaged in such activities as the registration of pregnant women, health education, home visits, and prenatal, delivery, and postpartum care. Periodic increases in the MMR have been ascribed, for example, to the malaria epidemic of the 1930s, which devastated certain parts of the country. The steep decline in the MMR after 1948 was due to developments in preventive health activities and curative services, and general social improvements.

Developments in preventive health include the introduction of family planning in 1953, and the establishment of a separate agency to coordinate MCH activities throughout the country, the Family Health Bureau, in 1968; the expansion of prenatal care services through prenatal clinics and health centers; the appointment of trained midwives, MCH Medical Officers, and Medical Officers of Health; central monitoring of MMR since 1988, in an effort to ascertain specific causes of death and implement appropriate measures; the in-service training of field staff; and the employment of volunteer health workers.

Developments in curative services include the expanding of secondary and tertiary care facilities and blood transfusion services; increasing referral of complicated cases; increasing access to and utilization of medical institutions (85 percent of deliveries now take place in medical institutions); training interns and Intern Medical Officers; and training of Assistant Medical Officers in obstetrics. In addition, MCH teams visit regions with high maternal mortality and conduct seminars with local obstetricians, District Medical Officers, and heads of medical institutions, which have proven an effective forum for the discussion of all aspects of the problem.

General social change, particularly as it affects women's role in society, is also believed to be responsible for the decline in maternal mortality. These changes include improvements in the status of women, women's increased access to education and the resulting high literacy rate, and the proliferation of women's organizations.

Sri Lanka has been able to reduce maternal mortality to a modest level, due in part to a historical governmental commitment to health as a social goal, with an emphasis on primary health care. A strong social welfare component has also contributed to heavy government investment, in health and education, resulting in a highly literate population likely to practice preventive health measures and utilize available services. (Fernando, 1991)
TANZANIA

Safe Motherhood in Tanzania

Tanzania faces a significant challenge in its efforts to improve the health and well-being of women. Maternal mortality and morbidity are high and appear to have increased during the past 15 years, reflecting a decline in the quality and coverage of health services. These high rates also reflect a range of interrelated underlying factors: poor health conditions for women and girls, inadequate access to family planning services, and women's low social and economic status.

Concern over the maternal health situation has been growing in Tanzania among the general public as well as within government ministries and non-governmental organizations (NGOs) since 1988, when a newspaper report first indicated a sharp increase in maternal mortality at Muhimbili Medical Center, the main referral hospital in Dar es Salaam. The issue was discussed during various seminars and conferences during 1989 and 1990, including the 1989 maternal and child health (MCH) meeting of the Ministry of Health, seminars organized by the Tanzania Media Women’s Association, and the General Council meeting of UWT in 1990. It is also a major issue for the newly-established Medical Women’s Association of Tanzania.

A national Safe Motherhood conference was held in August 1990 in Morogoro, bringing together representatives from the Ministry of Health (MOH), Planning commission, Ministry of Community Development, and various NGOs. Presentations were made on the health status of women in Tanzania, teenage pregnancy and abortion, community-based maternal health services, pregnancy monitoring, and traditional practices related to the goal of reducing maternal mortality by 50 percent by the year 2000. The conference outlined a national Safe Motherhood strategy to address the problem of poor maternal health, with activities in four areas:

- raising the socioeconomic and political status of girls and women;
- ensuring access to appropriate family planning and family life education services for all;
- strengthening community-based maternal health services; and
- providing back-up and support services at the referral level for high-risk and emergency obstetric cases.

Since the August workshop, a number of other activities have taken place. A Safe Motherhood seminar was held for members of parliament in Dodoma in January 1991, opened by the Prime Minister, John Malecela. At the seminar, more than 50 parliamentarians and policy-makers expressed their commitment to supporting the development and implementation of Tanzania’s Safe Motherhood plan by ensuring that it receives adequate human and financial resources; by examining related laws and policies; and by mobilizing their communities to participate in related activities.
Since then, the Ministry of Community Development, Women’s Affairs and Children has developed a five-year plan of action that includes a major emphasis on Safe Motherhood, including a campaign to raise the age at marriage for females from 14 to 18. The Ministry of Health has moved ahead with a number of activities, including the revision of the training curriculum for midwives to enable them to carry out essential obstetric functions, the improvement of supplies and equipment for treatment of maternal health complications, and the development of a national maternal mortality data collection programme. In addition, UNICEF is supporting a pilot programme in Mufindi district to educate health workers from the district to the village level on Safe Motherhood, and to establish a model pregnancy monitoring system. It is expected that the training curricula and pregnancy monitoring system will be adopted nationally after this pilot phase.

In order to complement and support these programs, a consortium of NGOs, in collaboration with selected government agencies, is proposing to implement a three-year Safe Motherhood project with the goal of educating and mobilizing the community to improve women’s health status. The main project activity will be the production and distribution of non-technical, action-oriented educational materials on women’s health, in collaboration with Family Care International (FCI). These materials will provide information in Swahili, the national language, on the direct and underlying causes of poor maternal health and will focus on steps that can be taken at the community level to prevent or minimize pregnancy-related complications. Anthropological research and focus group discussions will be used to gather information on existing beliefs and practices, and identify knowledge gaps in the community. The materials will be distributed to women, men, adolescents, community health workers and other target groups in 11 pilot districts through Safe Motherhood seminars for village residents and through a number of government and NGO channels. In addition, target villages will be encouraged and supported to develop community activities aimed at increasing women’s access to health services and improving women’s health generally.

Recently, in light of the range of Safe Motherhood activities currently being developed and implemented, the government of Tanzania has made a commitment to reviewing the national Safe Motherhood strategy which was drafted after the August 1990 conference. It is expected that the national Safe Motherhood Task Force will be revitalized under the chairmanship of the Ministry of Community Development, Women’s Affairs and Children; the Safe Motherhood situation analysis and action plan will be updated and revised; a new commitment will be made to coordinating and sharing information about Safe Motherhood activities; and new priorities will be identified for national action. (Safe Motherhood Coordinating Board, 1991)
TUNISIA

Tunisia: The Sfax Postpartum Program

At the Maternal and Neonatal Hospital of Sfax, the second largest city in Tunisia, approximately 11,000 births take place each year, representing 65 percent of all the births in southern Tunisia. In an effort to promote family planning and provide well-baby care, the Hospital implemented an innovative postpartum program in 1983, scheduling a follow-up visit for every mother and child 40 days after birth. The approach adopted immediately proved to be very successful; hospital records indicated that 83 percent of the women who had delivered in the Sfax Maternity in 1987 had returned for their postpartum visit. The success of the program is primarily attributable to two important service design factors: 1) the appointment is for both the child and the mother, providing services for each at the same time and in the same place, and 2) the appointment is scheduled on the fortieth day after delivery, a day that has both cultural and religious significance for the Tunisian mother and child.

In most Muslim cultures, a rest of forty days after delivery is considered essential for the convalescence of the mother and the development of the infant. The fortieth day marks the end of this period. The mother may then resume her household responsibilities and appear in public. For the infant, the fortieth day represents the beginning of a new stage of development. The degree to which these traditions are adhered to in Tunisia today varies by region and by family, but the fortieth day itself is still celebrated throughout the country. The Sfax Center has succeeded in incorporating the postpartum visit into the day’s observances.

From the day of delivery, the link between the infant’s health and the health of the mother is stressed at the Maternity. Immediately after giving birth, every woman is examined by a gynecologist and visited by a pediatrician, who examines the infant at her bedside. The pediatrician also encourages the mother to breastfeed and informs her of the fortieth day consultation. The woman is then seen by a social worker. The fortieth day consultation is also promoted through the use of audio cassettes, which combine music and promotional messages and are routinely played throughout the maternity ward.

On the fortieth day, the new mother returns to the Center, going to the special ward set aside for postpartum consultations. The space has been arranged so that pediatric care is provided on the same floor and in conjunction with gynecological services. The mother and child are seen by a pediatrician and a midwife consecutively. By keeping the infant beside her during her examination, the mother feels more secure, and does not experience the anxiety many women feel when they do not know where their infants are or how they are faring. Also stressed is the importance of good nutrition for the nursing mother and of immunization for the child are discussed. Services for the mother include a gynecological exam and a discussion of any specific health problems she may have. Birth spacing as an important means for the recovery and good health of the mother, and for the mental and physical development of the infant, is also discussed.
Family planning services are readily accessible in most parts of Tunisia, provided free of charge by the Office National de la Famille et de la Population. Contraceptive services are provided in all health centers and hospitals and by mobile units, which serve rural areas lacking health facilities. "Animatrices" (female family planning educators) make home visits in their communities and keep family planning centers informed of any woman requiring particular attention or follow-up. According to the 1983 Tunisian Contraceptive Prevalence Survey conducted by the Institute for Resource Development/Westinghouse, 42 percent of the women of reproductive age in Tunisia were practicing contraception and 34 percent were using a modern method. The two most commonly used methods in 1983 were the IUD and tubal ligation. Contraceptive methods available at the Maternal and Neonatal Center of Sfax include tubal ligations, IUDs and spermicides. While oral contraceptives are available, they are rarely prescribed due to staff concerns about their safety for breastfeeding women. This situation is exacerbated by the fact that low-dose, progestin-only oral contraceptives, which are compatible with breastfeeding, are not readily available in Tunisia. Abortion is legal and available through the national family planning program.

As indicated above, the postpartum program has achieved a high return rate. It has also succeeded in effectively promoting the use of contraceptives. In 1987, of the 7,686 women who returned for their postpartum visit, 55.6 percent accepted a family planning method, and all were informed about the methods available and services nearest their home. (Coeytaux et al., 1989)
Abortion Care in Turkey

In the early 1980's, the growing incidence of unsafe abortion and resulting morbidity and mortality in Turkey led the Turkish Ministry of Health (MOH) to modify legislation that limited women's access to reproductive health and family planning care, and especially their access to safe, legal abortion. Anticipating large caseloads of abortion patients and changing delivery service needs, the MOH prepared for the legalization of abortion by training health care workers in relevant skills.

In a 1981 project sponsored by the MOH, Hacettepe University, and the World Health Organization (WHO), general practitioners from all over the country learned to perform early pregnancy termination using the manual vacuum aspiration (MVA) technique. Shortly thereafter, in 1983, Turkey passed a law authorizing obstetricians, gynecologists, and certain general practitioners to perform menstrual regulation (MR), defined in Turkey as early pregnancy termination to 10 weeks following the last menstrual period, which was to be made available upon request. Additional legislation permitting nurse-midwives to insert IUDs and legalizing voluntary surgical contraception was also enacted.

MR services are currently available in almost 150 MOH hospitals, where more than 43,000 procedures were performed during 1988. Training in MR is offered in at least 20 of the country's 45 teaching hospitals. The Turkish Ministry of Health worked with International Projects Assistance Services (IPAS) to develop a set of MR service delivery guidelines for use in all medical teaching institutions, and to design a comprehensive strategy for incorporating standard MR training into all medical school which have obstetric and gynecology departments. The MOH plans to extend training to all currently practicing obstetricians and gynecologists, as well as certain general level practitioners throughout the country. An updated version of the MOH guidelines for MR reflects concerns for supportive counseling, post-abortion family planning services, and deals with other related non-clinical issues.

Although Turkish law does not permit nurses or midwives to perform MR, limiting the availability of services in rural settings, these health care workers play an extremely important role in screening and referring women who face unwanted pregnancies. In order to address this crucial need for training in referral and other MR support services, the MOH recently initiated the first in a series of Family Planning Counseling and Referral Seminars for trainers of nurses at post-graduate family planning teaching institutions, and further plans to incorporate information about referral services for MR into nursing and midwifery curricula. (FCI, 1991)
UGANDA

Safe Motherhood in Uganda

In 1988, a consortium of non-governmental organizations in Uganda formed the Safe Motherhood Coordinating Board (SMCB) to develop and implement a national Safe Motherhood strategy. The SMCB is composed of both professional health associations and mass membership women’s groups with community-level structures. Under the auspices of the National Council of Women, the SMCB organized a national conference in Kampala in September 1989; a project proposal was subsequently developed and funded by the U.N. Population Fund and the World Bank. The two-year pilot project, which began implementation in November 1990, covers eight of Uganda’s 38 districts.

The overall aim of the project is to reduce maternal mortality and morbidity by carrying out community education and mobilization activities that promote improved reproductive health and support community-level preventive health measures. The Ministry of Health and the Ministry of Women in Development, Culture and Youth provide guidance and support to the SMCB in project design and implementation. In addition to project staff at the central level, there are two levels of personnel who work part-time on the project at the district level, as follows:

- Each district has a District Safe Motherhood Officer (DSMO) who is responsible for overseeing the project activities in that district. The responsibilities of the DSMOs include making arrangements for seminars and training workshops; disseminating information on Safe Motherhood within the district; supervising Pregnancy Monitors; and serving as liaison with district-level health personnel.

- Each district also has 25-30 Pregnancy Monitors. Their responsibilities include:
  - Promoting Safe Motherhood within the local community;
  - Providing basic information and counselling on health and family planning to women of childbearing age and their families;
  - Maintaining records on selected pregnancy-related health indicators that can be used to evaluate the impact of the project.

There are six project activities as follows:

- Networking Visits: Preliminary visits were made to project districts by representatives of the SMCB. The purpose of these visits was to meet with representatives of the District Development Committees, women’s non-governmental organizations (NGOs), local leaders, and others to inform them about the project, outline project activities, discuss specific plans for implementation, and gather ideas from people in the districts about priority needs and issues.
Preliminary Survey: A preliminary survey of women and men was conducted in all project districts to identify obstacles to women’s utilization of health and family planning services. The survey gathered background information on respondents, then asked a series of questions designed to elicit information on attitudes and behavior regarding pregnancy, childbirth, and the use of family planning methods. The findings of the survey indicate that while attendance at antenatal care is relatively high (90 percent), most women do not make the ideal number of visits and those most at risk of developing complications are least likely to receive care. In addition, the quality of antenatal care is questionable, with only 70 percent stating that they received any health education. Coverage of delivery care is even poorer, with half of women delivering outside of health facilities alone or with an untrained family member of birth attendant to help them. Lack of transport was cited as a major factor in low rates of institutional delivery; in general, the survey indicated that a large proportion of women would prefer to deliver in health facilities, but are unable to get transport or reach the facility in time. Finally, interest in family planning was high among women, largely for health-related reasons; men were also interested in family planning (despite an average desired family size among male respondents of 10.8 children), although their primary motivation was the cost of raising a large family.

Seminars: Seminars were held at the district, sub-county, and parish levels in all project districts. They were designed to raise awareness about the problem of maternal mortality and morbidity, to educate community members about practical, effective means to improve maternal health, and thereby provide a foundation for mobilizing communities to develop and support Safe Motherhood activities. The seminars were quite successful, especially at the sub-county and parish levels where the number of participants often exceeded expectations. Discussions during these sessions highlighted a number of issues, beliefs, and practices that need to be addressed through other project activities.

Pregnancy Monitoring: The responsibilities of Pregnancy Monitors are outlined above. In order to enable them to carry out these responsibilities, training workshops were held in all project districts between September 1991 and January 1992. In each project district, 25-35 Pregnancy Monitors were trained (one per sub-county). The topics covered in the training curriculum were:

a. Antenatal care
b. Maintaining good health during pregnancy
c. High risk factors
d. Complications during pregnancy
e. Complications of labour and delivery
f. Good care during labour and delivery
g. Post-natal care
h. Taking care of the infant
i. Family planning
j. Sexually transmitted diseases and AIDS
The work of the Pregnancy Monitors involves identifying all pregnant women in their sub-counties and visiting each woman at least four times during pregnancy and two times after delivery. During these visits, the Pregnancy Monitors are responsible for providing information and counselling on the topics listed above, and for gathering information that will enable the project on the incidence of pregnancy-related complications and maternal mortality in the project districts.

Future project activities include:

- **Community Safe Motherhood Activities:** A pool of seed money allocated for each district will provide partial support to appropriate community projects aimed at improving women’s health and well-being. Activities will be identified and developed by community members, with guidance from Pregnancy Monitors and District Safe Motherhood Officers. Projects may include emergency transport schemes, building maternity waiting homes, establishing a loan fund to enable women to hire additional labor during peak agricultural periods, or other activities. Additional funds for the projects will come from community contributions or other sources.

- **Health education materials:** Project activities carried out to date have highlighted the need for educational materials that could be used during seminars and by Pregnancy Monitors in their community education work. Some funds have been set aside to develop materials in cooperation with the Ministry of Health, the Family Planning Association of Uganda, and other appropriate agencies. These materials, including pamphlets, posters, and audio visual materials, as well as traditional and folk media, will focus on the issues and problems identified as being of major concern to the target communities during seminars and the survey.

A mid-term review conducted by one of the funding agencies, UNFPA, found that the project was proceeding on schedule and meeting its stated objectives. UNFPA had committed itself to funding an expansion of the project to additional districts once the pilot phase is completed, pending the availability of funds in its Country Programme. Major issues that remain to be addressed include linkages with other health-related projects in the pilot districts, and how to ensure that services are accessible and of adequate quality to meet the demand raised by the project’s education and mobilization activities. (Starrs, 1992)
Regional Resource Group on Safe Motherhood in Francophone Africa

In 1989, experts and political leaders of the sub-Saharan Francophone African countries met in Niamey to identify problems related to maternal health in their countries and to draw up a health services plan to lower the high rates of maternal mortality and morbidity.

The recommendations of the Niamey Conference included a commitment by the participating countries to reduce maternal mortality by 50 percent within a decade. Participants urged both their governments and citizens to promote Safe Motherhood. In addition, the Conference recommended that the health sector in each country set the following priorities in order to strengthen maternal health services: (a) improving the management of human resources so that they can be used more efficiently to provide maternal health and family planning services; (b) assuring more appropriate allocations of financial and material resources for maternal health and family planning services; (c) assuring coordination with non-health sectors to promote improvements in women’s economic, social, and legal status; (d) improving data collection and conducting operations research related to maternal mortality, and disseminating findings among countries; (e) establishing emergency obstetric care systems (including referral systems) to ensure effective management of obstetric emergencies and high-risk pregnancies at every level of the health care system. Several countries indicated that they would establish national commissions and hold national conferences on Safe Motherhood. To date, national conferences on Safe Motherhood have been held in Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Congo, Djibouti, Guinea, Mali, Mauritius, Senegal, and Togo.

In order to follow up on the Conference’s recommendations and resolutions, a regional Resource Group of African experts from different disciplines related to maternal health was established in conjunction with the World Bank to review and backstop national efforts to develop and implement Safe Motherhood activities. The first meeting of the Resource Group was held in Abidjan in 1991. The objectives of this initial meeting were to review the findings of a recent World Bank survey on ongoing regional Safe Motherhood activities, to identify priority needs and measures that would contribute to strengthening existing Safe Motherhood programs, and to identify those countries where appropriate Safe Motherhood actions most needed to be taken.

The questionnaire used to obtain information for the survey was sent to the Ministry of Health in each of the 22 Francophone African countries and to all regional conference participants.

Both the survey findings and the Resource Group confirmed that there are still significant socioeconomic and institutional barriers to reducing maternal mortality in sub-Saharan Francophone Africa. Maternal mortality rates (maternal deaths per 100,000 live births) in most francophone African countries range from approximately 400 to 1,000 and are
undoubtedly higher in some rural areas. Improvements in the quality and availability of maternal mortality data are needed. Data on maternal morbidity are almost non-existent.

Based on the survey results, the Resource Group emphasized that activities to promote Safe Motherhood must be integrated in sector programs and that their implementation must maximize inter-sectoral cooperation. The Resource Group also conducted a country-by-country review of Safe Motherhood activities, using responses from the survey, country documents, and their individual knowledge of country programs.

Mali, Rwanda, and Senegal are now implementing integrated maternal and child health and family planning (MCH/FP) programs that include staff training and specific activities to promote Safe Motherhood. These countries still lack effective obstetric emergency services and need support to strengthen them. Cameroon and Benin have designed their MCH/FP programs to address specific Safe Motherhood problems, as an integral part of their health care systems. In Benin, training activities and facility upgrading measures are in progress. In Cameroon, the Safe Motherhood program awaits official approval.

Niger, Burundi, and Togo have adopted strategies for integrating Safe Motherhood into their maternal health and family planning policies, but related programs are not yet operational. Burkina Faso, Cote d'Ivoire, and Guinea are in the process of developing national strategies. In Guinea, maternal mortality studies have been carried out and are guiding the strategy development.

Less has been done in the Congo, Gabon, Mauritania, Central African Republic, and Chad, and there is need to initiate dialogue with the governments of these countries to sensitize them to the magnitude of the maternal mortality problem and encourage them to accord a higher priority to Safe Motherhood. The Resource Group agreed that although many initiatives have begun in Madagascar and Zaire, little could be achieved in the short term in soliciting official commitment to national strategy development given the current political climate in those two countries.

At the Abidjan meeting, the members of the Resource Group pledged to continue supporting, strengthening, and monitoring safe motherhood activities in the region, and to meet annually to review each country's progress. The Group strongly urged all of its members to remain active between meetings, helping their respective countries to identify maternal health priorities and develop clearly defined objectives and strategies. The Group also emphasized the need for an increased and regular exchange of information among the countries, and committed itself to working with the governments of all Francophone African countries to assist in the development of effective Safe Motherhood activities.
Finally, the Group recommended that efforts be made to build the capacity of local institutions to conduct staff training and operational research in maternal health. The Group strongly supports the objectives of the Regional Training Center in Family Health, based in Kigali, Rwanda, and encourages its use as a family health training center for sub-Saharan Africa. The Center was established in 1988 with the assistance of the World Health Organization. (Azefor et al., 1991)
Regional Plan of Action for the Reduction of Maternal Mortality in the Americas

The Pan American Health Organization recently adopted a regional plan for the reduction of maternal mortality in the Americas. For the purposes of the plan, countries of the Americas have been divided into four groups: Central and South American countries are classified in the first three groups, and Canada and North America in the fourth group. In light of the differing general health situations and levels of maternal mortality in the four groups, different targets have been set for each. For Groups One, Two, and Three, the goals of a 30 percent reduction by 1995 and 50 percent by the year 2000 are proposed. For Group Four, the goals are 40 percent by 1995 and 60 percent by the year 2000.

The Plan aims to reduce maternal mortality through activities in the following areas: improving the health conditions of women in the region through increased coverage and improved quality of reproductive health services; and increasing the capacity and quality of institutional delivery care through strengthening of the first level of referral, increasing the number of hospital beds, and establishing birthing centers for low-risk deliveries. Additional physicians, nurses, and traditional birth attendants will be trained, and monthly information will be provided by reporting institutions to the appropriate health authorities in order to increase epidemiological surveillance of maternal mortality.

Specific strategies for the improvement of services have been devised for each of the country groups. General strategies for the improvement of health conditions for women include the development of comprehensive institutional and community-based women's health care programs, including sexual health education. The Plan also recommends:

- including educational activities on sexual health in adolescent health programs;
- developing comprehensive fertility regulation programs with unrestricted access for all users, to prevent unwanted pregnancies;
- instituting supplementary feeding programs for pregnant women;
- establishing committees on maternal mortality at the national, regional, and local levels;
- reforming legislation, including updating existing laws protecting the health of women so that women's right to health care and protection of their reproductive health is specified, with provisions regarding timeliness, coverage, cost, and accessibility, and revising legislation on abortion, with provisions for a preventive component, as well as free and timely care when complications arise;
• developing information, education, and communication components using social, group, and intersectoral communications media to promote health programs for women and foster greater utilization of services;

• educating and training health service personnel and community health workers in women’s health and maternal health, ensuring the development of continuing education programs in conjunction with universities, scientific societies, and other training institutions;

• preparing or updating standards on pregnancy and delivery care, care in the puerperium, and fertility regulation, based on an appropriate classification of risk;

• supporting population-based research on maternal mortality, including epidemiological studies and health services research;

• developing a national system for epidemiological surveillance of maternal mortality to determine the real scope of the problem, the structure of its causes, and its social determinants;

• improving registration systems on all health actions relating to pregnancy, delivery, the postpartum period, and family planning, and extending the use of that information to peripheral areas and the community itself.

The Regional Plan to Reduce Maternal Mortality in the Americas constitutes a commitment shared by the member countries of the Pan American Health Organization. In order to carry out the Plan, countries need to develop their own polices, particularly those aimed at mobilizing and allocating resources, mobilizing social and community participation, outlining national and subregional plans, and securing international cooperation. (PAHO, 1990)
APPENDIX II: INTERNATIONAL AGENCIES AND NON-GOVERNMENTAL ORGANIZATIONS

This Appendix contains descriptions of some of the international agencies and non-governmental organizations involved in activities related to the Safe Motherhood Initiative. These brief reports, submitted by the agencies themselves, summarize history, progress, constraints encountered and future plans related to Safe Motherhood.

American College of Nurse-Midwives ........................................ 87
Le Centre International de l’Enfance ......................................... 89
Center for Population and Family Health, Columbia University:
  Prevention of Maternal Mortality Program .................................. 91
Family Care International ........................................................ 94
Finnish International Development Agency ................................. 96
The Ford Foundation ............................................................... 98
The German Agency for Technical Cooperation .............................. 100
International Center for Research on Women ............................... 102
International Confederation of Midwives .................................. 104
The International Council of Nurses ......................................... 107
International Federation of Gynecology and Obstetrics ................. 109
International Federation of Red Cross and Red Crescent Societies ... 112
The International Planned Parenthood Federation ......................... 114
International Projects Assistance Services ................................. 117
The International Women’s Health Coalition ............................... 121
Italian Ministry of Foreign Affairs ........................................... 123
The London School of Hygiene and Tropical Medicine:
  Maternal and Child Epidemiology Unit ................................... 124
The John D. and Catherine T. MacArthur Foundation ..................... 127
Marie Stopes International ..................................................... 128
Marie Stopes International in Kenya .......................................... 129
MotherCare ................................................................. 130
Mother and Child International ................................................ 133
Norwegian Agency for Development Cooperation .......................... 136
The Pew Charitable Trusts ..................................................... 138
The Population Council ........................................................ 139
Program for Appropriate Technology in Health ............................ 142
The Research Network for Reproductive Rights, West Africa .......... 144
The Rockefeller Foundation ..................................................... 145
Swedish International Development Authority ............................. 146
Swiss Development Cooperation .............................................. 148
The Netherlands’ Directorate for International Cooperation ............. 149
United Nations Children’s Fund ............................................... 152
The United Nations Development Program ........................................ 154
The United Nations Population Fund ............................................. 156
United States Agency for International Development ....................... 158
Women's Global Network for Reproductive Rights ............................ 160
World Assembly of Youth .......................................................... 162
The World Bank ........................................................................ 164
The World Health Organization ....................................................... 167
AMERICAN COLLEGE OF NURSE-MIDWIVES

The American College of Nurse-Midwives (ACNM), founded in 1955, is the professional organization for nurse-midwives in the United States and has more than 3,700 members. The organization is autonomous, and represents certified nurse-midwives on issues pertaining to the education standards of clinical practice, and professional development of nurse-midwifery.

ACNM International Health Experience

Since 1982, members of the ACNM have provided their expertise to a variety of maternal child health and family planning projects in Africa, Asia, and Latin America. The Special Projects Section (SPS) of the ACNM conducts international projects which share a common goal: to improve maternal and infant health and to better the lives of women through improved midwifery services and education. Areas of experience include needs and resource assessment, project design, curriculum development, technical assistance, training of trainers, training of service providers, evaluation of continuing education, pre-service and in-service training programs in the public and private sector, midwifery association building, and research.

Safe Motherhood Activities

All of the projects of the SPS have as their goal to improve the life-long health of women as well as the health of their children. The ACNM has conducted traditional birth attendant (TBA) training in a variety of nations including Zaire, Tanzania, Sierra Leone, Nigeria, Ghana, Uganda, Ivory Coast, and Guatemala. These programs have focused on leaving in-country expertise able to carry on training long after projects have finished.

The expansion and updating of midwifery practice is an ongoing effort of SPS projects. The addition of family planning, physical assessment, and well-woman gynecology skills have been the focus of projects in Ghana and Uganda. These projects are administered through sister midwifery associations in those two countries, which fosters institution building and the ability to offer a wide variety of continuing education opportunities both during and after the project.

Midwifery practice in the prevention and management of emergency obstetrics has been expanded and updated through Life Saving Skills (LSS) training in Ghana, Nigeria, and Uganda. These projects provide intensive "hands-on" clinical practice and teach advanced midwifery skills targeting the reduction of maternal mortality. Skills taught during the LSS training include: suturing of episiotomies and lacerations, vacuum extraction, manual removal of the placenta, management of labor through use of the partograph, and adult and infant cardio-pulmonary resuscitation.
The ACNM SPS has also been involved in formative and summative research through evaluation of its various projects. Additionally two maternal mortality studies have been conducted. One study analyzed mortality data from the Greater Accra Region of Ghana. The second study was a qualitative assessment of cultural and service (access) factors which affect maternal mortality in the same geographic area. Results of these two studies proved to be very helpful in designing Safe Motherhood programs which address critical local needs.

Future plans are to continue to match problems, resources, and human talent to achieve high quality care for women and children.

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Le Centre International de l’Enfance (CIE), located in Paris, was founded in 1949 by Professor Robert Debre and Ludwick Raichman, then director of UNICEF. The purpose of the organization is to promote study and research in the areas of maternal and child health care throughout the world. Following the Nairobi conference on Safe Motherhood, the reduction of maternal mortality and morbidity became a priority at CIE. The organization’s commitment to these issues is reflected in the projects it has implemented over the last five years.

In October 1986, CIE organized a workshop in Paris on issues surrounding maternal mortality in the countries of sub-Saharan Africa. The goal of the conference was to make health officials and medical professionals aware of the gravity of the problem. Representatives from over 20 African countries as well as representatives from international non-governmental organizations (NGOs) and multi-lateral agencies, including the World Bank, the World Health Organization (WHO), and the United Nations Population Fund (UNFPA), attended the meeting. In their recommendations, the conference participants stressed that it is important to analyze the problem of maternal mortality from an historical perspective including an examination of the traditional beliefs and myths associated with pregnancy in Africa and causes of maternal mortality when formulating strategies.

In 1989 and 1990, CIE established small research centers in Africa to study ways to reduce maternal mortality. In 1989, two centers were opened, one in Nabeul, Tunisia, and the other in Cotonou, Benin. In 1990, another center was set up in Ouagadougou, Burkina-Faso. These centers were opened in cooperation with the Division of Family Health at WHO and with the aid of the French Ministry of Cooperation. The purpose of the centers was to collect the following country-level information:

- an estimation of the Maternal Mortality Ratio (MMR);
- an analysis of the causes of maternal mortality and morbidity, avoidable health service factors, with the aim of improving maternal health services and upgrading family planning services;
- an evaluation of existing health care system;
- the socioeconomic and cultural factors which affect the maternal mortality and morbidity rates;
- an estimation of maternal health and family planning needs;
- a description of possible research projects.
These centers have provided researchers with valuable information in the field of maternal health. Appropriate resources, country-specific approaches, and other information, are being made available to planners and policy-makers to assist them in planning Safe Motherhood programs.

CIE is committed to helping countries that wish to begin their own research projects. In Cameroon, for example, a research team has begun to outline the best strategy to prevent maternal mortality and morbidity in the rural and semi-rural regions; in Benin, CIE is supporting a project to examine the risk factors associated with prenatal and maternal mortality and morbidity; in Burkina-Faso researchers plan to analyze the difficulties related to caesarian deliveries as well as their consequences.

Finally, in 1991, CIE organized a course about maternal and perinatal mortality at the Institute of Maternal and Prenatal Care in Hanoi, Vietnam. CIE is proposing to organize a six-week course focusing on the research methods appropriate for maternal health care and fertility, in collaboration with other international organizations.

The progress of CIE’s efforts has been encouraging. There are, however, many constraints and difficulties associated with organizing such projects, such as lack of political support, poor economic conditions, and the absence of adequate infrastructure.

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The Center for Population and Family Health (CPFH) of Columbia University's School of Public Health has been involved in Safe Motherhood issues for many years. In 1985, Allan Rosenfield and Deborah Maine asked the question, "Where is the 'M' in MCH?" in an article in The Lancet, are called for increased attention to maternal mortality on the part of the World Bank, other international agencies and developing country governments. In 1986, with support from the United Nations Development Programme, the Center began a program of technical cooperation with the Government of Senegal and the World Health Organization. During the next several years, the Center assisted the Senegalese Government in preparing and conducting a thorough needs assessment and in designing a phased national plan for the reduction of maternal mortality.

In 1987, the Center's Prevention of Maternal Mortality (PMM) program was formally initiated with support from the Carnegie Corporation and The Pew Charitable Trusts. The goals of this program are:

1) to strengthen research capabilities in developing countries;
2) to provide and disseminate models for the Safe Motherhood Initiative (SMI); and
3) to inform policy-makers.

Field-Based Activities

The Center's PMM program provides and coordinates technical assistance to colleagues in developing countries. In West Africa, the Prevention of Maternal Mortality Network, is comprised of eleven multidisciplinary teams: seven in Nigeria, two in Ghana and two in Sierra Leone. The purpose of the Network is to develop, implement and evaluate programs designed to reduce maternal mortality and to strengthen research capabilities in Africa.

Each African team consists of an obstetrician-gynecologist, a professional midwife, a community medicine specialist and a social scientist. The African professionals apply for their own grants, design and implement their projects, analyze results and disseminate their findings in various fora in Africa and around the world. CPFH provides technical assistance and coordinates the exchange of expertise between teams. Network members meet to exchange experiences and expertise twice a year at week-long workshops.

To date, the PMM teams have conducted systematic needs assessments in their study areas, and are now testing a variety of different strategies in operations research projects. A sampling of the projects' components includes:
• proposing and facilitating improvements in hospital management to reduce waiting times and improve the quality of care;

• organizing blood donors’ associations and establishing blood bank capabilities at the secondary level (e.g., at maternities and small hospitals);

• mobilizing communities and associations of transport workers to provide transportation to emergency care facilities. This is a critical program component, since women with pregnancy complications often have no way of reaching health care facilities; and

• conducting community information campaigns aimed at improving knowledge of obstetric complications and of what to do when they occur. Teams are making use of a variety of local communications channels -- including town criers and community meetings (durbars in Ghana) -- to reach the rural populations in their project areas.

In Ecuador, PMM staff have worked with local researchers and universities to document the utilization of hospital services to treat complications resulting from illicit abortions. During the study, 40 Ecuadorians received training in social science research methods. As a result of this work, the Ministry of Health plans to evaluate the quality of care in the country’s two largest maternities.

New York-Based Activities

A major activity of the PMM program is the utilization of existing data to provide guidance to international organizations and program planners involved in the SMI. For example, recent publications such as Safe Motherhood Programs: Options and Issues (Maine, 1991) and Safe Motherhood: Priorities and Next Steps: A Forward-Looking Assessment (McCarthy and Maine, 1992) and Indicators of Success in Programs Designed to Reduce Maternal Morbidity and Mortality (Ward et al, 1991) provide models for the examination of factors affecting maternal mortality and the evaluation of projects.

Constraints Encountered

Constraints can be divided into two types: practical and conceptual. The major practical constraints have been those connected to the dire (and worsening) economic situation in Africa. For example, while there is no shortage of enthusiastic, well-trained professionals in the collaborating institutions, devaluation of the currency has made their salaries woefully inadequate. Similarly, economic pressures on health systems have worsened some of the problems that the teams aim to confront.
In terms of conceptual constraints, it seems that the Safe Motherhood Initiative is still in its formative stages. At present, there is continuing debate about strategies and priorities. The tendency to broaden the SMI, so that it includes practically anything which might improve women's lives, has created a great deal of confusion amongst policymakers and program planners. This has hampered the development of focused and feasible intervention projects. Clearly, during the coming years, the emphasis of the SMI needs to be on such projects.

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FAMILY CARE INTERNATIONAL

Family Care International (FCI) began operations in 1987 to develop creative and practical solutions to health problems, especially those affecting women in the developing world. FCI is based in New York and has established a limited number of field offices in developing countries. The organization's work focuses on assisting governments and non-governmental organizations (NGOs) to develop community-based programs to improve women's health, and on raising awareness about critical health issues, through the following programs:

**Advocacy and Planning for Women's Health:** FCI has been a key participant in the Safe Motherhood Initiative since it was launched at an international conference organized by FCI in Nairobi in 1987. To expand upon the commitment generated by the Nairobi conference, FCI has conducted planning and advocacy activities for approximately 90 countries (please see Appendix 3 for a complete list). A regional conference for Central America, held in Guatemala in January 1992, began activities which will continue through three other meetings in 1992 and 1993.

**FCI's Information Exchange:** Governments and NGOs often lack access to information that would enable them to implement effective programs to reduce maternal mortality. In 1989, FCI published the first sections of *Safe Motherhood: Action Kit*, a series of resource materials summarizing examples of successful activities and technologies that respond to the problem. The second edition of this document, now available, has three new "Action Series": Women's Status; Information, Education, and Communication; and Transport. It also includes an Appendix on safe services for pregnancy termination and updates to the first edition. Each Action Series provides an introduction to its topic, examples of successful activities, bibliographic references, and contacts. The focus is on community-level interventions which are affordable, practical, and responsive to local needs and resources. *Safe Motherhood: Action Kit* is now available in Spanish and French.

FCI is also developing model health education materials in collaboration with local organizations in Africa that can be modified for use elsewhere. In Africa, FCI is currently collaborating on an illustrated reference document on women's reproductive health which will be completed in 1992.

In 1990, FCI developed an award-winning audio-visual presentation on maternal mortality in South Asia called "Safe Motherhood in South Asia: We Can Get There from Here," and another video entitled "Safe Motherhood...Starting Now" (sub-Saharan Africa). More recently, FCI has produced "Madres y Mujeres: Making Motherhood Safe" (Latin America: Spanish and English versions available), which was debuted at the Central American Safe Motherhood Conference in January 1992. A fourth presentation, "Vital Allies: Making Motherhood Safe for the World's Women," provides a brief overview of
global maternal health conditions, highlighting the progress of the first five years of the Safe Motherhood Initiative, and featuring general strategies and specific programs that are proving effective in reducing maternal mortality and morbidity.

Technical Assistance for Developing Country and Community-Level Health Programs: Many potential actors in the women’s health arena (both governmental and non-governmental organizations) are hampered by a lack of coordination with one another, and inadequate informational, financial, and technical resources. FCI is currently working with NGOs in Africa to develop projects to improve maternal health. These NGOs have requested assistance in response to local need and FCI’s advocacy and planning work in their countries. Project activities include health education programs for women and other community members, and training programs for community health workers. Following workshops in South Asia and Africa, FCI has received more requests for direct assistance than it has been able to accommodate. In the next two years, FCI hopes to begin working with additional local partners in South Asia and Latin America where multi-sectoral groups are already active in planning follow-up activities to the workshops.

Improving Women’s Health: Cost Effective Strategies: Government and donor support cannot keep pace with the demand and need for maternal health services in developing countries. In response, FCI is involved in efforts to promote cost-effective solutions. At the field-level, FCI is working with the African Medical Research Foundation (AMREF) to establish a not-for-profit, fee-for-service outpatient family health center in Nairobi that will generate excess revenues to subsidize needed maternal health services for neglected communities in Kenya. At the international level, FCI has worked closely with the World Bank and other Safe Motherhood colleagues to develop a framework for assessing the cost-effectiveness of different Safe Motherhood interventions. Both efforts are in the preliminary phase.

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FINLAND: Finnish International Development Agency

Maternal and Reproductive Health Activities

Policies and Strategies

The policy guidelines for the health sector approved in 1986 are, at present, under revision. Similarly, the strategy paper for the population sector will be finalized within a few months. Maternal and child health care (MCH), as a part of primary health care (PHC) has been given a special emphasis in the earlier policy guidelines and their importance will not change. Gender issues will also be emphasized in health care development cooperation.

Due to the tight budget of the Finnish government, an increase in the actual allocations to development cooperation (health sector, among others) is not anticipated. However, the Finnish International Development Agency (FINNIDA) aims to improve the quality and effectiveness of aid in all sectors.

Organizations and Resources

FINNIDA does not have a special health or population bureau nor are there special program officers for health or population. However, FINNIDA’s health adviser collaborates with bilateral and multilateral divisions as necessary and acts as a focus person in overall substance and sectoral issues in health, population and social welfare.

To ensure that appropriate expertise is available to guide health sector assistance, FINNIDA established a Health Development Cooperation Group (HEDEC) in the National Agency for Welfare and Health in 1990. HEDEC participates in health and social welfare development cooperation by identifying expertise for FINNIDA’s use, by training the resource base in Finland, and by producing and distributing information. This group has good connections with the resource base in Finland, through which expertise in maternal and reproductive health care can be located. FINNIDA also collaborates with the health sector experts in the Ministry of Social Welfare and Health.

Bilateral Cooperation

FINNIDA has supported several projects with maternal health components. For example, in Kenya, PHC program support includes training programs for TBAs and purchasing of MCH equipment for the health centers. Similarly, in the Bani Suef PHC-project in Egypt, FINNIDA is supporting the training of village midwives (dayas) and community health workers. Health education to mothers is also included in these projects.
Multilateral Cooperation

UNICEF, UNFPA, and WHO receive FINNIDA’s support annually. The World Bank’s Fourth Population Programme received FINNIDA funding for its Norplant component.

Non-governmental Organization Cooperation

In 1991, FINNIDA’s support for NGO projects was 130 million FIM, of which about 40 percent was targeted to the health sector. In many of these NGO projects, maternal health care is a special activity.

The Family Planning Association of Bangladesh received support from FINNIDA through IPPF for its family planning clinics.

FINNIDA gives core support to the Population Council and its regional activities in sub-Saharan Africa.

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THE FORD FOUNDATION

The Ford Foundation seeks to improve sexual and reproductive health by focusing on the social, economic, and cultural factors that influence reproductive health. Grants are directed mainly to developing countries, with special attention given to the needs and concerns of disadvantaged women and adolescents in both rural and urban areas. Three inter-related strategies are pursued in this regard. The first strategy is to promote and develop multidisciplinary social science research to increase knowledge, influence policies, and test practical interventions. The second strategy is to empower women to articulate their needs and to participate in designing and implementing interventions to meet these needs at the family, community, and national levels. The third strategy involves promoting informed public discussion of these issues with a view to developing ethical and legal frameworks for reproductive health and rights appropriate to the various cultures in which the Foundation works.

With offices in 15 developing countries, the Foundation is able to place a strong priority on supporting locally generated initiatives and developing country institutions. In addition, much more limited funds are provided for regional and worldwide activities.

Within this framework, much of the Foundation’s work touches on goals similar to those of the Safe Motherhood Initiative. Support has been provided for the regional conferences held in the Middle East, Nigeria, and Latin America and to Family Care International for their role in organizing such conferences worldwide. A grant to the Society of Gynecology and Obstetrics of Nigeria funded regional meetings, enabling women, health providers, and others to have input into the Safe Motherhood Conference and for follow-up activities. In Latin America, funds were provided to expand participation of local non-governmental organizations (NGOs) in the Conference planning and follow-up activities.

In addition to the projects explicitly related to the Safe Motherhood Conferences, Ford supports a wide range of activities related to improving reproductive health in developing countries. Some of the issues addressed through Ford funded projects include the participation of women in program design and policy debates, adolescent pregnancy and education, research on sexuality, development of model reproductive health programs, symposia on the ethical, legal, and policy implications of new reproductive technologies, disseminating information on reproductive health, with a particular concern to ensure that women’s perspectives are included in all discussions of reproductive health and population.
The challenge for the future is to obtain greater government and public commitment to improving reproductive health. There is also a need to move from a disease-oriented approach to reproductive health to one that gives equal recognition to the social, cultural, and economic realities of women's lives.

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GERMANY: Deutsche Gesellschaft für Technische Zusammenarbeit
(The German Agency for Technical Cooperation)

Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) is the official organization for development cooperation in Germany, and is funded by the German government. Its role is to advise the government on the formulation of policies and strategies, and to plan and implement development programs and projects.

Within the GTZ, the Division of Health, Population, and Nutrition plans, implements, and evaluates health programs and projects jointly with counterpart institutions in developing countries, based on the principles of participation and partnership. Program sustainability, equitable access to and utilization of services rank high among the Division's objectives, the guidelines being:

- adaptation to the local context;
- multi-sectoral commitment;
- participation of the communities concerned;
- self-help orientation;
- decentralization of decision making processes.

Experience

International assistance to projects in the field of health, population, and nutrition has been provided by Germany for 20 years. Currently, more than 100 projects are being carried out in nearly 50 countries. To ensure that projects are as effective as possible, GTZ attempts to keep abreast of relevant progress in the health and development fields, and monitors and evaluates all projects on a regular basis.

The financial volume of health projects presently assisted by GTZ exceeds the equivalent of $60 million annually, with more than one hundred staff seconded to the field. In recruiting specialists for its programs, GTZ draws on a pool of humanpower from both national and international markets, and endeavors to reflect in its performance the state of the art in development cooperation.

For example, GTZ is contributing to the support of large population programs in Bangladesh, Indonesia, Jamaica, Kenya, Rwanda, Thailand, the Philippines, and Zimbabwe, under the commission of the German Federal Ministry of Economic Cooperation (BMZ) and other donors.

Key Activity Areas

GTZ adheres to the strategy of primary health care (PHC) as the concept for sustained improvement of the health status of communities with limited resources; GTZ has a clear and determined policy in favor of the most vulnerable segments of society, i.e., women, mothers, and children.
In the context of the Safe Motherhood Initiative, emphasis lies on integrated approaches in three main areas of intervention:

- **Basic Medical Services**
  District health management, maternal and child health (MCH) services, environmental health, health service research, nutrition intervention (high risk groups).

- **Disease Control**
  Country specific programs on sexually transmitted diseases (STDs) and AIDS, malaria, schistosomiasis, dengue, etc.

- **Family Planning**
  Family planning activities are an integral part of health service provision, and thus principally integrated in all PHC projects, including clinic and community based (CBD) services, information, education, and communication (IEC) programs, youth health, training, and research.

**Service Packages on Offer**

The central element of project development consists of supporting partner countries and organizations to identify and implement appropriate technical solutions in a participatory process. Consultative services include:

- planning and implementation of programs;
- program management and evaluation through long term or intermittent management strategies;
- advice to governments, non-governmental organizations (NGOs), and the private sector;
- training and upgrading;
- procurement of equipment and supplies.

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The International Center for Research on Women (ICRW) began its Maternal Nutrition and Health Care (MNHC) program in late 1987. Funded by the Office of Nutrition and the Office of Health of the U.S. Agency for International Development, the program was designed to contribute to knowledge about maternal mortality, morbidity, and malnutrition and to explore innovative approaches to improve nutrition and health care for mothers and infants in developing countries. The principal component of this two-and-a-half year program was the funding of 20 research projects around the world that focused on both specific topics, such as a study of a novel delayed-release iron formulation in Jamaica, and more general subjects, such as a descriptive study of women’s health and nutritional status on tea plantations in Sri Lanka. ICRW monitored the progress of these research projects and provided technical assistance as required.

In 1990, the program culminated in the publication and dissemination of the findings of the 20 research projects through a research report series, a synthesis paper, three issues papers, and a three-day policy conference in Washington D.C.

The Synthesis Paper

The synthesis paper, entitled "Better Health for Women: Research Results from the Maternal Nutrition and Health Care Program," summarizes the results of the research projects across the three following themes: maternal nutrition, prenatal care utilization and adolescent maternal care.

The Issues Papers

The three issues papers published under the program are as follows: "The Utilization of Formal Services for Maternal Nutrition and Health Care in the Developing World," "Understanding and Evaluating Traditional Practices: A Guide for Improving Maternal Care," and "Improving Nutrition Interventions for Women."

The Policy Conference

The policy conference attended by donors, development practitioners, and women’s health experts was held in February 1990. It provided the researchers from the MNHC program with an opportunity to present and discuss their work.

The findings of the MNHC program highlighted the need for preventive interventions, both during and before pregnancy, to reduce women’s maternal health risks. An ideal time to focus preventive efforts prior to pregnancy is during girls’ adolescent years. Improving the health and nutrition of adolescent girls is expected to better prepare women for their reproductive roles as well as their work responsibilities. Very little is known, however, about the circumstances of adolescent girls in developing countries. Multidisciplinary information on many aspects of girls’ lives is needed so that programs can be expanded to address their health and nutrition concerns.
To meet this need, ICRW began a research program in 1990 on the nutrition of adolescent girls. Funded through a cooperative agreement with the Office of Nutrition and the Office of Health of the U.S. Agency for International Development, the Nutrition of Adolescent Girls program aims to support research that identifies key factors in the lives of adolescent girls that influence their nutritional status. The program has four components:

A research grants program that supports nine research projects: four from Latin America and the Caribbean, four from Asia, and one from Africa.

An ICRW research project, in collaboration with a research team in a developing country, to investigate the relationship between psychosocial factors in girls’ lives and their nutritional status.

Technical support to research teams.

Synthesis and dissemination of the research findings through papers, conferences, bulletins, and other mechanisms.

The Nutrition of Adolescent Girls program will continue through 1993.

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INTERNATIONAL CONFEDERATION OF MIDWIVES

Workshops

1987 The Hague, The Netherlands: A World Health Organization (WHO)/International Confederation of Midwives (ICM)/United Nations Children’s Fund (UNICEF) collaborative workshop attended by 40 delegates representing 28 countries. A report of this workshop was published, entitled "Women’s Health and the Midwife - a Global Perspective." The action statement is being converted into position statements.

1990 Kobe, Japan: A WHO/ICM/UNICEF collaborative workshop, attended by 42 delegates representing 23 countries. Its report is entitled "Midwifery Education - Action for Safe Motherhood." The workshop recommendations have also been translated into French.

Further initiatives from this workshop include:

a) In Tanzania, a workshop for senior midwife managers and midwife educators originated by Stella Mpanda.

b) In Indonesia, changes are being made to midwifery educational system.

c) The Ghana Midwives’ Association, in collaboration with the Ministry of Health of Ghana and the American College of Nurse Midwives, has set up a pilot study to train midwives in Life Saving Skills, with sponsorship from the Carnegie Corporation.

d) Our Sierra Leone Association reports that:
   1. In conjunction with the Sierra Leone Economics Association they have produced pictorial booklets and cards and have trained Traditional Birth Attendants in the use of these materials in three pilot areas.
   2. A midwife is undergoing training to become a midwifery tutor.
   3. The syllabus for professional midwifery training is being restructured to include more time for community based work experience.
   4. An application for drug supplies has been made through Direct Relief International.
   5. A training information campaign has been conducted for Maternal and Child Health Aides in an attempt to reduce the incidence of traditional harmful practices.
   6. Routine use of the partograph is planned.
   7. The national office of UNICEF is providing materials for use in the midwifery school.
e) Asia Pacific Regional Representatives are arranging a workshop and conference in March 1992 based on the Kobe Report, in conjunction with the Australian College of Midwives.

f) In Botswana, WHO has appointed a consultant to set up a modular training system, which is currently being piloted.

g) ICM Headquarters is considering a workshop in the Indian sub-continent.

Other Workshops

1989 Accra, Ghana: Five countries were represented by 34 delegates. The Workshop report was published in English and French and entitled "Planning for Action by Midwives."

1990 Ouagadougou, Burkina Faso: Eight countries were represented by 42 delegates. The Workshop report was published in French and entitled "Mortalite Maternelle: les Sages-femmes se Mobilisent."

Evaluation of these two workshops is currently underway.

Regional workshops have also taken place with the aim of teaching midwives safe practices and the evaluation of practices.

ICM has been represented, in either a participating or an observer role, in at least eleven major meetings related to and promoting the Safe Motherhood Initiative, as well as other meetings at the international and national levels.

The International Day of the Midwife was celebrated for the first time in 1991; it will now be celebrated on the 5th of May each year so as to highlight the work of the midwife and promote the Safe Motherhood Initiative.

Constraints

There have been difficulties in targeting the right people as well as a lack of co-ordination. Information about what other groups have achieved or are currently undertaking, whether in a large area or an individual country, is not always easy to come by.

Financial considerations have also influenced what work is undertaken, as have the difficulties of working in languages other than English.

Recognition of the value of the midwife as the person nearest to the mother to afford safe care is being achieved very slowly.
Future

ICM will continue its work on behalf of the Safe Motherhood Initiative. Plans include work with WHO, UNICEF, and WABA on "Baby Friendly Hospitals" and the promotion of various breastfeeding initiatives.

The ICM also seeks to work with other international organizations. Preliminary plans are in hand to work with the International Federation of Gynecology and Obstetrics (FIGO) and the International Council of Nurses (ICN), in moving the Safe Motherhood Initiative forward. It is envisaged that these plans will be developed over the next two years.

Workshops are being planned for Vancouver in 1993 (Midwifery Practice - Measuring, Developing and Mobilizing Quality in Care), in collaboration with WHO and UNICEF. Another is planned in Oslo in 1996.

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THE INTERNATIONAL COUNCIL OF NURSES

The International Council of Nurses (ICN) is an independent, non-governmental federation of national nurses associations (NNAs) in over 100 countries, representing 1.2 million nurses worldwide. Founded in 1899, ICN is the oldest international professional organization in the health care field. Since its inception, it has worked for the improvement of health services and the recognition of nursing’s vital health care role.

As a representative body, ICN works closely with international organizations on matters related to health in all parts of the world. As a federation of nurses’ associations, ICN works with its members to develop nursing leadership in health care; to strengthen health services, through developing adequate standards for nursing education, practice and management; and to increase the participation of nurses in policy formulation and health planning. In addition, ICN provides guidance to its members on a broad range of professional concerns.

Initiatives in the Field of Safe Motherhood

International Nurses Day 1988. Safe Motherhood was the focus of International Nurses Day 1988. Over 4000 resource kits in English, French and Spanish were distributed to approximately 120 NNAs and many ministries of health. Conferences, seminars and continuing education programs were organized, and NNAs provided a variety of community outreach services during the celebration, including health education for Safe Motherhood, consultation, checkups and immunization.

Increasing nurses’ effectiveness in maternal and child health care through national continuing education programs: ICN and three of its member associations (Nigeria, Swaziland and Zaire) implemented a three year project (1987-1989) to improve the health status of mothers and children through community mobilization activities, with financial support from UNICEF. One of the project’s major goals was to document the impact of nurse-initiated community mobilization activities on the health of mothers and children. A total of twelve village-based workshops were held, involving 843 nurses. More than 1500 families, or approximately 7,000 people, benefitted from nurses’ visits.

Mobilizing nurses for AIDS prevention and care in eight African countries: ICN and eight of its member associations in Africa implemented a two year project (1990-1991) to increase the ability of the NNAs to participate in their countries’ plans for reducing HIV transmission and associated morbidity and mortality, with financial support from the WHO/GPA program. A major project objective was to train trainers from each of the NNAs to plan, implement and evaluate educational sessions for nurses in their respective countries. As a result of this activity, at least 800 nurses in the eight countries are now knowledgeable in this field and able to train colleagues who did not attend the workshops.
Nursing regulation: This four year project (1988-1991) focused on assisting NNAs and nurses in government and regulatory agencies to effect changes in the laws, rules and regulations that apply to nursing education and practice. Studies by ICN and the World Health Organization had shown that inadequacies in current regulatory systems and outdated, inappropriate laws represented significant barriers, preventing nurses and midwives from providing the full range of services required, especially in the field of primary health care.

The project has now reached over 80 countries. Although bringing about regulatory change takes a great deal of time, considerable progress has been reported. Changes have occurred, particularly in the areas of education standards and the legal scope of practice, which should permit more effective use of nurses in areas related to the Safe Motherhood Initiative. Guidelines for the development of standards for nursing education and practice have been prepared and are in use in several countries.

Field work: During country visits, ICN nurse consultants encourage and assist NNAs in the planning and implementation of community-based programs in areas of special concern. NNAs have been successful in a variety of areas related to the Safe Motherhood Initiative, including immunization campaigns and health education programs focusing on the childbearing woman and practices harmful to women’s health.

Future Plans

Nurses’ access to all levels of health policy and planning, maintaining an adequate and appropriate supply of nurses and midwives, and achieving better management of nursing resources in the present climate of financial constraints will be major areas of focus in the coming years.

ICN will continue to urge the World Health Organization to make more resources available through its regional and country programs for the purpose of strengthening national nursing and midwifery programs.

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INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS

Following the International Conference on Safe Motherhood held in Nairobi on 10-13 February 1987, several members of the World Health Organization (WHO)/International Federation of Gynecology and Obstetrics (FIGO) Task Force have played an important role in promoting greater awareness of the problem of maternal mortality in the medical community:

a) A Safe Motherhood information kit (in English, French and Spanish) prepared by WHO for the Nairobi conference, was made available to participants in the Xllth FIGO World Congress of Gynecology and Obstetrics held in Rio de Janeiro in October 1988.


c) A workshop on "Women's Health and Safe Motherhood - the Role of the Obstetrician and Gynecologist" was organized in collaboration with WHO and took place in Rio de Janeiro in October 1988. The recommendations of this workshop were accepted by the FIGO Xllth General Assembly and published in the IJGO (1989, 28: 79-84). One of the important recommendations called for FIGO to address the World Health Assembly and WHO Regional Committee meetings, to draw the attention of WHO member states to FIGO's offer of collaboration with and support for national efforts, in order to ensure Safe Motherhood and the health of women. The first such address took place during the 42nd World Health Assembly in May 1989, when a presentation was made to Committee A.

d) Another workshop on "Professional Responsibilities in Maternity Care" was organized with Mother and Child International in collaboration with WHO and International Confederation of Midwives (ICM), in Rio de Janeiro in October 1988. The recommendations of this workshop were accepted by the FIGO Xllth General Assembly and published in the IJGO (1989, 28: 79-84) as were the proceedings (1989, 30: 1-50).

The FIGO Committee on "Safe Motherhood" was created in October 1988 under the chairmanship of Dr. Vivian Wong. This Committee's primary objective is to bring the "Safe Motherhood Initiative" to the attention of obstetricians and gynecologists and to promote member involvement in the Safe Motherhood Initiative, and communicate with FIGO member societies initiating Safe Motherhood activities, as well as monitoring these activities. To this end, a questionnaire was circulated in December 1989 to societies affiliated with FIGO. Replies indicated a need to target countries with high maternal mortality rates.

109
In February 1989, FIGO sent a representative to attend a conference on Safe Motherhood for Francophone sub-Saharan Africa held in Niamey (Niger). In the same month, the President of FIGO attended a conference on the role of non-governmental organizations in reducing maternal mortality and morbidity in Bellagio (Italy).

FIGO was represented at the 2nd and 3rd meetings of Interested Parties organized by WHO in June 1989 and in June 1990.

FIGO was also represented at the joint ICM/WHO/UNICEF workshop on Midwifery Education - Action for Safe Motherhood which took place in Japan in October 1990.

Dr Mahmoud Fathalla, from WHO, presented a paper entitled "Strategy for Mothers’ Survival" at the Safe Motherhood Conference held on the occasion of the XIIIth Latin American Congress of Gynecology and Obstetrics in Uruguay in November 1990.

In September 1991, prior to the XIIIth FIGO Congress of Gynecology and Obstetrics, the Safe Motherhood Committee co-organized a workshop with Mother and Child International, in collaboration with WHO and ICM. The objective of this workshop was to discuss the proposals concerning the proper delegation of responsibilities to health workers other than obstetricians in an effort to reduce maternal mortality and morbidity. The workshop issued recommendations, which were accepted by the FIGO General Assembly and published in the International Journal of Gynecology and Obstetrics. Background papers and a summary of the presentations will be published and circulated as a IGJO supplement.

Another pre-congress workshop entitled "Women’s Perspectives and Participation in Reproductive Health" was co-organized with WHO. Its objective was to discuss and recommend nationally oriented and feasible actions for increased involvement of women and women’s groups in the development of policies, design of strategies, implementation of services, and assessment of training and research needs in reproductive health. The recommendations from this workshop were also published in the IJGO and widely circulated.

In addition, subjects and topics connected with Safe Motherhood were given high profile in the scientific programme of the XIIIth FIGO conference of Gynecology and Obstetrics.

FIGO was represented at the Central American Regional Meeting on Safe Motherhood held in Guatemala City in January 1992.

Future Plans

FIGO’s main endeavor through the Safe Motherhood Committee is to liaise with national and regional professional organizations to:
1. promote the use of maternal mortality audit procedures at the hospital, district, regional, provincial, state and/or national level, where ever feasible;

2. promote the development of "essential obstetric care" at peripheral hospitals;

3. publish and distribute the recommendations of the workshop on delegation of responsibilities to non-obstetricians, and assist in their implementation through training and supervision programmes;

4. assess progress through a workshop on "maternal mortality audit," which will be held in Montreal in September 1994 immediately before the XIVth FIGO World Congress of Gynecology and Obstetrics.

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INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES

In a global organization such as the International Federation of Red Cross and Red Crescent Societies, with 150 National Societies around the world, it is always a challenge to develop new priorities and programs. We have had experience with different approaches, but currently, in an effort to ensure better sustainability, we tend to favor an integrated approach. While this provides fewer high-profile activities in the short term, we believe that it is likely to have greater long-term impact.

The Federation has therefore developed its Safe Motherhood-related activities in the following ways:

- Adoption of Resolutions during the International Federation's General Assemblies, in 1989 and 1991, the former specifically on Safe Motherhood and the latter a more general Resolution on the Health of Women and Children (see attached). These Resolutions have the purpose of both informing and mobilizing the national Societies that comprise the Federation.

- Use of existing channels of communication within the Federation to mobilize and share information. For example, an article on Safe Motherhood was prepared for the "Red Cross Red Crescent," the magazine of the Red Cross and Red Crescent Movement.

- Use of existing networks to raise the issue, for example, through the non-governmental organizations (NGOs) Primary Health Care (PHC) Group (which the Federation currently chairs) and the NGO Committee of UNICEF. A background paper on Safe Motherhood was prepared by the Federation for the 1989 NGO Committee of UNICEF Forum in New York.

- Encouraging National Societies to attend regional meetings, for example, the meeting on Safe Motherhood organized for southern African countries.

- Providing simple information materials for national Societies: a booklet focusing on Safe Motherhood in the Federations "Learn More About...." series is about to be revised.

- Support, through technical advice and the provision of other resources, for Red Cross and Red Crescent Society programs that focus specifically on women, primary health care and development.
• Plans to help alleviate the suffering of women caused by vesico-vaginal fistulae (VVF) had to be stopped in Somalia due to the political situation, but a feasibility study for a similar project will soon be undertaken in Nigeria.

Within the Federation we have placed a major emphasis on the fact that Safe Motherhood is not only an issue for obstetric services. This is especially relevant since few National Societies are directly responsible for such services. We have stressed that Safe Motherhood has everything to do with development, with the health of girl children, with the role and status of women in society, and with the quantity and quality of health care and education.

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THE INTERNATIONAL PLANNED PARENTHOOD FEDERATION

In full support of the goals of the Safe Motherhood Initiative, the International Planned Parenthood Federation (IPPF) promotes family planning activities, which have a direct impact on the prevention of maternal mortality and morbidity, chiefly through its 135 affiliates around the world.

IPPF is an active partner in the Safe Motherhood Initiative's collaborative effort to improve the quality of life for girls and women. IPPF representatives from international offices, regional offices, and national family planning associations have participated at all regional and national Safe Motherhood conferences and have strongly advocated for family planning to be included in all Safe Motherhood activities.

Two examples of IPPF efforts to support the Safe Motherhood Initiative are the Youth for Youth Project and the reduction of unsafe abortion.

Youth for Youth: Promotion of Adolescent Reproductive Health Through NGO Collaboration

IPPF has executed, with UNFPA funds and technical assistance from WHO, a program to promote adolescent reproductive health by involving youth in defining solutions to their own reproductive health problems. Non-governmental and governmental youth-serving organizations are collaborating at the national and international levels to promote and implement the project, which is currently underway in six countries: Jamaica, Senegal, Colombia, Egypt, Sri Lanka, and Sierra Leone. Specific project topics, which are identified by young people in each country, are diverse.

The Youth for Youth Project was developed in response to a number of specific issues related to the Safe Motherhood Initiative. Traditional health systems often ignore young people and their reproductive health needs, particularly those of young females. Also of concern is the high risk of mortality and morbidity related to pregnancy and unsafe abortions faced by very young girls. The prevention of AIDS and STDs is also vital to improving the health and quality of life of young women.

All the projects contain a sexual health element. Half the projects deal directly with Safe Motherhood, through IEC programs concerning a variety of topics: in Egypt, the prevention of early marriage and its consequences; in Sri Lanka, the prevention of illegal abortion; and in Sierra Leone, the prevention of female genital mutilation. In Colombia, Jamaica and Senegal, the projects focus on training youth in communication skills and counselling methods, to enable them to teach their peers about sexuality, decision-making, contraception and STD prevention. In all countries, the projects are being run by highly motivated young people. In addition, all have produced IEC materials and have integrated reproductive health into the local network of youth-serving organizations.
The expansion of a network of organizations concerned with adolescent reproductive health, at both the international and national levels, has been an additional outcome of the Youth for Youth Project. The International Steering Committee of the Youth for Youth Project is comprised of: IPPF, League of Red Cross and Red Crescent Societies, World Assembly of Youth, World Association of Girl Guides and Girl Scouts, World Organization of the Scout Movement and World YWCA. The World Bank, the Population Council, UNICEF and UNDP have also contributed to the project. In addition, the following organizations have been involved in the Project through correspondence, meetings, exchange of ideas, and feedback: the Population Crisis Committee, the Center for Population Options, the Commonwealth Institute, the Centre Internationale de L'Enfance (CIE), and Gesellschaft Technischer Zusammenarbeit (GTZ).

In several countries, high level government representatives attended the first national-level workshop, and in each country the government gave their support for the Youth for Youth Project. Representatives from youth-serving NGOs also attended the initial workshops, at which each country established a National Task Force and a Youth Committee devoted to adolescent reproductive health. One NGO in each country has taken the lead in coordinating the Task Force: in Jamaica, the Red Cross Red Crescent Society; in Senegal, the Boy Scouts; in Egypt, the Boy Scouts and Girl Guides; and in Sierra Leone, the YWCA. The total number of national level NGOs involved in the Youth for Youth Project has risen from six to forty seven.

Unsafe Abortion

For every death due to unsafe abortion, many more women experience serious complications that impair their sexual and reproductive health. IPPF has identified unsafe abortion as a major Safe Motherhood and reproductive health concern worldwide and is working to reduce rates of unsafe abortion by increasing the availability of contraceptive services. IPPF also recommends that all member associations:

- review the physical, emotional, spiritual, and social costs of unsafe abortion;
- advocate for the availability of appropriate health care services for women suffering from the complications of unsafe abortion;
- maintain a positive dialogue and work constructively with other NGOs or groups devoted to reducing the prevalence of unsafe abortion in areas where access to safe abortion services is restricted;
- defend safe and responsible abortion services against unjustified criticism and restriction where such services are available; and
- assist health professionals to implement safe abortion services, where appropriate, according to contemporary interpretations of the law, and to facilitate women's unrestricted access to these services.
Partnership with other organizations, the development of youth-oriented projects, and the reduction of unsafe abortion are examples of some of the ways in which IPPF promotes family planning, joining the Safe Motherhood Initiative in improving the quality and safety of girls' and women's lives.

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INTERNATIONAL PROJECTS ASSISTANCE SERVICES

Introduction

International experts have identified unsafe abortion as one of the most common medical causes of maternal death. Approximately 200,000 women die annually from the complications of unsafe abortion, while thousands more suffer permanent injury. The Safe Motherhood Initiative has advocated programs to improve the management of abortion complications as one potential strategy for reducing maternal mortality worldwide. International Projects Assistance Services (IPAS), a U.S.-based non-profit organization working primarily in Latin America and Africa, has pursued this strategy through collaborative projects with institutions to improve the quality of abortion care they provide. IPAS works directly with health care providers, medical educators, administrators, and ministries of health to design comprehensive programs that include safe, timely treatment for abortion complications, increased access to safe, voluntary abortion services, where appropriate, and comprehensive family planning counseling and services that break the tragic cycle of unwanted pregnancy and reduce the need for abortion.

Medical Training Programs

One of the most important factors influencing abortion-related morbidity and mortality is access to safe and timely treatment for abortion complications. Numerous studies have shown that vacuum aspiration is the safest method of uterine evacuation, with half the complication rate of sharp curettage (or D&C), which is still the standard clinical technique used in much of the developing world. In addition, the World Health Organization has recommended vacuum aspiration as the procedure of choice for the clinical management of incomplete abortion. Manual vacuum aspiration (MVA), a variation of vacuum aspiration, is a safe, simple and efficient method of uterine evacuation that is particularly appropriate to health care settings with limited resources. MVA can be performed on an outpatient basis with minimal pain control, thereby consuming fewer scarce hospital resources than D&C and enabling women to receive more timely care.

IPAS sponsors training programs for physicians and health personnel in major teaching hospitals throughout the developing world, facilitating incorporation of MVA and appropriate post-abortion family planning counseling into medical curricula and improving the quality of abortion care for women. IPAS programs also promote decentralization of MVA service delivery to hospitals and health care centers in rural areas to increase women's access to timely treatment of abortion complications. Finally, IPAS works to develop sustainable MVA training and service delivery programs to the greatest extent possible given each country's resources.
Programs that influence Policy

**Policy Impact at Hospital Level.** In addition to improving clinical care for women, IPAS programs strive to influence health policies at the hospital level to bring about changes that will reduce abortion-related morbidity and mortality. For example, in an IPAS study documenting the average cost expended per patient in the management of incomplete abortion, the use of MVA was found to result in a 35-63% savings in Kenya and Mexico. MVA also reduces the length of time women wait for treatment, lowering the likelihood that they will develop infections that can lead to severe complications or death. The results of this study are being used to promote policy changes in treatment protocols that will improve the management of clinical services and help to reduce abortion-related maternal mortality.

Several IPAS-sponsored programs have also influenced positive changes in hospital policies on the provision of contraceptive counseling for patients suffering from incomplete abortion -- a high-risk group that is often overlooked in family planning programs. These changes encourage all women treated for incomplete abortion to seek family planning counseling and, if desired, to choose and begin using a contraceptive method of choice following treatment.

**Policy Impact at National Level.** IPAS programs strive to improve health care policies at the national level. Specifically, IPAS collaborates with ministries of health to improve the quality of abortion care on a system-wide basis. Such policies include:

- decentralizing abortion services to the primary care level to ensure that women have access to timely treatment for abortion complications;
- authorizing the purchase and distribution of MVA equipment to ensure that the safest technology for treating abortion complications is available throughout the health care system;
- broadening access to contraceptive methods and family planning counseling services for high risk groups, such as adolescents and unmarried women.

**Examples of IPAS Program Impact**

IPAS programs in Latin America and Africa have approached the need for safe abortion care in a variety of ways. Following are several examples of program impact at both the hospital and national levels.

**Nigeria**

- The Federal Ministry of Health (FMOH) has recognized the appropriateness of MVA technology and has purchased MVA equipment for training and use in four major teaching hospitals. The FMOH plans to extend this support to several more tertiary care institutions in the coming years.
The Nigerian Medical Association (NMA) has advocated the need for MVA training for physicians at all levels and is actively working to influence policies that regulate medical training. The NMA is also developing standardized protocols for the management of incomplete abortion, including use of MVA, to be used at all levels of the health care system.

Kenya
- A recent meeting of Ministry of Health officials and IPAS representatives in Kenya regarding the status of abortion care resulted in recommendations to adopt MVA as the standard method for treating incomplete abortion in all Kenyan hospitals. These recommendations were the outgrowth of collaborative MVA training, sponsored by IPAS since 1989, for health care personnel at the district level.
- Meeting recommendations also included a review of policies prohibiting distribution of contraceptives to adolescents and unmarried women, and an evaluation of how the current laws regulating abortion affect abortion-related mortality.

Mexico
- Both the Ministry of Health and the Mexican Institute of Social Security (IMSS), the country’s largest health care providers, have recognized the importance of MVA for improving the quality of abortion care and accessibility of treatment services. MVA is currently utilized at 41 health care facilities in six Mexican states and plans are underway to extend these services more widely throughout both systems.

Nicaragua
- With support from the Ministry of Health, MVA training and treatment services have been decentralized to hospitals and health centers throughout the country. The Ministry has designed national guidelines for the management of incomplete abortion and is actively working to monitor the quality of services and improve abortion care.

Conclusion. The impact of Safe Motherhood programs on reducing maternal mortality is often difficult to document. Nevertheless, in many settings, clinical improvements in the management of incomplete abortion and system-wide improvements in abortion care can be traced directly to the use of the MVA technology. MVA is safer and less traumatic than D&C for women requiring uterine evacuation and allows for decentralization of its use and an increased number of service delivery points for abortion care. As demonstrated in several countries, savings resulting from use of this safer technology can allow scarce health resources to be devoted to other activities to reduce maternal mortality. Finally, in addition to the direct impact on women’s health, IPAS programs
have focused attention on abortion as a major cause of maternal mortality and on the need for preventive approaches to reduce unwanted pregnancy and unsafe abortion.

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THE INTERNATIONAL WOMEN’S HEALTH COALITION

The International Women’s Health Coalition (IWHC) is a private North American organization working in alliance with women’s health advocates, women’s organizations, health professionals and government officials in Southern countries and Northern institutions. Together, we promote women’s reproductive health and rights and serve as a catalyst for action. We are concerned with the daily realities of women’s lives and with programs and policies that affect women’s ability to manage their sexual health and attain their reproductive rights. IWHC’s objectives are to enable women to do the following:

• manage their own fertility safely and effectively by conceiving when they desire to, terminating unwanted pregnancies, and carrying wanted pregnancies to term;

• experience a healthy sexual life and remain free of disease, disability, fear, pain or death associated with reproduction and sexuality; and

• bear and raise healthy children as and when they desire to do so.

To achieve these objectives, IWHC engages in a variety of activities:

• we support women, women’s organizations and health professionals who are working to promote reproductive rights and comprehensive high-quality reproductive health services.

• we encourage projects that demonstrate that high-quality reproductive care, including safe abortion services and the management of reproductive tract infections, is appropriate and feasible in resource-poor communities.

• we document the incidence and consequences of critical but neglected reproductive health problems, such as clandestine abortion and sexually transmitted diseases, among women in the general population.

• we undertake advocacy in the United States and internationally, for financial support and public policy recognition of women’s reproductive health and rights.

IWHC provides professional, moral and financial support to colleagues in eight countries of Asia, Africa and Latin America. We seek to identify and sustain leaders and to facilitate contact among colleagues both within and across countries and regions; our network includes 3,000 people. We also initiate and convene international conferences, collaborate with established organizations and publish issue papers.
At the heart of our effort and our concern is the hope that we can contribute to a worldwide women's health movement, premised on the full participation of women at all levels of decision-making -- community, national and international.

During the last seven years, we have developed and supported service delivery projects, research and public education and advocacy programs in Bangladesh, Indonesia, the Philippines, Brazil, Chile, Peru, Venezuela, Cameroon and Nigeria. In addition to making small grants to women, women's organizations, and health professionals, IWHC helps local organizations achieve professional and financial autonomy, nurtures emerging leaders, and facilitates contact among colleagues in different countries. On the advice of our Southern colleagues, we are increasing our emphasis on activities directly concerned with public education and advocacy in the United States and on initiatives among international agencies concerned with development in Southern countries.

Cutting edge issues of concern to IWHC in the current year are the promotion of understanding about the prevention of reproductive tract infection:

- iatrogenic infections acquired during medical procedures such as birth, abortion or IUD insertion.
- endogenous infections caused by overgrowth of organisms normally present in the genital tract.
- sexually transmitted diseases including AIDS.

Sexual behavior, sexuality and gender power are crucial to the search for solutions to these problems and are therefore high on our agenda.

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ITALY: Ministry of Foreign Affairs

Italy's current policy in the field of women's health stresses development of health and sexual education, and strengthening and improving the skills of the women staff (nurses and midwives), primarily in Africa.

Support for and cooperation with an Italian non-governmental organization (NGO) in the anti-sexual mutilation campaign in Muslim Africa is an important example of activities undertaken in Africa. Italian cooperation is also active in Djibouti (in the slums of Balbala) and has created a mother-and-child hospital managed by an Italian team.

As far as Latin America is concerned, following the Curacao meeting of Latin American women, the Italians are working with Argentina to prepare a pilot project that will create family planning centers -- social and health structures set apart from hospitals -- to provide sexual information, health information, contraceptive methods, prenatal care, pap smears, etc.

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Since January 1989, the Maternal and Child Epidemiology Unit (MCEU) has coordinated a unique international program of methodological research on women’s health in developing countries. The primary objectives of this five-year program are to evaluate existing methods for measuring women’s health, particularly in the community, and to develop, pilot and promote the use of new approaches. Two principal phases of activity can be distinguished. The first two-year phase has been devoted to essential background research, with funding from the British Overseas Development Administration and the Ford Foundation. Completed activities include: writing four review papers relevant to measuring women’s health; conducting analyses to illustrate the potential of existing survey data to examine maternity care patterns; developing a computerized reference collection; refining the sisterhood method for estimating maternal mortality, which was pioneered by the program director (Dr. Wendy Graham); hosting a workshop; and establishing formal links with institutions working on women’s health.

Phase II of the programme commenced in January 1991, with two major components. Firstly, field studies to explore women’s health issues using a range of methodologies will be carried out in collaboration with six institutions in developing countries. Secondly, the findings of the field studies will be used to develop both a model questionnaire schedule on women’s health suitable for application in community-based surveys and a critical review of the content and design of women’s health records used in health services. The summary titles of the six studies are as follows:

- A prospective study to assess patterns of care among pregnant and postpartum women admitted to Assiut University Hospital, Upper Egypt;
- Measurement of the effectiveness of case-management procedures on contraceptive use in a new settlement area of Istanbul, Turkey;
- An investigation into the nature and determinants of maternal morbidity related to delivery and the puerperium in Bangladesh;
- A study of maternal mortality and morbidity related to prolonged and obstructed labour among women in Zaria, Nigeria;
- Determination of levels and causes of maternal mortality in Honduras, using the sisterhood method;
- Health profile of women in Lower Egypt assessed at health services and in the community.
Summary descriptions of these six studies are available on request. Together, the studies cover the major aspects of maternal ill-health, and each has important programmatic and methodological components. With regard to programmatic issues, collaborating institutions have pinpointed relevant, local women’s health issues as perceived by providers of care at ministerial and service levels. In methodological terms, the collaborative studies provide an opportunity for evaluating alternative sources of information on women’s health and for identifying appropriate means of obtaining reliable information directly from women using structured questions. The Phase II programme findings will be disseminated through reports and publications on the individual and collective results of the field studies, the model questionnaire schedule, and the review of women’s health records, through local workshops held at the collaborating institutions, and presentations at key scientific meetings.

This program, co-ordinated by MCEU, is currently the only major international research initiative which is specifically focusing on measurement-related issues in women’s health.

MCEU Staff: W.J. Graham, O.M.R. Campbell, V.G.A. Filippi, E.A. Goodburn, J.L. Davies

Collaborators: Professor S.A.H. Abdullah, Assiut University, Assiut, Egypt; Dr. G. Bidegain, Population and Teaching Research Unit, University of Honduras, Tegucigalpa, Honduras; Dr. A. Bulut, Institute of Child Health, University of Istanbul, Turkey; Dr. M. Chowdhury, Bangladesh Rural Advancement Committee, Dhaka, Bangladesh; Dr. E. Essien, Ahmadu Bello University, Zaria, Nigeria; Ms. S. Schkolnik, Centre for Latin American Demography, Santiago, Chile; Dr. Y. Waheeb, Suez Canal University, Ismailia, Egypt.

Key References:
(Except where noted, all the following are publications of the Maternal and Child Epidemiology Unit of the London School of Hygiene and Tropical Medicine).


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THE JOHN D. AND CATHERINE T. MACARTHUR FOUNDATION

The Population Program

A major component of the Population Program has women’s reproductive health as its focus. The objective of this component is to promote creative strategies for improving women’s reproductive health and to encourage the full participation of women in decisions that affect their health and reproduction.

This program recognizes that the range of issues affecting women’s reproductive health goes well beyond their childbearing role and includes such factors as their legal rights, household responsibilities, and access to education and employment.

The program supports action, advocacy, and research concerned with the reproductive health and well-being of women and girls, particularly adolescents and poor women who are underserved by current programs. It places priority on programs initiated by women from the four focus countries, Brazil, India, Mexico, and Nigeria, and which emphasize the importance of social, cultural, and economic factors in influencing individual reproductive choices and behaviors.

In this context, the program makes grants for the following purposes:

• helping women to make informed decisions about sexuality, marriage, and childbearing;

• supporting programs of social and epidemiological research and action on neglected aspects of women’s health, including reproductive tract infections, infertility, abortion, maternal mortality and morbidity, AIDS, and the accessibility of safe, quality health care; and

• facilitating communication and networking among women’s groups, health care providers, and policymakers regarding these issues.

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MARIE STOPES INTERNATIONAL

Marie Stopes International (MSI) is a non-governmental organization comprised of a domestic division, which provides well-woman and family planning services throughout the United Kingdom, and an international division, which provides maternal and child health care and family planning in 22 countries of the developing world.

Marie Stopes, who was the pioneer of family planning in the UK, started a "mothers clinic" in London in the 1920s. The clinic has operated continuously since then from the same Victorian house, which now serves as headquarters of an extensive organization working for women and their families. The first of MSI's overseas initiatives was the India program, which commenced in 1978. Twenty-eight clinics now operate in nine states, offering integrated maternal and child health care and family planning, including gynecological and pediatric consultations, safe delivery services, immunization and provision of nutritional supplements. Rural communities are served by mobile and outreach projects. Innovative IEC projects involving women's groups and students have been undertaken. Training of doctors and paramedics is an important part of the India program, as is the social marketing of contraceptives.

The India program is the flagship of MSI and a model for other country programs. On the African Continent, Kenya boasts a mature MSI program. In South America, the MSI Nicaragua program is one of the fastest growing and most exciting.

MSI is dedicated to improving the health and opportunities of women by:

1. helping them avoid high-risk pregnancies and reducing the number of unwanted pregnancies;
2. enhancing women's health during pregnancy;
3. providing safe delivery services coupled with postpartum family planning; and
4. providing safe abortion services.

A description of the Kenyan MSI clinic is attached. For further information, please contact:

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With a population of 25.2 million, Kenya not only has one of the highest population growth rates in the world (currently estimated at 3.8% per annum) but also one of the most youthful populations, with 50% under 25 years of age. Kenya has had an official family planning program since 1965, and although progress has been made, solutions still have to be found for the continuing problems of poorly spaced births, adolescent pregnancies and extremely large families.

Marie Stopes International has been providing family planning services in Kenya since March 1986 when European Economic Community (EEC) funds were secured for a maternal health care clinic. The Kenyan program now includes three Nairobi-based MSI Clinics, which provide out-patient sterilization and contraception and maternal and child health services. These services are complemented by undertaking educational talks in and developing literature for schools, colleges and factories; training health personnel in female sterilization and vasectomy procedures; providing free immunization of infants; and distributing contraceptives at the community-level.

A grant was received from the EEC in early 1989 for the establishment of three further clinics in agricultural areas of Kenya. Clinics are now open in Muranga, Meru and Kakamega.

1987 saw the introduction of a family planning education and service program, funded by the Overseas Development Administration (ODA), for the National Youth Service (NYS) of Kenya, a country-wide government organization for training and mobilizing young people for national development projects. Selected groups of young people are provided with information and education on reproductive biology, spacing and prevention of births and maternal and child health, as well as the responsibility of parents towards children and each other, and the choice and proper use of reliable contraception methods.

ODA has granted funds for an extension of this project, as requested by NYS officials. It will now be possible to provide 20 hours of family life education to each of the 8000 NYS recruits.

Funding was recently secured from the EEC for the establishment of an integrated essential obstetrics service, incorporating maternal and child health and family planning support for underprivileged women in the Eastleigh area of Nairobi. This service assisted over 280 women giving birth in the first nine months of 1991.
THE MOTHERCARE PROJECT

Maternal and perinatal health problems are "silent" problems -- they remain, to a large extent, uncounted and unreported. Pregnant women and newborns have had no advocates; if they die, it is often attributed to fate. Changing this prevailing attitude to "pregnancy is special" is the major challenge for Safe Motherhood programs.

MotherCare aims to improve pregnancy outcomes for women and newborns through a household and community-based approach. Basic strategies to achieve this aim are as follows:

- Promote awareness of maternal and neonatal health and nutritional problems and options for addressing them, including advocacy for policy and program change.

Actions include:

- MotherCare Matters 1 (1-4), 2 (1), Quarterly literature update with a mailing list of 1500 people and institutions.
- Working Paper Series on a variety of topics, ranging from specific problems (e.g., anemia, neonatal tetanus) to case studies of model maternal care programs.

- Improve maternal and newborn health through increased practice of health-promotive behaviors during the reproductive and neonatal periods and by developing strategies to reach women with health-promotive messages.

Actions include:

Project activities include the development of communication strategies to promote the following:

- recognition of danger signs in the puerperium and during pregnancy, labor and delivery, and appropriate use of services in response, in Indonesia, Bangladesh, Bolivia, Guatemala, and Nigeria.
- compliance with the iron folate supplementation regimen in Indonesia.
- use of new peripheral facilities and providers in Indonesia (e.g., MCH Huts where normal births can take place).

- Improve the recognition of and response, practices and required skills related to the major causes of morbidity and mortality among women and the neonate at each level of service, from the community to the hospital level.

Actions include:

- Protocols for major causes of maternal and neonatal problems for health center and hospital personnel, in Guatemala, Indonesia and Bolivia.
- Demonstration Projects:
  - Perinatal Regionalization Project, Tanjungsari, Indonesia.
  - Quetzaltenango Project, Guatemala.
  - Cochabamba Reproductive Health Project, Bolivia.
  - Maternal Mortality Reduction in Nigeria, with the Federal Ministry of Health.
  - Strengthening Midwifery Life Saving Skills in Uganda.

- Clarify issues and identify useful methods and tools for assessing maternal and neonatal health and nutrition problems and their determinants.

Actions include:

- Longitudinal surveillance system for maternal morbidity and pregnancy outcomes, Indonesia.
- Retrospective case review for maternal and perinatal mortality, Guatemala, Bolivia and Bangladesh.
- Training needs assessment tools for use with TBAs and health workers, Guatemala and Indonesia.
- Effectiveness of the Kangaroo Mother Method, Ecuador.

MotherCare is funded by the U.S. Agency for International Development under a five-year technical assistance contract to John Snow, Inc. (JSI), in collaboration with The Population Council, The Manoff Group, Save the Children Federation, The Centre for Development and Population Activities, the American College of Nurse Midwives, Women's International Public Health Network and the Western Consortium for Public Health.

For further information, please contact:

MotherCare
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U.S.A.
Tel: 703 528 7474
Fax: 703 528 7480
Telex: 272896 JSI WUR
MOTHER AND CHILD INTERNATIONAL

Mother and Child International (MCI) was founded in 1977 in Geneva as the International Association for Maternal and Neonatal Health (IAMANEH) by the late Professor Hubert de Watteville. The objectives of the organization are consistent with those of the Safe Motherhood Initiative (SMI). The central secretariat, based in Geneva, stimulates activities related to the SMI, which are then carried out by the organization's 30 national affiliates. These MCI projects are primarily related to trials of new innovations and cross-fertilization of ideas through educational meetings among representatives of our national affiliates. Some of the key activities within the context of the SMI since 1987 are as follows:

1. The Third International Congress for Maternal and Neonatal Health held in Lahore, Pakistan in November, 1987. The Congress was opened by the President of Pakistan and the keynote address was given by Professor Carl Taylor. One Congress session was devoted to the reduction of maternal mortality with addresses by Professors K.A. Harrison, S.S. Ratnam, A.R. Omram and S.F. Begum. A Declaration of Lahore was issued and widely publicized. The complete proceedings of the Congress were published as Maternal and Child Care in Developing Countries, edited by E. Kessel and H.K. Awan.

2. A Workshop on Professional Responsibility in Maternal Care was held in Rio de Janeiro, Brazil in October, 1988, co-sponsored by MCI and the International Federation of Gynecology and Obstetrics (FIGO) in cooperation with the World Health Organization (WHO) and the International Confederation of Midwives (ICM). The proceedings of the Workshop were published in the International Journal of Gynecology and Obstetrics, volume 30, 1989, edited by G. Rooth and E. Kessel. To quote from the foreword:

   Development of a professional attitude is accomplished through instruction, and especially in-service training, during which an opportunity is afforded to establish a reputation among one's peers. The essence of this preparation is study of relevant educational material depicting achievement of standards of service in a group dynamics context. The energy driving the resultant professional commitment is the ego of participating colleagues.

This concept was successfully tried by our Pakistan national affiliate in their MCH program for a depressed area of Lahore, including evidence for a decline in maternal mortality in the area.
Recommendations of the Workshop were approved by the General Assembly of FIGO.

3. A Regional Congress on Innovations in Family Planning and Maternal and Child Health for Better Mother and Child Survival was held in October, 1989 in Lahore, Pakistan. Representatives from the seven SAARC countries plus China and Vietnam attended. The proceedings of the Congress were published by the Maternal and Child Welfare Association of Pakistan as Innovations in FP and MCH for better Mother-Child Survival, edited by A. K. Awan and M. Aslam Khan.

4. A Workshop on Delegation of Responsibilities in Maternity Care in Developing Countries was held in Singapore in September 1991, and was cosponsored by MCI and FIGO in cooperation with WHO and the ICM. The proceedings of the Workshop will be published soon in the International Journal of Gynecology and Obstetrics with G. Rooth and E. Kessel as editors. The recommendations of the Workshop were approved by the General Assembly of FIGO.

5. The Fourth International Congress for Maternal and Neonatal Health was held in September, 1991 in Bandung, Indonesia in conjunction with the Fourth National Congress of the Indonesian Society for Perinatology, with the theme, Maternal and Infant Mortality: Closing the Gap Between Perinatal Health Services. A report of the Congress Proceedings are in preparation.

6. MCI and the International Federation for Family Health cosponsored the First International Symposium on the Quinacrine Pellet Method of Nonsurgical Female Sterilization in September, 1991 in Bandung, Indonesia. The consensus of the researchers who are testing this method was that it is safer than surgical sterilization and easier and less costly to deliver. As greater access to sterilization can help to prevent high risk pregnancies, the method has potential to lower maternal mortality.

7. The MCI Newsletter is regularly published as a medium of continuing education and exchange of information among and about our national affiliates. It has a circulation of 2000.

8. Since 1991, MCI has administered a grant from the World Bank for innovative maternal and child health projects that are low cost and have the potential for financial self-sufficiency and growth. Approximately $100,000 in grants have been awarded to date.
9. MCI has served as consultant to the WHO Safe Motherhood Initiative program of operational research to reduce maternal mortality and morbidity. Two projects developed with our consultative assistance have been funded by WHO and two are under consideration for funding.

10. MCI together with the International Federation for Family Health has supported trials of the quinacrine pellet method of nonsurgical sterilization. The Government of India and Vietnam are conducting official trials, and many other hospitals and outpatient clinics are participating in trials of this promising new family planning method.

For further information, please contact:

Mother and Child International
Chemin de la Grande Gorge 16
1255 Veyrier/GE
SWITZERLAND
Tel: 41 22 790 5820
Fax: 41 22 784 0658
NORWAY: Norwegian Agency for Development Cooperation

Norway has been a strong supporter of the Safe Motherhood Initiative (SMI) since its inception and it will continue to give Safe Motherhood high priority within Norwegian development cooperation.

Since 1971, approximately 10 percent of Norwegian official development assistance has been earmarked for health and family planning. During the last few years, the Norwegian contribution to maternal and child health and family planning (MCH/FP) has been the highest of the OECD countries. The urgent need to accord women a more central role in the development process has been reaffirmed by the Norwegian government at regular intervals through development assistance directed toward women. Women’s health as a priority in its own right has received particular attention.

The Norwegian Agency for Development Cooperation (NORAD) has made it a priority to strengthen and support the Safe Motherhood activities of some multilateral organizations as well as international non-governmental organizations (NGOs). Financial support has been given to international and regional Safe Motherhood conferences and to the Safe Motherhood Operational Research program of the WHO.

The following activities are supported bilaterally:

The Muhimbili Medical Center in Tanzania

The Government of Tanzania, NORAD, and the UNFPA are collaborating to strengthen family planning service delivery, training, and research at Muhimbili Medical Center. This project is intended to assist the national referral and teaching hospital to provide comprehensive family planning services as part of the reproductive health care service routinely available at the Center; to use the clinical and case material as a basis for systematic training of medical students, doctors, and nurse tutors in family planning skills; and to support both activities through the development and promotion of family planning research.

The Population and Family Health Project in Bangladesh

Norway has been the largest donor to the multi-phased Bangladesh Health and Population Program supported and coordinated by the World Bank since 1976. NORAD is allocating substantial support to Phase IV of the project which is about to be launched. Safe Motherhood related activities include: family planning service delivery, strengthening of MCH services, clinical service delivery, maternal and neonatal health care, establishment of quality assurance system for medical care, improvement of MCH/FP program management, support to the Management Development Unit and the Family Planning Clinical Surveillance Team (FPCST).

NORAD has given particular support to the baseline studies for maternal health in Bangladesh which were followed up by a special Maternal Health Initiative. This has been institutionalized by a Maternal Health Unit in the Ministry of Health and followed up by a maternal and neonatal health project and FPCST.
Zimbabwe Family Health Project

NORAD and the World Bank have co-financed a project that aims to increase the quality and quantity of MCH/FP services, and involves upgrading of district hospitals and referral services as well as training and management activities at central and district levels.

Botswana

Since 1973, NORAD has assisted with the development of PHC facilities which offer FP and MCH services, as well as provision of maternity wards in rural clinics, health centers, and hospitals.

Mozambique

Through a special Women in Development grant, support has been given to the establishment of maternity wards and MCH clinics.

India

Since 1990, NORAD has supported the project "Training Interventions for All India Hospital Postpartum Program" (AIHPP) at the sub-district level in Rajasthan. The project aims to achieve safe motherhood and child survival improvements through increasing the availability, appropriateness, and acceptability of family planning, ante-natal, perinatal, and postnatal care services. The Indian Institute of Health Management Research (IIHMR) in Jaipur is contracted to carry out this project, which covers three districts in Rajasthan.

Other Activities

Through UNICEF, UNFPA, and PAHO, Norway supports other projects central to the Safe Motherhood Initiative predominantly in Central America but also in Madagascar, Tanzania, Zambia, and Mozambique through bilateral and multi-bilateral funding. In a number of countries, Safe Motherhood activities are supported through Norwegian and local NGOs.

For further information, please contact:

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Oslo 1, Norway
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Fax: 472314401
Tlx: 76548
THE PEW CHARITABLE TRUSTS

The Pew Charitable Trusts, a national philanthropy based in Philadelphia, support non-profit activities in the areas of conservation and the environment, culture, education, health and human services, public policy and religion. The Trusts are a collection of seven individual charitable funds established between 1948 and 1979 by the sons and daughters of Joseph N. Pew, Founder of the Sun Oil Company.

Activity pertaining to the Safe Motherhood Initiative has been supported through the international health and development program, and international grant-making program within the Trusts' program of health and human services. In recent years, the Trusts have supported Columbia University's Center for Population and Family Health and its efforts to promote Safe Motherhood in sub-Saharan Africa as well as Family Care International and its international mobilization and advocacy efforts. Currently the Trusts provide partial funding for Family Care International's efforts to promote the Safe Motherhood Initiative in Mexico, Central America, and the Caribbean.

The Trust's current grantmaking guidelines emphasize Mexico, Central America, and the Caribbean. Within this region of the world, the Trusts support projects in applied nutrition research and training as well as projects in the areas of family planning, reproductive health and regional population policy. Safe Motherhood-related activity is viewed as an integral component of the Trusts' interests in family planning and reproductive health in the region.

The Trusts would be pleased to review Safe Motherhood proposals pertaining to Mexico, Central America and the Caribbean. However, it should be noted that the Trusts are only able to award grants directly to organizations that have obtained 501(c)(3) status from the U.S. Internal Revenue Service. This requires non-governmental organizations (NGOs) and universities in other countries to enter collaborative relationships with U.S.-based partners in order to be eligible for grant awards.

In order to be considered for grant support, prospective applicants should send a brief letter of inquiry in English describing the project for which funding is sought. For further information, please contact:

The Pew Charitable Trusts
Health and Human Services
One Commerce Square
2001 Market Street, Suite 1700
Philadelphia, PA 19103-7017
U.S.A.
Tel: 215 575 9050
Fax: 215 575 4939
The Population Council’s activities related to Safe Motherhood fall under the Robert H. Ebert Program on Critical Issues in Reproductive Health and Population. The Ebert Program was established by the Population Council in 1988. The program grew from an awareness that many important reproductive health problems -- and the ways women experience them -- have been neglected by policymakers, program planners and practitioners. Consequently, Council staff involved in the Program work closely with governments, institutions and scientists in developing countries to improve women’s reproductive health through scientific inquiry, technology assessment, service experimentation, international meetings and information dissemination.

The program is currently focusing on four areas:

- Improving the quality of services in reproductive health programs;
- Managing unwanted pregnancy and preventing the consequences of unsafe abortion;
- Devising new approaches to postpartum care to meet the health and contraceptive needs of the mother and the health needs of her child;
- Designing programs that address STDs, including AIDS, within the larger context of women’s reproductive health.

Quality of Services

The Ebert Program emphasizes the link between women’s reproductive health and family planning services and accords high priority to improving service quality. The Program seeks to: (1) develop concepts and research tools to define and assess the quality of care rendered and received; (2) encourage experimentation with service design to enhance the quality of care, particularly the interpersonal dimension, which is often neglected; (3) facilitate and undertake research to demonstrate the importance of quality of care in helping individuals meet their reproductive goals; and (4) document exceptional programs in developing countries that offer high-quality reproductive health care -- often with severely limited resources -- and disseminate these findings to program managers.

Unwanted Pregnancy and Unsafe Abortion

The Ebert Program aims to assess the consequences of unwanted pregnancy to individuals, to the community and to those providing medical care. The Program seeks to gather information about the situations that lead women to define a pregnancy as unwanted and to terminate it, as well as about the social and medical obstacles women face in obtaining safe abortions. The Program pursues the goals of providing safer choices for women who decide to terminate their pregnancies and helping providers to reduce the negative effects of unsafe abortion through: (1) documentation of women’s experiences with unwanted pregnancy and abortion, and analysis of related social, economic, and service delivery factors; (2) technical improvement of the quality of abortion services, through assessment of different service systems and evaluation of the
gains from lower risk technologies; and (3) expansion of the constellation of reproductive health services to correct deficiencies in family planning programs that contribute to unwanted pregnancy and to ensure that women receive appropriate and caring post-abortion contraceptive counseling.

Postpartum Care

The Council's program aims to identify an appropriate mix and timing of family planning services. To realize this, the Ebert Program (1) undertakes diagnostic studies in different countries to learn about all aspects of the postpartum period, including women's perceptions and needs, providers' knowledge and attitudes, and service delivery systems and practices; (2) designs and tests interventions to translate information gained from diagnostic studies into programs that serve the mother and child in the postpartum period; and (3) develops family planning service models that offer contraceptive choices appropriate to postpartum women, including explicit consideration of the contraceptive effects of breastfeeding and lactational amenorrhea.

Sexually Transmitted Diseases, including AIDS

The Ebert Program argues for incorporating sexually transmitted disease (STD) services into a comprehensive reproductive health program rather than addressing them in a separate, potentially stigmatizing manner. The Program responds to the problems presented by STDs, including AIDS, by: (1) documenting the extent to which women's reproductive health is threatened by STDs and the risk of STDs associated with various contraceptive methods; (2) collaborating on social and behavioral research to better understand the ways individuals and communities can take action to lower the risk of STD transmission; and (3) designing and evaluating programs that integrate STD diagnostic, treatment and referral services into family planning programs and reproductive health services.

Program Activities

Technical collaboration between Ebert staff and colleagues around the world and South-to-South exchange of expertise among researchers are central activities of the Program. In addition, the Program accomplishes its work through:

Workshops and Seminars
Examples include:

- "First Latin American Conference on Quality of Care in Family Planning", Mexico, August 1990.

140
Research Projects
Examples include:

- Reproductive tract infections in semi-rural women (Egypt).
- A series of diagnostic studies on women’s perceptions, practices, and needs related to the postpartum period (Chile, Mexico, Brazil, Indonesia, Tunisia and Turkey).
- Two programs of abortion research, one in Latin America (9 studies) and one in Kenya (8 studies).

Publications
Examples include:

- "Quality/Calidad/ Qualite," which documents innovative reproductive health services that provide quality care.
- "Rethinking Postpartum Family Planning."
- "Sexually Transmitted Diseases and the Reproductive Health of Women in Developing Countries."
- Seminar proceedings: "Methodological Issues in Abortion Research."
- Translation, adaptation, and distribution of selected materials, such as "Contraception During Breastfeeding."

For further information, please contact:

The Population Council
Programmes Division
One Dag Hammarskjold Plaza
9th Floor
New York, NY 10017
U.S.A.
Tel: 212 339 0500
Fax: 212 755 6052
PROGRAM FOR APPROPRIATE TECHNOLOGY IN HEALTH

The Program for Appropriate Technology in Health (PATH) is a nonprofit, non-
governmental, international organization whose mission is to improve health, especially
the health of women and children in developing countries.

The Safe Birth Program

The Safe Birth Program was initiated by PATH in 1984 to improve maternal and
newborn health by developing and introducing appropriate technologies for health
workers at the primary care level. Too often, standard-issue equipment is provided
without sufficient thought being given to its usefulness or acceptability to health care
workers. At the other extreme, workers are often left without even the most simple
tools because resources are scarce, supply systems are inadequate, or suitably designed
devices have not been developed. To address this problem, PATH utilizes an interactive
methodology based on user participation at every stage, from health needs assessment
and the setting of desired technology characteristics through field testing of technologies
and the development of introduction strategies.

Safe Birth Program activities are designed in collaboration with ministries of health and
with non-governmental organizations (NGOs) that have responsibility for pregnancy and
newborn care. They deal with both hard technologies (such as equipment) and soft
technologies (such as pictorial referral guides and mothers’ educational materials). The
participation of users at every stage, from design to introduction, is the keystone of the
PATH approach to technology. Similarly, individual Safe Birth projects are tailored to fit
country situations and to complement ongoing local activities. The common thread
throughout all these activities is the commitment to improving the health of mothers and
their newborns and to bringing them safely through the birthing experience.

Country Experiences

In Malawi, Zambia, Yemen, and Sierra Leone, Safe Birth projects were set up that
focused on the technology gaps in national traditional birth attendant (TBA) programs.
In these countries the need was expressed for tools to assess newborn babies’ weight, to
identify pregnant women at risk of hypertensive disease of pregnancy, and to increase
TBAs’ awareness of risk conditions in pregnancy. The following technologies were tested
as part of the Safe Birth Program: a color-coded, inexpensive scale for weighing
newborns, an inexpensive, tear-off dipstrip for testing protein in urine, and pictorial risk
assessment cards for TBAs. Both the scale and risk cards are now integrated into the
national programs of Malawi, Zambia, and Yemen. Field trials are ongoing in Sierra
Leone.

In Bangladesh, the Safe Birth Program worked with a local NGO and with UNICEF to
develop an inexpensive, simple delivery kit that could be sold without subsidy to families
in rural areas of the country. The main purpose of the kit was to promote hygienic delivery practices. In a test market, the kit was successfully sold through several types of outlets, including women’s organizations’ small shops, and itinerant salesmen. Similar projects are now starting in Nepal and in Egypt. In the latter country, the project will be used as an income-generating project for a women’s organization.

In Kenya, Pakistan, Peru, and Sierra Leone, pictorial booklets have been developed with local NGOs to convey important messages about antenatal care. These booklets illustrate antenatal visits, the value of good nutrition and hygiene, the need for limiting heavy work late in pregnancy, and the timing for tetanus immunization.

In Zimbabwe, the Safe Birth Program is collaborating with the Ministry of Health staff in one district to carry out a community study of low birth weight. TBAs, farm health workers, and village development workers are using the simple, hand-held scale and a simple pictorial tally sheet to identify those areas with higher rates of low birth weight babies. Also in Zimbabwe, the Program assisted a local pharmaceutical company in setting up production of the proteinuria dipstrip. This single-purpose dipstrip is inexpensive and easy to use. Local production should make the proteinuria test more accessible for antenatal care programs, whether by health center staff or TBAs.

In Seattle, at PATH’s headquarters, the product development team is studying several technologies related to maternal and newborn care. These include several devices to make diagnosis of anemia easier; a single-use injection device prefilled with either tetanus toxoid or an oxytocic agent, and better diagnostic tests for syphilis and gonorrhea.

For further information, please contact:

Program for Appropriate Technology in Health (PATH)
4 Nickerson
Seattle, Washington 98109
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Tel: 206 285 3500
Fax: 206 285 6619
Telex: 4740049 PATHUI
THE RESEARCH NETWORK ON REPRODUCTIVE RIGHTS

The Research Network on Reproductive Health in West Africa was initiated by the regional office of the Population Council to develop strategies for program and research implementation in West Africa. The network, composed of gynecologists/obstetricians, social scientists, demographers and population and public health specialists from twelve West African countries (Benin, Burkina Faso, Cameroon, Congo, Guinea, Ivory Coast, Madagascar, Mali, Niger, Senegal, Togo and Zaire) focuses its efforts on maternal and child health, fertility, birth spacing and the well-being of the family. The Network is a highly unusual group because it breaks the traditional pattern of obstetricians/gynecologists designing and carrying out research in reproductive health, and instead incorporates a multidisciplinary approach with a range of professionals.

In addition to coordinating and carrying out research, the Network is also responsible for a large dissemination program. It publishes a quarterly magazine, Vie et Santé, to report on research findings and provide current information on reproductive health issues of the region. In 1990, there were issues devoted to maternal morbidity and mortality, women’s health and socio-economic status, unwanted pregnancy and abortion and AIDS in Africa. A future issue will cover postpartum care.

Within the Network, Rockefeller funds have helped to support an African adaptation of the book, Our Bodies, Ourselves. The purpose of this book is to provide African Women with practical and comprehensive information on sexuality, sexually transmitted diseases and reproductive health. The Network is also planning a resource handbook on the current state of reproductive health in West and Central Africa. It will serve as a reference for researchers, providers, policy makers, international organizations and NGOs.

For further information, please contact:

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SENÉGAL
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221 24 19 98
THE ROCKEFELLER FOUNDATION

The Rockefeller Foundation has awarded over $1.7 million toward projects to reduce the high rates of maternal mortality in developing countries since the Safe Motherhood Initiative was launched. Almost all of this support has gone to the WHO, although the Foundation has also provided funds to Family Care International in support of some regional and international Safe Motherhood meetings, and related materials (both print and audio-visual).

Following is a sampling of the Foundation’s related activities:

Since 1982, the Foundation has allocated almost three million in support of studies on the determinants of fertility in 24 developing countries.

In 1988, the Foundation joined with the International Development Research Centre, the John Merck Fund, and the Ford Foundation in supporting the creation of the AIDS and Reproductive Health Network as a mechanism for strengthening developing country HIV research.

A major appropriation in 1991 supported selected biomedical centers of excellence in Latin America and Africa to enhance regional training opportunities and strengthen national capacity for advanced research in contraception, fertility regulation, and women’s health.

For further information, please contact:

Rockefeller Foundation
1133 Avenue of the Americas
New York, N.Y. 10036-6755
U.S.A.
Tel: 212-869-8500
Fax: 212-764-3468
SWEDEN: Swedish International Development Authority

Starting in the late 1950s, Sweden began to advocate family planning in Sweden and also international support for family planning programs in developing countries. In the 1960s and 1970s, Sweden continued to be an important international advocate of family planning and became a major supplier of contraceptives to family planning programs in the developing world.

Since the early 1980s, the Swedish International Development Authority (SIDA) has made a conscious effort to include maternal health in the aid program, recognizing that the "M" part of MCH in PHC programs had been neglected for the first decade after the Alma Ata PHC declaration 1978.

Policy, Advocacy and Programmatic: Support for Safe Motherhood

SIDA supports Safe Motherhood activities at both the country and global levels.

Special program budgets for population/family planning, primary health care, and women in development are used for global support to advocacy, method development, and analytical work and studies. Country-level activities are supported through the bilateral cooperation program.

The impact of the HIV/AIDS epidemic on women has prompted SIDA to broaden the scope of its Safe Motherhood related programs. SIDA is presently in the process of formulating a strategy for support to reproductive health that includes sexually transmitted diseases (STDs) and HIV/AIDS, adolescent fertility, abortion care, sex education, and gender-related health programs in addition to maternal health and family planning services.

In recent years, SIDA has supported a variety of Safe Motherhood efforts. At the international level, these include the following:

- The WHO-Technical Discussions on Women’s Health and Development;
- Regional Safe Motherhood meeting for SADCC countries in November 1990;
- The Meeting of Partners for Safe Motherhood in Washington, D.C., March 1992;
- The FIGO symposia on "Delegation of Responsibilities in Maternity Care in Developing Countries" in relation to the global conference in Singapore September 1991;
SIDA has also provided funding to various agencies for their Safe Motherhood activities; including:

- The World Bank study in Bangladesh on the posting of midwives in villages in the Matlab district;
- WHO's Maternal Health and Safe Motherhood Program, and related operational research activities;
- UNFPA, UNICEF, and UNDP for international efforts and country level programs.
- The Population Council;
- The International Planned Parenthood Federation; and
- Family Care International.

Related support, for advocacy and analytical efforts has gone to:

- Women’s Global Network for Reproductive Health; and
- International Women’s Health Coalition.

SIDA has provided financial or technical support for Safe Motherhood efforts in the following countries: Angola (Luanda Province), Ethiopia (national), Kenya (national), Tanzania (NGO), Uganda (UNFPA), Zimbabwe (World Bank), Bangladesh (NGOs), and India (UNFPA). Integrated MCH projects will be supported in Tanzania, India, and Laos through UNICEF. Several Swedish NGOs are also supported by SIDA for their MCH projects in many different countries.

In 1991-1992, SIDA support totalled 25 million SEK for maternal health, and 40 million SEK for family planning (excluding budget support to UNFPA, UNICEF and IPPF).

For further information, please contact:

Swedish International Development Authority (SIDA)
Birger Jarlsgatan 61
S-105 25 Stockholm
Sweden
Tel: 46 8 72 85 100
Fax: 46 8 612 63 80
SWITZERLAND: Swiss Development Cooperation

Contributions during 1987-1992

Soon after the 1987 Nairobi meeting which launched the Safe Motherhood Initiative, Switzerland was among those who decided to help finance another seminar for francophone African countries. This seminar, convened by the World Bank, WHO, UNICEF, UNFPA and UNDP, was held early in 1989 in Niamey (Niger). The Swiss Development Cooperation (SDC) contribution amounted to $50,000.

SDC has also been supportive of the efforts of IAMANEH (International Association for Maternal and Neonatal Health), and a non-governmental organization (NGO) known as Mother and Child International (MCI), which was created in the late 1970s in Switzerland. SDC’s contribution to MCI is currently supporting an interesting pilot project of the Maternity and Child Welfare Association of Pakistan (MCWAP), described in more detail in Appendix I.

At present, SDC’s main Safe Motherhood contribution goes to WHO: Switzerland began supporting WHO’s Maternal Health and Safe Motherhood Programme in 1991. For the years 1991-93, SDC has contributed SFR 1.75 million to WHO (i.e., approximately US $1.2 million for three years).

Besides these specific activities, several health services projects and programmes supported by the SDC in various countries in Africa and Asia are dealing with maternal health and Safe Motherhood. They include support to hospitals and health centers (of which maternities are often a component) and to integrated family planning programs.

For further information, please contact:

Swiss Development Cooperation
DDA, DFAE
3003 Berne
SWITZERLAND
Fax: 41 31 61 35 05
THE NETHERLANDS: Directorate for International Cooperation

The Dutch policy on development cooperation corresponds to the World Health Organization's (WHO) comprehensive definition of health and promotes cooperative and multisectoral approaches toward improvements in health, population, and nutrition.

Health

Dutch policy on health emphasizes supporting the poorest sections of the population by encouraging self-help and community participation, and focuses on the improvement and extension of comprehensive primary health care.

Dutch assistance is channeled through international organizations (WHO, UNICEF, UNDP), national governments, international and national NGOs, and supports a variety of approaches, as follows:

a) Sectoral cooperation among donors, international NGOs, local government and non-governmental groups aimed at long term, sustainable improvements in PHC systems that are equitable, efficient and effective.

b) Comprehensive primary health care in regional urban and rural development projects. Depending upon local needs, MCH, environmental hygiene, special initiatives by communities or critical population groups, information, administrative and financial systems can be emphasized.

c) Priority programmes where needed -- such as AIDS, EPI, Essential Drugs, MCH, CDRD, Nutrition, and/or TB/leprosy. These should be integrated into established health care services, and should involve popular participation.

d) Special programmes for underprivileged population. Target groups may include: populations in slums and deprived rural areas, minority groups, women, street children and adolescents. Where relevant, aspects of physical and mental health (e.g. due to civil war) can be included.

e) Training programmes: management in decentralized primary health care, and public health.

f) Research programmes: social and economic aspects of development processes, and applied research in PHC and public health.

Population

Dutch policy considers population issues in their overall socio-economic context. As such, priority is given to promotion of the "demand side" of the family planning equation.
through efforts which seek to increase the autonomy of women, (e.g., improvement of education and in overall health), rather than to efforts which stress increased supply of family planning services. Family planning services are increasingly considered as a component of MCH, preferably placed in the wider context of primary health care. Of special concern are: cultural values and concepts, free choice of couples, public information, sex education, ensuring that a wide array of contraceptives are available, and adolescent needs.

Cooperation in the field of population is channeled through international organizations such as UNFPA, IPPF, Population Council, HRP/WHO and national NGOs and is mainly realized through:

- Intensified and expanded MCH and FP services.
- Efforts which combine MCH/FP programmes with efforts to increase women’s income and autonomy (e.g., formal education).
- Policy support toward and applied research on behavioral and social determinants of reproductive health.
- Improved supplies (contraceptives, equipments, micronutrients, etc.)
- Improved effectiveness and efficiency in management.

Nutrition

Malnutrition is considered both as a consequence and determinant of underdevelopment. Dutch cooperation is concerned with increasing food security particularly at the household level, improving food consumption by individuals, and combatting the negative influence of infectious diseases. The promotion of breast feeding and adequate weaning practices receive special attention since most malnutrition starts at the early years of childhood.

Cooperation in the field of nutrition are carried out in collaboration with international organization (WHO, UNICEF, FAO, WFP), national governments and (inter) national NGOs through activities that:

- combat poverty and malnutrition by improving household food security;
- promote and protect breast feeding;
- promote local production of low-cost weaning foods and adequate weaning practice;
• encourage attention to nutritional issues by health care providers, with special emphasis on MCH providers;

• combat micronutrient deficiencies mainly through improved dietary intake; and;

• support institutional development of related consumer organizations.

For further information, please contact:

Directorate-General for International Cooperation (DGIS)
Ministry of Foreign Affairs
Bezuidenhoutseweg 67
P.O. Box 20061
2500 EB, The Hague, The Netherlands
Fax: 31 70 348 48 48
Safe Motherhood is one of the key interventions for improving children's health. United Nations Children's Fund (UNICEF) supports major programmatic responses that are necessary to reduce maternal deaths: provision of pre-natal care, provision of adequate delivery and post natal services, improvement of overall maternal health and nutrition, improved child spacing and family planning, and improvement of the overall status of women.

Female education, birth-spacing and breast-feeding are principal elements of the Fund's GOBI-FFF strategy to promote child survival. UNICEF has supported female education and literacy programs around the world and an effort launched by SAARC (South Asian Association for Regional Cooperation) to reduce discrimination against girls by developing national policies promoting education for girls, and encouraging later marriage and pregnancy. Family spacing is one of the principal messages in Facts for Life, a joint publication of UNICEF, WHO and UNESCO. UNICEF and WHO have been partners in protecting, promoting and supporting breast-feeding.

UNICEF has been the principal supporter of training for traditional birth attendants world wide. The organization also assists programs for improving maternal health and nutrition, as well as pre-natal and post-natal care within the context of maternal and child health services. Additionally, UNICEF has promoted activities to combat specific nutrient deficiencies such as iron, vitamin A and iodine, in order to improve maternal health and nutrition. UNICEF has been a major supplier of iron and folate, vitamin A and iodized oil for girls and pregnant women.

Safe Motherhood Policy Review

In February of 1990, UNICEF issued a Safe Motherhood Policy Review paper. This paper describes the global problem of maternal morbidity and mortality and the rationale behind the Safe Motherhood Initiative and examines the steps to be taken to achieve the goal of reducing maternal mortality by half by the year 2000. It was decided that UNICEF's ongoing activities in support of Safe Motherhood, often isolated, should be replaced by the development of a systematic, integrated approach to consolidate current programs within a comprehensive framework.

Workshop on Safe Motherhood

In August 1991, a five day workshop on Safe Motherhood was held in Sri Lanka, a nation which has achieved a maternal mortality rate among the lowest in the developing world. The objectives of this workshop, attended by 25 UNICEF program officers from the Africa, South Central Asia and East Asia/Pacific regions, included: 1) an assessment of the maternal health situation in Sri Lanka and identification of key factors contributing to low maternal mortality, 2) based on field observation and discussion of the Sri Lanka experience, to recommend strategies and actions for promotion of Safe Motherhood through UNICEF programs in countries where maternal mortality is high, and 3) to
provide the perspective of field staff on priorities and topics to be included in the development of a training package on Safe Motherhood for UNICEF staff.

**Training Package**

In 1991, background information and materials were assembled in a wide range of subject areas, directly and indirectly related to maternal health and the status of women, and an outline, format and learning objectives for a draft Safe Motherhood training package were produced. This draft was pretested at the Sri Lanka conference mentioned above. Based on extensive videotaped feedback of workshop participants and others, the draft is currently in the process of revision and further development.

The UNICEF Safe Motherhood training package is intended to provide guidance to project officers in developing nations on development of comprehensive, effective community level programs and strategies to reduce maternal mortality and morbidity and generally improve the health and social status of women. As with other UNICEF technical training manuals, the package will be used as part of week long regional and national training workshops, and will contain key facts or "learning points", in this case, focusing on precisely what program officers need to know about major topics influencing maternal health.

The Safe Motherhood training package will be a "user-friendly" product, without the bulk often associated with training materials that cover such a wide range of technical areas. In addition to "key facts", and essential supporting information, additional references will be included in the package in diskettes, to allow for later in-depth study of particular topics as required. The package may also include a short preworkshop training video, to familiarize participants with the basic issues, facilitate gathering of specific information for use at the conference, and generally enliven the preworkshop preparation process.

It is expected that the revised UNICEF Safe Motherhood training package will be ready for technical review and further field pretesting by early 1992. UNICEF has scheduled and inter-regional training program to be held in West Africa in early June 1992.

**Workshops & Conferences**

UNICEF has supported or participated in events in Jordon, Niger, Pakistan, Tanzania, Nigeria and Zimbabwe.

For further information, please contact:

United Nations Children’s Fund (UNICEF)
Sr. Advisor-Primary Health Care
Three United Nations Plaza
New York, NY 10017
U.S.A.
Tel: 212 326 7000
Fax: 212 888 7465
The United Nations Development Program (UNDP) continues to expand its advocacy and technical assistance efforts for programs seeking to reduce maternal mortality and morbidity.

Human Development Report

For the first time, maternal mortality and Safe Motherhood are priority themes in the UNDP Human Development Report. The major objective of the Report is to promote the restructuring of aid allocations in favor of human development, with strong recognition of women’s needs and priorities. Maternal mortality is now included among the health indicators in the Human Development Index. It is also one of the twelve indicators used in regional comparisons on human development.

An important policy shift of UNDP is the modification of the Human Development Index (HDI) to increase its sensitivity to gender disparities. One result has been a dramatic shift in ratings in both developing and developed countries. For example, in Chapter One of the Report the female HDI is shown as only half to three-fourths of the male HDI in a large percentage of the countries for which data was available. These internal disparities, based on a number of such aspects as life expectancy, need to be highlighted. The gender-sensitive HDI, developed on the basis of separate HDIs for men and women, will be useful as a more refined tool for aid determination by donors as well as for countries themselves in recognizing their performance on female survival and well-being. Again, maternal mortality is used as a factor in this modification of the Index. A small item in the Report "100 Million Women Missing" highlights the active discrimination at all points in women’s lives, from womb to old age, which inhibits female survival.

Social and Health Sector Restructuring

In the past UNDP has directed its support for Safe Motherhood largely toward individual projects. A new opportunity for mainstreaming Safe Motherhood objectives and institutionalizing their support appeared in 1991. UNDP has become involved in several IMF restructuring programs, many of which are now being approved with substantial women’s health components including a specific maternal mortality emphasis. Clearly global advocacy efforts in Safe Motherhood are influencing both program choices by governments and project design.

The largest of these programs was recently approved for North East Brazil (BRA/90/032), where the World Bank, the Government and UNDP have joined in a $40 million program to restructure the management and delivery of health services, with a large women’s health emphasis. PAHO, UNICEF, and UNFPA are also involved in the aspects of the program concerning women.
In El Salvador (ELS/91/009 - Support in the Implementation of the Social Sector Rehabilitation Loan - $15 million) the Government's restructuring of the health and educational sectors includes the establishment of Safe Motherhood programs in very poor areas. UNDP is providing technical assistance, the World Bank has made loan capital available and several other partners are also contributing to the programs.

UNDP has approved support to other social investment funds during 1991, the largest ones being in Honduras, Nicaragua and Egypt. While the emphasis on Safe Motherhood-related objectives varies among countries, UNDP and its partners are working toward the full integration of Safe Motherhood priorities into these large national health sector initiatives. In this way, UNDP is attempting to achieve sustainability for Safe Motherhood priorities.

Projects Approved in 1991

In 1991 UNDP-supported projects with an impact on maternal health became operational in the following countries:

- Angola - maternal health training
- Benin - primary health care (PHC) encompassing Safe Motherhood
- Burundi - women's health priorities within structural adjustment
- Central African Republic - two projects within MCH and PHC
- Indonesia - national Safe Motherhood plan of action
- Malawi - direct support in health services to women
- Qatar - health education and training on MCH
- Regional Asia - PHC strategies for the South Pacific
- Rwanda - maternal health within women's cooperatives
- Senegal - operational research on maternal mortality
- Zaire - training within PHC

Discussions at field level are underway on potential projects in several other countries, including: Afghanistan, Chad, Guinea, a subregional Latin American initiative, Myanmar, Nigeria and Sudan. At the global level a new proposal for a WHO-hosted program is currently under discussion and is expected to become approved in 1992. In addition, UNDP plans to become involved in the recently launched Safe Motherhood activities in the Latin America subregion.

For further information, please contact:

United Nations Development Programme (UNDP)
Technical Advisory Division
Bureau for Programme, Policy and Evaluation
One United Nations Plaza
New York, NY 10017
U.S.A.
Tel: 212 906 5000
Fax: 212 826 2057
The United Nations Population Fund (UNFPA) policies and strategies to promote Safe Motherhood are designed to strengthen the institutional capacity and self-reliance of countries. In addition to assisting in the development of maternal and child health and family planning services, UNFPA is deeply interested in improving the status of women and involving women in population and development efforts at all levels. Family planning is viewed as one of the most important tools to give women control over their own fertility, to improve maternal and child health and to give women a chance for a fuller life.

Collaboration between countries, UNFPA, and a number of United Nations agencies and organizations, notably WHO, as well as NGOs and bilateral donors, has made it possible to establish, develop and expand programs to improve the health and welfare of women and children. UNFPA was one of the main initiators of support to efforts to improve reproductive and maternal health, through, inter alia, assistance to the WHO program of research on maternal morbidity and mortality, and a wide range of activities at the regional and country levels.

**Workshops & Conferences**

UNFPA provided critical support to the initial International Conference on Safe Motherhood in 1987, organized by Family Care International (FCI). UNFPA has supported and/or participated in many Safe Motherhood planning and advocacy activities, most of which were organized by FCI, including the following:

- Conference, Brazil, September 1988
- Workshop, Jordan, September 1988
- Workshop, Niger, February 1989
- Workshop, Bellagio, February 1989
- Workshop, Pakistan, March 1990
- Workshop, Tanzania, August 1990
- Workshop, Nigeria, September 1990
- Workshop, Zimbabwe, November 1990
- Conference, Morocco, October 1991
- Conference, Guatemala, January 1992

The Fund will also contribute to the forthcoming March 1992 Safe Motherhood Conference to be held in Washington D.C. by organizing a session on "Adolescent Fertility," and supporting developing country participation.
Related Activities

Other Safe Motherhood activities, such as service delivery and training programs in maternal and child health and family planning, are carried out within the framework of UNFPA country programs worldwide.

In mid-1990, UNFPA provided partial support for the development and production of a brochure on the Safe Motherhood Initiative, undertaken by FCI, and has also promoted its wide dissemination. UNFPA has assisted in the production and dissemination of other Safe Motherhood materials produced by FCI, including the Safe Motherhood in Action kit, audio-visual productions, etc.

Future Involvement

UNFPA’s contribution to the Safe Motherhood Initiative (SMI) will continue and increase in the future, focusing on the following areas:

- Effective implementation of SMI activities at the country and regional levels.
- Efficient coordination of SMI programs/projects among donors at the country level.
- Development of strategies tailored to the maternal health needs of the regions and countries.
- Promotion of women’s status.
- Support for a SMI framework that is not too “verticalized,” and which makes best possible use of the existing staff, facilities and programs.
- Replication of successful SM experiences and utilization of lessons learned in different geographic and thematic areas.

For further information, please contact:

United Nations Population Fund (UNFPA)
Technical and Evaluation Division
220 East 42nd Street
New York, NY 10017
U.S.A.
Tel: 212 297 5000
Fax: 212 370 0201
The Agency for International Development (AID) provides assistance to countries, communities, and individuals to implement the following solutions to women's widespread health and nutrition problems:

- provision of safe delivery kits and training in screening and referral of high-risk pregnancies and life-saving delivery skills to traditional birth attendants (TBAs), midwives, and other health workers;
- strengthening referral systems between TBAs, health centers, and hospitals, and improving prenatal care;
- providing food and iron supplements to pregnant and lactating women;
- communication activities for women to increase utilization of prenatal care, awareness of dangerous conditions, and self care;
- integration of maternity care with family planning;
- treatment of infections, especially sexually transmitted diseases.

The following countries have significant USAID-assisted maternal health and nutrition programs:

Afghanistan  Ecuador  Mozambique
Bangladesh  Egypt  Nigeria
Bolivia  El Salvador  Pakistan
Botswana  Guatemala  Philippines
Burkina Faso  Haiti  Rwanda
Cameroon  Indonesia  Senegal
Chad  Jordan  Uganda
Cote d'Ivoire  Kenya  Yemen
Dominican Republic  Morocco

Programming for the 1990s

An important focus of AID activity is advocacy for improvements in women's health. In June 1991, AID provided support for the annual conference of the National Council for International Health (NCIH), which featured women's health as its topic of concern. The conference resulted in an Action Agenda for the 1990s. It is expected that this will receive additional attention in May 1992 at annual World Health Assembly Technical
Discussions, which will focus on women's health. AID has assisted in the preparation of the background document for the WHO Technical Discussions.

Through its MotherCare contract, AID is also sponsoring a series of demonstration projects that are testing interventions to improve maternal and neonatal survival in target areas. Midwives are being taught life-saving skills for coping with obstetrical emergencies in Uganda and Nigeria, and TBAs in Guatemala are being trained to utilize safer delivery practices. An innovative system for distribution of iron folate tablets to combat maternal anemia is being tested in Indonesia. Maternity huts, to facilitate referral of emergency cases to health care facilities, are also being established in Indonesia. In Bolivia, a health communications project is improving utilization of existing health services, and women's groups have been encouraged to participate in the identification of local health problems and the planning of interventions.

These demonstration projects will contribute to the identification of effective interventions for possible replication in other areas that are affected by high maternal mortality, morbidity, and women's anemia. Since the MotherCare contract will be completed in September 1993, a significant component of the final year's activities will be devoted to documentation and broad dissemination of results and "lessons learned" from these and other MotherCare subprojects. Already, experience and information acquired under MotherCare's auspices have been utilized in the development of a set of guidelines ("Programming for Safe Motherhood") for the World Bank's maternal health initiative.

Activities aimed at improving maternal health will continue throughout the 1990s, and increasingly, the scope of AID's involvement will expand to include other women's health issues. For example, food aid resources will be harnessed to provide supplementation to more women who are malnourished. AID is also supporting research on the nutrition of adolescent girls, and attacking iron-deficiency anemia through the distribution of iron folate supplements to women. Additionally, programmatic attention will be paid to providing services for prevention and treatment of reproductive tract infections (RTI), which can contribute to maternal mortality, infertility, and, in some cases, pelvic pain and social ostracism. Through this expanded mandate, AID will contribute to the worldwide effort to assure Safe Motherhood by improving the health and nutritional status of women.

For further information, please contact:

United States Agency for International Development (USAID)
Health Services Division, Office of Health
Bureau for Research and Development, Room 1239 SA-18
Washington, DC 20523
U.S.A.
Tel: 703 875 4521
Fax: 703 875 4686
WOMEN'S GLOBAL NETWORK FOR REPRODUCTIVE RIGHTS

The Women's Global Network for Reproductive Rights is a network of groups and individuals in every continent who are working for and support reproductive rights for women.

Reproductive rights means women's right to decide whether, when and how to have children -- regardless of nationality, class, ethnicity, race, age, religion, disability, sexuality or marital status -- in the social, economic and political conditions that make such decisions possible. Reproductive rights means the right and access to:

- full information about sexuality and reproduction, about reproductive health and health problems, and about the benefits and risks of drugs, devices, medical treatments and interventions, without which informed choice is impossible;
- good quality, comprehensive reproductive health services that meet women's needs and are accessible to all women;
- safe, effective contraception and sterilization;
- safe, legal abortion;
- safe, women-controlled pregnancy and childbirth;
- prevention of and safe, effective treatment for the causes of infertility.

The network has been in existence, and growing, since 1978. There are currently about 1300 members and subscribers in 112 countries.

The network has a small coordination office in Amsterdam. Among its activities are solidarity actions, networking, a newsletter and the Campaign against Maternal Mortality and Morbidity.

The Campaign Against Maternal Mortality and Morbidity

In 1987, the Policy Meeting for Members of WGNRR, held in Costa Rica, launched a global campaign on maternal mortality. Through the Campaign on Maternal Mortality and Morbidity, the members of WGNRR hoped to draw particular attention to the high proportion of pregnancy-related deaths resulting from illegal abortions, and to the underlying social values which damage and destroy the bodies and lives of women.

In later years, maternal morbidity was taken up as an issue along with maternal mortality. Country-level Campaign activities are decided on by the country members.

Internationally, activities have centered around the International Day of Action on Women and Health, celebrated on May 28th each year. The Amsterdam Coordination Office issues a yearly call to action to mobilize public attention and stimulate members to organize activities on May 28th. Several other women's networks have sponsored the
Campaign in the past. Every year, the Campaign focuses on a specific theme. Special reports or newsletter issues are published to inform members of developments in the Campaign.

The number of groups involved in the Campaign continues to grow. A total of 80 groups in 34 countries are active participants in the Campaign. Several groups are networks themselves, further increasing the number of participating groups.

The Policy Meeting for Members of the Women's Global Network, held in Manila in 1990, voted for a continuation of the Maternal Mortality and Morbidity Campaign. Members stressed that high maternal mortality is not only the result of lack of technical medical services, but it is above all the result of unequal power relations between women and men, on both individual and institutional levels. The Campaign against Maternal Mortality and Morbidity is, therefore, a political campaign, questioning not only medical facilities and services, but specifically the power dynamics at play, both within health services and in society at large.

Specific Campaign strategies and tactics have to be worked out locally. The best way to broach the topic of maternal mortality differs by country and region. The fact that the Campaign is seen within a political framework and from a global perspective, however, unites the members of WGNRR.

For further information, please contact:

Women's Global Network for Reproductive Rights
Nwezijds Voorburg Wal 32
1012 R.Z., Amsterdam
THE NETHERLANDS
Tel: 31 20 209 672
Fax: 31 20 622 2450
WORLD ASSEMBLY OF YOUTH

The World Assembly of Youth (WAY) is an international coordinating body of national youth councils and national youth organizations from 90 countries worldwide. WAY has consultative status "I" with the Economic and Social Council of the United Nations (ECOSOC), and official relations with UNESCO, UNFPA, WHO, ILO, UNDP and other specialized U.N. agencies.

Since the 1960's, WAY has promoted youth involvement in education about population issues with assistance from USAID and UNFPA. WAY has also worked with WHO's adolescent health program to begin training youth workers in counseling skills, and promote counseling in national youth organizations.

WAY initiated an action research program for Safe Motherhood in cooperation with WHO. This program aims to assess the impact of information, education, and communication programs on young mothers receiving clinic services. The project will be completed by the end of 1992.

In cooperation with the Population Center, the United Kingdom, and the European Economic Community, WAY has also conducted a series of training courses to involve youth and their organizations in issues related to adolescent fertility. A regional workshop will be organized in the Caribbean soon the review the existing program. Another Regional Workshop in Asia is planned in Kuala Lumpur with support from UNFPA.

WAY also played an active role in the first UNFPA consultation on its youth and adolescent population program in 1991.

A unique effort was supported by the World Bank to bring together youth organizations and U.N. agencies to promote linkages and cooperation at the grassroots level. UNFPA, WHO, and UNICEF played active roles in this collaboration. Similar efforts are underway in Zimbabwe and Malawi.

WAY adolescent health and fertility activities that took place in 1990 include the following:


Nairobi, Kenya: Adolescent Health Meeting on Survey Results and Reports Technology (with WHO).

Guayaquil, Ecuador: Andean Youth Workshop to Provide Skills in Communication and to Develop Health Messages (with PAHO).
Accra, Ghana: Intercountry Workshop of Youth NGOs and Governments to Promote Adolescent Reproductive Health (with World Bank).

For further information, please contact:

World Assembly of Youth
Ved Bellehoj 4
2700 Bronshoj
Copenhagen
DENMARK
Tel: 45 31 607 770
       45 31 748 900
Fax: 45 31 605 797
Tlx: 16600
THE WORLD BANK

The World Bank continues to affirm its commitment to the reduction of maternal mortality and morbidity through three levels of activity: advocacy and policy support, analytical work and the operational lending program. Safe motherhood and women's health are integral to the Bank's objectives of human resource development and poverty reduction.

Advocacy and Policy

This continues to be an important component of the Bank's support for Safe Motherhood. The Bank served as Executive Secretariat of the Inter-Agency Group for Safe Motherhood (WHO, UNFPA, UNDP, UNICEF, World Bank, Population Council and IPPF) in 1990 - 1992. In that capacity the Bank hosted an international Safe Motherhood meeting in March 1992 and supported the development of related technical papers and audiovisual materials, with the assistance of Family Care International. The Bank has also actively participated in the planning of regional and national conferences.

At the country level, policy dialogue with governments, including Ministries of Finance and Planning, provides a valuable opportunity to raise women's health as an element of overall social and economic development.

The Bank has encouraged participation of non-governmental organizations in supporting maternal health through the provision of small grants to community-level efforts. A community-based demonstration project in urban Lahore to increase access to maternal and child health care is an example of this support to NGOs.

Analytical Work

The Bank has prepared safe motherhood guidelines which will be used by Bank staff and others involved in the planning, design, implementation and evaluation of safe motherhood programs. The Bank is also preparing a Best Practices paper on women's health and nutrition, which will address a broader range of women's health issues.

On the research side, the Bank is funding work on issues relevant to operations in borrowing countries. For example, the Bank financed a recent study in Matlab, Bangladesh, to estimate effectiveness and costs of program components used in a demonstration project where the posting of midwives in villages led to a 68 percent reduction in maternal mortality. Research is also being supported in other countries on maternal health care utilization, post-abortion family planning, and cervical cancer diagnosis and treatment.
The Bank helped establish and has contributed annually to the World Health Organization’s Safe Motherhood Operational Research Program and participates in its Scientific and Technical Advisory Group and Steering Committee.

**Operations**

Project and sector work undertaken by the Bank continue to increase. Sector work in the form of assessments of women’s reproductive health carried out collaboratively by the Bank with governments can provide the basis for policy dialogue and program planning. Such an assessment was carried out in Brazil and in India. In FY86 there were nine projects with Safe Motherhood components; by FY92 there were 70. Lending for population, health and nutrition in fiscal 1992 (PHN projects and PHN components of social development projects) amounted to $96.6 million. This was 4.3 percent of total Bank lending, a sharp increase from the fiscal 1989 figure of 2.6 percent. Examples of Bank lending for safe motherhood follow:

- **The India Child Survival and Safe Motherhood Project**, co-financed with UNICEF, will serve an estimated 115 million poor women in rural areas and slums. The project will upgrade the skills of health providers to deliver maternal health services and strengthen routine delivery and emergency obstetric services, while concurrently promoting birth spacing, postpartum counselling, and prophylaxis and control of nutritional anemia.

- **Indonesia Family Planning and Safe Motherhood Project** will help the Government of Indonesia strengthen its program to lower fertility and maternal mortality. The project is supporting the development of a National Safe Motherhood Strategy which emphasizes the training and utilization of community midwives in the delivery of services.

- **Bangladesh Fourth Population and Health Project** will support safe motherhood through the training of TBAs, strengthening maternal and child health (MCH) services, supporting a comprehensive maternal and neonatal health care project and strengthening obstetric and gynecological services in urban centers and district hospitals.

- **Togo Population and Health Sector Adjustment Project** assists the Government to improve MCH and birth spacing services at all health facilities; improves the quality of and accessibility to prenatal, childbirth and postnatal counseling services; encourages NGO participation in MCH and FP; and strengthens nutrition, health education and MCH in primary care programs.
Madagascar Health Sector Improvement Project assists the Government to expand and promote family planning services and supports maternity care through training of health providers and upgrading of health centers to deliver maternal care and family planning services.

Operational work has also put a special emphasis on Africa, where women face the highest risks of premature death and disability. The Bank has conducted an assessment of Francophone African countries on progress to date on safe motherhood. A Resource Group of Francophone African experts in maternal health has reviewed this assessment and a report on the recommendations of this group has been sent to each Government. The Francophone African Resource Group is available to help African countries and donors promote and strengthen existing safe motherhood activities in the region.

For further information, please contact:

The World Bank
Population, Health and Nutrition Department
1818 H Street, NW
Washington, DC 20433
U.S.A.
Tel: 202 477 1234
Fax: 202 477 1315
The World Health Organization’s (WHO) Maternal Health and Safe Motherhood program is based on the premise that most of the knowledge and technologies needed to prevent the overwhelming majority of maternal deaths have been available for decades. Defined by Member States as “the directing and coordinating authority for international health work,” WHO plays a unique role in the international effort to make childbirth safer by:

- providing technical and managerial support to national authorities for the development and implementation of national strategies;
- conducting epidemiologic, operational and behavioral research;
- compiling and disseminating information; and
- developing training programs and materials for health personnel providing maternity care.

Technical cooperation with countries

Direct support through technical cooperation with national authorities in the planning, management and evaluation of their maternal health and family planning programs is the primary focus of the Organization’s efforts in Maternal Health and Safe Motherhood. WHO’s activities in technical cooperation have resulted in, among other achievements, the following examples:

- National plans for maternal mortality reduction have been submitted to and agreed to in principle by donors in Bangladesh and have been submitted to donors in Senegal. In Bangladesh and in Indonesia, preparatory work for the training component has been funded and is in progress.

- Committees for Maternal Health and Safe Motherhood have been set up in Guinea, the Philippines, Bangladesh, Senegal and Tanzania, although the level of activity varies widely.

- A draft regional plan for Maternal Health and Safe Motherhood has been prepared by the American Regional Office and the Pan American Health Organization (AMRO/PAHO) and a proposed plan for a situation analysis in twelve countries during 1992 is being drafted by the African Regional Office (AFRO).

- Requests for technical cooperation from many countries have demonstrated a high level of interest. Visits have been made to several countries by staff from the global and/or regional programs. These will be followed up actively in 1992 as additional resources and staff become available.
Research

The research component of the program focuses on four main areas:

1. Epidemiologic studies to determine the level and causes of maternal mortality.
2. Operational research to evaluate the impact of interventions to reduce maternal mortality.
3. Social and behavioral research to identify barriers to better maternity care.
4. Evaluation of new technologies, drugs or treatment to reduce mortality.

Support to these research efforts concentrates on interventions relevant to the major immediate causes of maternal mortality, namely, hypertensive disorders of pregnancy, obstetric hemorrhage, obstetric infection and obstructed labour, and the consequences of unwanted pregnancy and abortion. Within each topic area attention is paid to prevention, as well as treatment, and to barriers to the effective utilization of maternal health care, including the direct and indirect costs of care and social, cultural and behavioral issues. Research continues on the epidemiology of maternal mortality and morbidity and on unmet needs for maternal health care and family planning.

Information and advocacy

The program aims to provide scientifically sound information, in an appropriate form, on the nature and dimensions of maternal mortality and morbidity in different areas, what can be done to alleviate them and how change can be brought about.

Program publications include:

- Preventing Maternal Deaths, which is now in its second edition and of which over 9,000 copies have been sold or distributed worldwide;

- Maternal Mortality: A Global Factbook, a 600 page book which sets out the facts and figures needed to understand why so many women continue to die as a result of pregnancy and childbirth;

- Essential Elements of Obstetric Care at First Referral Level, which is aimed at those responsible for the planning, organization and management of maternity care services, particularly in developing countries;

- Obstetric fistulae: A Review of Available Information;

Efforts in the field of advocacy have concentrated on the production of materials for the education, orientation and training of health workers, and on those with a technical and health care content. A newsletter is published three times a year.

Resource development

The program also develops, tests and implements health learning materials and training programs for health care providers at the health center and first referral level. Prototype training packages are being developed at the global level for midwifery and essential obstetric care, and will be adapted for use in each country. The TBA Trainers Kit, issued in 1985, has been revised, tested and reissued in 1990. Practical guidelines for the prevention and treatment of common obstetric emergencies are being produced for wide distribution.

For further information, please contact:

World Health Organization (WHO)
Safe Motherhood Programme
Division of Family Health
1211 Geneva 27
SWITZERLAND
Tel: 41 22 791 2111
Fax: 41 22 791 0746
Telex: 415416
APPENDIX III: SAFE MOTHERHOOD INITIATIVE
UPDATE OF REGIONAL AND NATIONAL WORKSHOPS

February 1992

This briefing is based on information available to Family Care International as of February 1992. We welcome updates on the Safe Motherhood Initiative activities listed here as well as on all other related workshops and activities. Please contact us at: 588 Broadway, Suite 510, New York, N. Y. 10012, U. S. A.; Telephone (212)941-5300, Fax: (212)941-5563, Telex: 210474 FAMCAR UR.

A. PLANNED WORKSHOPS

<table>
<thead>
<tr>
<th>Site (Participants)</th>
<th>Date</th>
<th>Strategy</th>
<th>Expected Outcome</th>
<th>Principal Agencies Involved</th>
<th>Field Contacts</th>
</tr>
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<td>ANDEAN REGION (site to be determined)</td>
<td>late 1993</td>
<td>Mobilize and inform government and NGO leaders</td>
<td>Sub-regional &amp; national plans of action</td>
<td>FCI, Inter-American Parliamentary Group on Pop. &amp; Development</td>
<td>To be determined</td>
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<tr>
<td>(Bolivia, Colombia, Ecuador, Peru, Venezuela)</td>
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<tr>
<td>CARIBBEAN (site to be determined) (Participating countries to be confirmed)</td>
<td>early 1994</td>
<td>Mobilize and inform government and NGO leaders</td>
<td>Sub-regional and national plans of action</td>
<td>FCI, Inter-American Parliamentary Group on Pop. and Development</td>
<td>Billie Miller, Member of Parliament; Dame Nita Barrow, Governor General/Barbados</td>
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<tr>
<td>(Anguilla, Antigua, Barbados, Belize, Dominica, Grenada, Guyana, Haití, Jamaica, Montserrat, St. Kitts-Nevis, St. Lucia, St. Maarten, St. Vincent, Suriname, Trinidad &amp; Tobago)</td>
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<tr>
<td>MEXICO</td>
<td>early 1993</td>
<td>Mobilize and inform government and NGO leaders</td>
<td>National Plan of action</td>
<td>FCI, Inter-American Parliamentary Group on Pop. &amp; Development</td>
<td>Marie Carmen Letero, Senadora Blanca Esponda</td>
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<td>B. PENDING WORKSHOPS</td>
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<td>Conference Summary: Attended by representatives of sixteen of the world's largest international NGOs involved in health, family planning and women's welfare activities in developing countries. The World Bank, WHO, UNDP and UNFPA were also represented.</td>
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Recommendations include: educating and sensitizing affiliates and constituencies about Safe Motherhood; re-orienting and expanding activities to focus on the problem of maternal mortality and morbidity; working to improve the status of women; becoming more aggressive advocates of safer motherhood; identifying creative means of securing the resources to implement the Initiative; forging links with other NGOs, governments and inter-governmental agencies to maximize the effectiveness of individual contributions.


**Conference Summary:** About 60 participants attended, including governmental and non-governmental representatives from 10 states in northern Brazil, the Brazilian Federal Government, Angola, Mozambique, Guinea-Bissau, UNFPA and the World Bank.

Recommendations include: establishment of Maternal Mortality Committees; promotion and provision of family planning within maternal health program; studies on maternal mortality and incidence of abortion; taking steps to reduce high rates of cesarian sections; follow-up seminars in Northeastern states and Lusophone Africa.

3. **Cameroon** - December 1989. Final report, including recommendations will be available from CUSS in Yaounde.

**Conference Summary:** Approximately 40 participants, including doctors, nurses, nurse-midwives, TBAs and MOH representatives came together for a three-day conference focused on the issue of maternal mortality in Cameroon. Particular emphasis was placed on the high risk approach, community participation, and confidential inquiries into maternal death, as well as the role that family planning can play in reducing maternal mortality and morbidity.


**Conference Summary:** The meeting was opened by the Vice President of Guatemala and was attended by national delegations of parliamentarians, Ministers of Health, senior government officials, NGO representatives, and journalists from Belize, Costa Rica, Cuba, the Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua and Panama. International agencies and health professionals were also represented. About 160 people attended the five day conference.

Recommendations include: urging governments to establish officially recognized Safe Motherhood Committees with an intersectoral and multidisciplinary participation; the revising of legislation that pertains to violence or discrimination against women; establishing national reproductive health plans, including systems of epidemiological monitoring of maternal mortality; confronting the problem of abortion with honesty, recognizing that it is a public health problem with widespread ramifications and developing plans to integrate sex education into the formal and informal educational system.


**Conference Summary:** Two Safe Motherhood meetings were held in Indonesia. In June 1988, approximately 350 governmental and non-governmental representatives from all 27 provinces, as well as representatives from the international development community, attended a symposium to draw attention to the issue of maternal mortality. In August, an action-oriented workshop with about 50 participants from key government agencies and non-governmental organizations met to develop plans for specific sectoral programs. As a result of this workshop, various government agencies will be implementing Safe Motherhood activities as part of Indonesia’s five-year development plan. Specific areas of activity include health and family planning; information and education, and improving the status of women through basic education, income-generation, training, and expanding employment opportunities.

Conference Summary: Attended by delegations from thirteen of the least developed Arab states; included representatives from ministries of health and other sectors as well as from NGOs. The World Bank, WHO, UNFPA, UNDP, UNICEF and international NGOs and foundations were also represented. A total of about 130 people attended.

Recommendations include: establishing national and regional Safe Motherhood committees and a regional fund; improving the status of women by, for example, ensuring access to family planning and eliminating female circumcision; ensuring that each village has at least one TBA; improving the management of abortion complications; promoting and improving the quality of Safe Motherhood research and communications; evaluating progress at a follow-up conference in 1991.


Conference Summary: Opened by the President of Namibia and attended by various ministers and senior government officials; participants totaled about 150 and included representatives from regional and central levels, non-governmental and religious groups, and various donor and international agencies. Conference focused on examining medical and root causes of high maternal mortality, including adolescent pregnancy and STDs/HIV. Task Force has been established to prepare action plan, and 4 regional Safe Motherhood workshops are being held to gather more information on views and conditions in rural areas. IEC campaign is being designed, and Safe Motherhood is one of the major goals of the new national Primary Health Care Program.


Conference Summary: Delegations from 22 sub-Saharan Francophone African countries attended, representing ministries, NGOs and the media. Also attending were the World Bank, UNDP, UNFPA, UNICEF, WHO, the African Development Bank, international NGOs, bilateral donor agencies and regional institutions. About 230 people attended.

Recommendations include: conducting and disseminating medical and anthropological research; mobilizing and coordinating governmental, NGO and donor resources; decentralizing health care systems and increasing community participation in family planning, family life education programs and maternal health programs; policy reform to improve women’s status; establishing national committees to coordinate Safe Motherhood activities.

12. Nigeria -- September 1990. Conference papers, and report from four pre-conference seminars for women’s groups available from FCI. Communique and conference documents also available from SOGON.

Conference Summary: Attended by approximately 250 people representing women’s organizations, government ministries, medical associations, and international agencies. Participants discussed a wide range of factors affecting maternal health in Nigeria and proposed follow-up action by government and non-governmental agencies including increasing the availability of family planning services, improving and expanding health training programs that emphasize women’s reproductive health concerns, and various measures to improve the status of women such as legislating against early marriage and increasing female access to education at all levels.

13. Pakistan -- March 1990. Conference papers and plans of action (regional and national) available from FCI. Full conference report available from FCI. Safe Motherhood South Asia audio-visual presentation available in video format from FCI. Presentation recently nominated as public information finalist at New York Film Festival.

Conference Summary: Attended by high-level teams of government officials, parliamentarians, NGO representatives, and journalists from Bangladesh, Bhutan, India, Maldives, Myanmar, Nepal, Pakistan, and Sri Lanka. Also attended by observers from the Soviet Union and Afghanistan. A total of about 175 people attended.

Specific commitments to action issued by the conference as a whole as well as by each country team included: improving the status of women and girls; ensuring availability of basic package of general, maternal, and reproductive health care; developing high-profile public information campaigns; training and deploying.
appropriate health personnel; linking women to services through transport and communications; using all available resources to their maximum effectiveness. General strategies include: mobilizing political will, involving communities and NGOs, sharing information and ideas, involving the media, and sensitizing men.


**Conference Summary:** August technical workshop attended by approximately 90 participants representing government ministries, the political party, NGOs, international agencies, and local administrative units of the Ministry of Health, as well as Zanzibar. Participants discussed a draft strategy document and adopted a statement outlining the actions needed in the areas of raising women's status, expanding family planning services, and improving routine and emergency maternal health services. Seminar for parliamentarians and senior party representatives held in January 1991, opened by the Prime Minister and addressed by the Ministers of Health and Community Development, Women's Affairs and Children. About 40 parliamentarians attended and endorsed a statement endorsing the development and implementation of a national multi-sectoral safe motherhood strategy. Follow-up is being carried out by various ministries and NGOs in research, service delivery, training & IEC.


**Conference Summary:** Attended by representatives of women's NGOs, district-level health workers, and women's representatives from local governments, as well as representatives from the Ministry of Health, the Ministry of Women in Development, and various donor agencies. A total of approximately 75 people attended.

Recommendations focused on community-level actions that could be taken by NGOs and government agencies to prevent and treat pregnancy-related complications. Conference is the starting point for two-year Safe Motherhood project to be implemented by NGOs in cooperation with the Ministry of Health and the Ministry of Women in Development.


**Conference Summary:** Attended by teams of government officials, parliamentarians, NGO representatives, and journalists from Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, Swaziland, Tanzania, Zambia, and Zimbabwe. Also represented were regional and international NGOs, technical agencies, and donor/co-sponsoring organizations. About 250 people attended.

Recommendations focused on country-level and regional interventions to promote social change, empower women, and combat poverty; strengthen and expand family planning and maternal health services; improve information and community education programs; increase the availability of skilled health personnel at all levels; improve transportation and communication systems; improve operational research and data collection; involve community members, NGOs, and all media in all programs; expand, coordinate, and share the resources available to implement Safe Motherhood interventions.
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175
5. **NGOs**

   Participating NGOs:

   ASSOCIATED COUNTRY WOMEN OF THE WORLD  
   FAMILY CARE INTERNATIONAL  
   INTERNATIONAL ASSOCIATION FOR MATERNAL & NEONATAL HEALTH  
   INTERNATIONAL CONFEDERATION OF MIDWIVES  
   INTERNATIONAL COUNCIL OF NURSES  
   INTERNATIONAL COUNCIL OF WOMEN  
   INTERNATIONAL FEDERATION OF BUSINESS & PROFESSIONAL WOMEN  
   INTERNATIONAL FEDERATION OF GYNECOLOGY & OBSTETRICS  
   INTERNATIONAL PLANNED PARENTHOOD FEDERATION  
   LEAGUE OF RED CROSS AND RED CRESCENT SOCIETIES  
   MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION  
   SOROPTIMIST INTERNATIONAL  
   WORLD ASSEMBLY OF YOUTH  
   WORLD ASSOCIATION OF GIRLS GUIDES & GIRL SCOUTS  
   WORLD COUNCIL OF CHURCHES  
   WORLD ORGANIZATION OF THE SCOUT MOVEMENT

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Magari, Dr. F. UNFPA Medical Advisor, personal communication, 1992.


MotherCare Project, John Snow, Inc. *Summary Description of Cochabamba Reproductive Health Project,* 1991.


### Maternal Mortality

#### Maternal Mortality Ratio (MMR)*

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<td>n/a</td>
<td>600</td>
<td>247</td>
</tr>
<tr>
<td>Brazil</td>
<td>140</td>
<td>200</td>
<td>250</td>
</tr>
<tr>
<td>Ghana</td>
<td>5000</td>
<td>1,500</td>
<td>n/a</td>
</tr>
<tr>
<td>India</td>
<td>400</td>
<td>n/a</td>
<td>1,152</td>
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<td>n/a</td>
<td>400</td>
<td>1,016</td>
</tr>
<tr>
<td>Mexico</td>
<td>65</td>
<td>200</td>
<td>n/a</td>
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<td>Nigeria</td>
<td>1,500</td>
<td>800</td>
<td>2,833</td>
</tr>
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<td>Pakistan</td>
<td>n/a</td>
<td>270</td>
<td>5,010</td>
</tr>
<tr>
<td>Senegal</td>
<td>n/a</td>
<td>600</td>
<td>933</td>
</tr>
<tr>
<td>Tanzania</td>
<td>185</td>
<td>200</td>
<td>680</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>77</td>
<td>n/a</td>
<td>57</td>
</tr>
</tbody>
</table>

*Maternal deaths per 100,000 live births

#### Lifetime risk of mortality

<table>
<thead>
<tr>
<th>Region</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>1 in 21</td>
</tr>
<tr>
<td>Asia</td>
<td>1 in 54</td>
</tr>
<tr>
<td>South America</td>
<td>1 in 73</td>
</tr>
<tr>
<td>Caribbean</td>
<td>1 in 140</td>
</tr>
<tr>
<td>Oceania</td>
<td>1 in 141</td>
</tr>
</tbody>
</table>

#### Coverage of maternal health care (percentage)*

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Prenatal care (at least one visit)</th>
<th>Trained assistance at delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Bolivia</td>
<td>15</td>
<td>42</td>
</tr>
<tr>
<td>Brazil</td>
<td>74</td>
<td>95</td>
</tr>
<tr>
<td>Ghana</td>
<td>82</td>
<td>40</td>
</tr>
<tr>
<td>India</td>
<td>45</td>
<td>33</td>
</tr>
<tr>
<td>Indonesia</td>
<td>10</td>
<td>49</td>
</tr>
<tr>
<td>Mexico</td>
<td>71</td>
<td>70</td>
</tr>
<tr>
<td>Nigeria</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Pakistan</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>Senegal</td>
<td>63</td>
<td>41</td>
</tr>
<tr>
<td>Tanzania</td>
<td>98</td>
<td>74</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>90</td>
<td>60</td>
</tr>
</tbody>
</table>

*Percentage of female health care coverage, trained assistance at delivery

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### Abortion

The complications of unsafe abortion take the lives of up to 200,000 women each year. Ensuring access to abortion services can prevent up to one million maternal deaths annually. Empowering women, improving access to family planning, and reversing laws that criminalize abortion can save millions of lives and prevent millions of complications and deaths.
Adolescent Fertility

Teenagers are at particularly high risk of pregnancy-related complications. They are also at higher risk of unintended pregnancy and unsafe induced abortion, as well as spontaneous abortion. As a result, the number of adolescents who become pregnant each year is much higher than indicated by the annual number of live births to adolescents (see chart below).

Percentage of rural women who have had a live birth by age 15, 18, and 20

<table>
<thead>
<tr>
<th></th>
<th>15</th>
<th>18</th>
<th>20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>21.6</td>
<td>65.6</td>
<td>80.7</td>
</tr>
<tr>
<td>Ghana</td>
<td>3.5</td>
<td>32.0</td>
<td>61.8</td>
</tr>
<tr>
<td>Indonesia</td>
<td>6.5</td>
<td>33.4</td>
<td>65.1</td>
</tr>
<tr>
<td>Mexico</td>
<td>5.7</td>
<td>30.5</td>
<td>55.3</td>
</tr>
<tr>
<td>Nigeria</td>
<td>16.9</td>
<td>48.0</td>
<td>64.2</td>
</tr>
<tr>
<td>Pakistan</td>
<td>5.1</td>
<td>32.9</td>
<td>51.5</td>
</tr>
<tr>
<td>Senegal</td>
<td>5.8</td>
<td>48.6</td>
<td>74.9</td>
</tr>
</tbody>
</table>

Economic Indicators

Gross National Product (GNP) per capita (US$, 1989)

<table>
<thead>
<tr>
<th></th>
<th>Bangladesh</th>
<th>Bolivia</th>
<th>Brazil</th>
<th>China</th>
<th>Egypt</th>
<th>India</th>
<th>Indonesia</th>
<th>Mexico</th>
<th>Nigeria</th>
<th>Pakistan</th>
<th>Senegal</th>
<th>Tanzania</th>
<th>Zimbabwe</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>180</td>
<td>620</td>
<td>2,540</td>
<td>390</td>
<td>990</td>
<td>370</td>
<td>300</td>
<td>2,910</td>
<td>360</td>
<td>300</td>
<td>700</td>
<td>670</td>
<td>130</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Mexico</th>
<th>Nepal</th>
<th>Nigeria</th>
<th>Pakistan</th>
<th>Peru</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2,910</td>
<td>350</td>
<td>250</td>
<td>370</td>
<td>650</td>
</tr>
</tbody>
</table>

Education

Enrollment rates (male/female, 1988)†

<table>
<thead>
<tr>
<th></th>
<th>Primary</th>
<th>Secondary</th>
<th>Tertiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>76/64</td>
<td>24/11</td>
<td>7/2</td>
</tr>
<tr>
<td>Bolivia</td>
<td>97/75</td>
<td>45/35</td>
<td>31/11</td>
</tr>
<tr>
<td>Brazil</td>
<td>101/97**</td>
<td>32/41</td>
<td>11/14</td>
</tr>
<tr>
<td>Ghana</td>
<td>81/66</td>
<td>47/30</td>
<td>1/1</td>
</tr>
<tr>
<td>India</td>
<td>114/83</td>
<td>50/27</td>
<td>9/4</td>
</tr>
<tr>
<td>Indonesia</td>
<td>121/117</td>
<td>53/42</td>
<td>12/6</td>
</tr>
<tr>
<td>Mexico</td>
<td>118/115</td>
<td>53/53</td>
<td>30/13</td>
</tr>
<tr>
<td>Nigeria</td>
<td>76/48</td>
<td>28/18</td>
<td>5/2</td>
</tr>
<tr>
<td>Pakistan</td>
<td>51/28</td>
<td>26/11</td>
<td>7/3</td>
</tr>
<tr>
<td>Senegal</td>
<td>70/40</td>
<td>21/10</td>
<td>4/1</td>
</tr>
<tr>
<td>Tanzania</td>
<td>67/66</td>
<td>5/3</td>
<td>0/1</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>130/126</td>
<td>60/42</td>
<td>8/3</td>
</tr>
</tbody>
</table>

†Gross enrollment rates. The number of children enrolled in a level of education expressed as a percentage of the population of the age group for that level, may exceed 100% because some pupils are younger or older than the country’s standard age for that level.

‡Data from 1980