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Supporting Safe Motherhood

A Review of Financial Trends

Summary

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Almost 500,000 women a year from developing countries die from pregnancy-related causes. In 1987, an international conference in Nairobi, Kenya launched a global Safe Motherhood Initiative with World Bank co-sponsorship. By 1989, how were the donors responding to the Initiative?

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This paper — a product of the Population, Health, and Nutrition Division, Population and Human Resources Department — is part of a larger effort in PRE to promote policy and resource commitment to the Safe Motherhood Initiative. Copies are available free from the World Bank, 1818 H Street NW, Washington DC 20433. Please contact Sonia Ainsworth, room S6-065, extension 31091 (16 pages with figures).

Financial trends for safe motherhood initiatives. Problems of definition and accounting methods preclude an accurate analysis of financial trends among donors. Global support for specific safe motherhood activities is limited. For the 17 major bilateral sources, funding for selected activities which contribute to safe motherhood is estimated to have increased (in current dollars) from $691.5 million in 1986 to $818.8 million in 1988. About half this amount was for so-called core* activities, including family planning services. The magnitude of support for prevention of the complications of pregnancy is less certain. General health, population, and nutrition sector flows increased substantially over the same period. These trends were positive for 13 sources, unchanged for three, and negative for one.

Of the six major multilateral sources, totals for selected safe motherhood activities were estimated to be $477.7 million in 1988, a 41.7 percent increase over 1987 and a 17 percent increase over 1986, reflecting differences in the annual volume of World Bank loan approvals. Half of this went for core services, primarily family planning.

Estimated World Bank safe motherhood expenditures in 1989 are triple the previous year's total. This is due primarily to substantial increases in general loans for health, population, and nutrition. New specific safe motherhood activities are beginning to emerge in the form of care for the complications of pregnancy, better secondary and tertiary facilities, training, and promotional workshops.

The magnitude and effectiveness of donor financing will require more attention to two special problems:

- Strengthening recipient countries' ability to articulate project demand — providing specific training, technical advisory assistance, and operational guidelines for mobilizing financial resources.

- Improving the data on safe motherhood financial trends — establishing a consensus on definitions; seeking a consensus on financially measurable program or project categories of safe motherhood; defining methods for the systematic collection of donor and recipient country data on financial trends.

For the full section on Interview Notes with different financing sources, see WPS 413.

* At the 1987 Conference on Safe Motherhood in Nairobi, Herz and Measham recommended a core program for safe motherhood that included reducing the number of pregnancies through family planning education, promotion, and community-based services; reducing the risks to pregnancy and childbirth; providing prenatal care, supervised deliveries, screening, and referral for high-risk mothers; and providing communication and transportation for complicated deliveries.

Produced at the PRE Dissemination Center

The author is an M.D., Dr. P.H consultant to the World Bank, and Senior Adviser, The Pragma Corporation. He wishes to express appreciation and thanks for the generous time and cordial cooperation extended by those interviewed. The informality of these meetings and the ability to exchange views were of immense value in gaining a perspective on the outlook for the Safe Motherhood Initiative. The author regrets that an internal reorganization of NORAD precluded a visit to Oslo. All conversations are considered unofficial exchanges and the author accepts full responsibility for estimates and interpretation.

The World Bank initiated this study with the endorsement of the Safe Motherhood cosponsors. Special thanks all extended to Bank staff for guidance and support, in particular to Dr. Anthony Measham, Chief of Population, Health, Nutrition Division; Dr. Barbara Herz, Chief of the Women in Development Division; Dr. Frederick Sai, Senior Population Adviser; Mrs. Eleanor Folta (PHN Division) and Ms. Anne Grimsrud (Women in Development Division).

The Director General of WHO, Dr. Hiroshi Nakajima, and his Director for Planning, Coordination and Cooperation, Dr. Yuji Kawaguchi, shared their perspectives on the problems and outlook for financial resource mobilization. Dr. Mark Belsey, chief of the Maternal and Child Health Unit at WHO, Geneva, was most helpful in collaborating on the initial design of the study, and his cooperation in arranging for a field questionnaire is greatly appreciated.

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I. INTRODUCTION

At the February 1987 Conference on Safe Motherhood in Nairobi[1], Herz and Measham (1987) presented a paper on "The Safe Motherhood Initiative," in which they proposed a new approach to reduce maternal mortality and morbidity in developing countries. Herz and Measham noted that in spite of progress toward child survival and improvements in life expectancy, an estimated 500,000 women, 99 percent of them from the developing world, die each year from pregnancy-related causes[2].

About three quarters of these deaths are the direct result of obstetrical complications -- hemorrhage, infection, toxemia, obstructed labor, and abortion (under primitive and illegal conditions). An estimated equivalent number of infants do not survive their mother's death. For surviving mothers, the consequences of pregnancy have a severe impact on health and family economics.

The proposed strategy for safe motherhood is based on two approaches. First, the encouragement of activities that indirectly improve maternal health. These include education, policies to improve women's rights and working conditions, health care and nutrition, transportation and communication systems, water and sanitation facilities, and increases in family income and food production.

The second approach, which serves as the core strategy for the Safe Motherhood (SM) Initiative targets activities to reduce maternal deaths. These activities include reducing unwanted pregnancies through the provision of family planning services, and through national policies that recognize the importance of this issue (although Maine (1985) estimates that even if all unwanted pregnancies were avoided, only a fourth to two fifths of maternal mortality would be avoided).

A second objective is to reduce the risks of pregnancy through providing community-based family planning and prenatal services to identify high-risk cases' adequate referral services for the complications of pregnancy, and communication and transport systems to support patient referral procedures.

Given the long history of support for maternal health by international bilateral, multilateral, and nongovernmental organizations (NGOs), the conference recognized that the limited progress in reducing maternal mortality and morbidity required moving to a systems approach utilizing selected, targeted, core activities.

II. TERMS OF REFERENCE

A. *Purpose*

In response to a request from the Meeting of Interested Parties, which serves as the international forum for monitoring the Safe Motherhood Initiative, the World Bank has undertaken this study to measure aid flows for this program since the 1987 conference. The study is designed to measure financial trends and new initiatives in support of the program's objectives; identify issues of statistical methodology that may constrain the analysis, and establish a baseline for 1988 against which to measure future financial trends.

A second objective of the study is to identify SM policies and programs among the major official sources of external financing. In view of the four-month timetable to complete this study, it concentrates on Official Development Assistance (ODA) and does not include nongovernmental and private contributions except for official contributions to nongovernmental organizations (NGOs)[3].

The expectations of this review are modest in view of four factors:

1. The wide variations in statistical methods for recording maternal health data make it difficult to compare data sets.

2. New projects started immediately after the conference are unlikely to have recorded expenditures in time to be included in this review.

3. The absence of international uniformity on the criteria for the initiative and the wide range of activities with direct and indirect maternal health effects means that much of the data were based on interpretations.

4. The relatively brief duration of the study.

B. *Assumptions*

1. The study looks at financial flows rather than cost-effectiveness, and does not assume that magnitude of investment is directly correlated to improvements in maternal health.

2. Because there is no comprehensive global system to monitor health expenditures by developing countries or external sources, the data would have to be obtained from each financial source.

3. Because of variations in statistical recording systems and in definitions of health, full comparability would be difficult to assure.

4. It would be premature to expect identifiable new financing specifically addressing the initiative. Official statistical systems have not been adjusted to identify SM components. As a result, the data reflect unofficial estimates derived from multiple sources. The author, not the sources, is responsible for the composite estimate.

5. To accomplish the study in the four-month period prior to the June 1989 Meeting of Interested Parties, direct interviews with the major bilateral and multilateral financial sources were considered preferable to risking a low response rate to a mailed questionnaire. For developing countries, however, the sources of information were resident WHO and UNDP representatives.

C. *Methodology*

1. The study drew on data sets for 1985 to 1989 in order to permit a comparison of trends before and after the Nairobi conference.

2. The data were examined for characteristics that would identify components.

3. Where there were no specific components within a health loan or primary health care program, the respondent was asked to estimate the amount of financing for SM. Information from interviews was supplemented by the official annual reports of bilateral and multilateral agencies.

4. For purposes of comparison, each financial source was asked to use common definitions and to include all major categories of ODA for the health sector as follows:

- **Bilateral financing** (regional or country projects or programs)
- Official contributions to multilateral sources (omitting assessed contributions, for instance, to WHO)
- Official contributions to nongovernmental and private organizations.

5. Interviews were held with the following countries and other international organizations[1] from January to March 1989:

Austria
Belgium
Denmark
DAC/OECD
European Community
Finland
Federal Republic of Germany (2)
France
Italy (2)
Japan
Netherlands
OPEC Fund for International Development
PAHO
Sweden
Switzerland
United Kingdom
United States
UNDP
UNFPA
UNICEF
WHO Headquarters
World Bank

The following financial sources were not canvased:

African Development Bank
Asian Development Bank
Inter-American Development Bank
Eight Eastern Bloc countries:
(Bulgaria, Czechoslovakia, German Democratic Republic
Hungary, OPEC Member Funds, Poland, USSR, Yugoslavia)
Greece
Ireland
Luxembourg

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[1] For governmental organizations, the responsible international development aid authority was interviewed. The bracketed number indicates the number of official aid-related agencies. Development agencies in Australia, Canada, Japan, Norway and New Zealand were canvased by mail or telephone. As of April 22 only two organizations had responded.

Spain
FAO
UNEP

D. *Definitions and Criteria for Safe Motherhood Activities*

This review uses the inclusive definition presented at the 1987 Nairobi conference. It defines the Initiative as an effort to accelerate the reduction of illness and death related to pregnancy in developing countries through integrated measures including maternal care, family planning, nutrition and information to enhance the social, economic and legal status of women and to encourage political commitment by developing governments and their financial partners. Additionally, there are many beneficial activities that are not primarily designed to improve maternal health but that have positive effects. In this category are labor-saving technology, nutrition, water, and sanitation improvements, food production, and improvements in the status of women. In acknowledging the importance of these indirect programs, Herz and Measham spell out a core program and a strategy that includes these activities as well as direct interventions for maternal health:

- Reducing the number of pregnancies through family planning education, promotion, and services.

- Reducing the risks to pregnancy and childbirth from medical factors (for instance, hemorrhage) and environmental factors which impair maternal health (anemia resulting from hookworm); limited motivation and financial resources to make use of health facilities; poor identification of high risk mothers; constraints to transportation and communication during a period of emergency need. This effort includes three major components:

  - community-based family planning services, prenatal care, supervised deliveries at home or local health centers, screening and referral for high-risk mothers.

  - facilities and services for referred high-risk mothers at designated centers equipped to manage the complications of pregnancy.

  - communication and transport for high-risk and complicated deliveries.

1. **Selecting Financially Measurable Program or Project Categories**

The issue here is that SM components often exist in projects without financial attribution, making it difficult to measure financial trends.

Given the need to examine financial trends in support of SM, what categories of project activity are currently available for measurement? To what extent are maternal health components sufficiently specific to permit measurement? And where the maternal health component is specific, does the financial source identify the component in its statistical system?

The financially identifiable program/project categories reviewed for this report include:

- Specifically labeled "Safe Motherhood" activities.

- Specifically labeled maternal health programs, including promotion, training, and research.

- Family planning and population.
- General health systems with components that contribute to the reduction of maternal mortality and morbidity. Projects may be listed as general health sector loans or primary health care projects and may include family planning, prenatal care, maternal care facilities, and transportation.
- Nutrition programs.
- Information, education and communications (IEC) programs.
- Women in development projects.
- Intersectoral programs that benefit women of childbearing age through improvements in education, employment, rural development, or agriculture.

2. Distinguishing between Inclusive (direct and indirect) and Core (direct) Projects

The inclusive definition of activities that promote safe motherhood includes all direct and indirect programs that influence maternal morbidity and mortality. The core definition is limited primarily to the Herz-Measham components -- family planning, community-based maternal care, referral facilities for the complications of pregnancy, and communication and transport systems to support referral objectives.

3. Calculating the Safe Motherhood Content

Because statistical systems to record SM programs are weak, the data used here are estimates based on the percentage of financing in a particular project or program that might be attributed to reducing maternal mortality and morbidity. The attribution was calculated as follows:

a. Core Maternal Health Projects - Direct

- The actual percentage was used in the case of projects with a specific core SM content.
- Family planning/population programs (excluding census activities): 100 percent.
- Specific maternal health projects: 100 percent.
- Contributions to and by UNFPA: 50 percent on expenditures for health, community-based delivery systems, fertility regulation and program management.
- Contributions to and by WHO: 100 percent for maternal health and the Program for Research on Human Reproduction. This figure/underestimates WHO contributions to member governments for general health programing and health systems that have a favorable indirect impact on maternal health.

b. Inclusive Projects - Direct and Indirect

This category includes core projects plus indirect or poorly defined components. The attributed percentages are the best initial estimates.

- Health sector loans and primary health projects that include components to improve geographic access to pregnant women and that reduce maternal morbidity and mortality - 30 to 50 percent.

- AIDS projects. Improving the safety of blood banks prevents infection during transfusions - 10 percent.[2]

- Malaria and other major endemic disease control projects that reduce anemia - 25 percent.

- Water supply and sanitation projects are not included, though donors note the relevance of reducing the distance pregnant women are obliged to walk to get water. Up to 25 percent of rural water supply is included, if it is an integral part of a primary health or general health loan.

- Contributions to and by UNICEF. Since only 80 percent of UNICEF contributions are applied to health (primarily child health), the maternal care component is probably about 10 percent of total UNICEF program expenditures. (Unofficial UNICEF estimates attribute a larger percentage).

- Assessed contributions by member governments to UN organizations are excluded. Voluntary contributions for SM components by UN organizations are included.

- Governmental contributions to NGOs are included at a level of 25 percent. Global NGO contributions for health have been estimated at $700 million. Information on funding for maternal health programs is extremely limited.

- Women in Development and other projects: as appropriate.

It is essential to emphasize that donors and other international health organizations do not follow these accounting distinctions. Although donors have assisted in these rough estimates, technical distinctions and financial attribution for many projects cannot be estimated on short notice. This observation does not challenge the definitions used here, but qualifies the data since there are differences among sources. Improving the specificity in financial attribution is a task that remains to be done. For accurate tracking of Herz-Measham criteria, agreement on definitions and improvements in statistical and accounting practices are mandatory.

E. *Official Multilateral and Bilateral Development Data*

Quite aside from the problem of introducing a new program classification into an ongoing statistical system, there are other problems with data collection. First, the basic organization of a development agency is geographic. Data are usually gathered by region or country; sector-specific data are of less operational interest. For example, no bilateral agency publishes an annual official summary of its total bilateral, multilateral, UN and NGO accounts in the health/population/nutrition sector. While data can often be assembled from separate organizational units that may have parallel

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[2] Herz and Measham refer to estimates by Rochat (1985) indicating that hemorrhage accounts for a third of all maternal deaths in the Anantapur area of India and a half of all deaths in Indonesia and Egypt.

responsibilities for multilateral contributions, UN organizations, bilateral projects and NGOs, the determination of a comprehensive health sector investment often requires special study.

Second, differences of statistical content make it difficult to compare expenditures. Not all agencies include water and sanitation health activity totals. One agency omits population and nutrition. Many agencies do not include contributions made to NGOs for health.

Third, official annual reports on concessional flows may not be released until a year after the fiscal year-end.

The Development Assistance Committee of the OECD asks donors to submit annual data on funds for health projects. But the questionnaire excludes contributions to the UN system -- WHO, UNICEF and UNFPA -- which accounts for sizable contributions to health in developing countries.

The Creditor Reporting System of DAC/OECD excludes a number of nonproject categories, including technical advisory assistance, which is a major cost for some donors.

From an organizational point of view, multilateral and bilateral staff assigned to in-house technical advisory functions may not be assigned to collect project-specific data. Such comprehensive data collection for the health sector represents an additional and usually time-consuming task. The definitions and criteria to facilitate a general sector review -- or special SM reviews -- will require joint agreement if the resulting output is to be comparable or complete.

These variations in statistical practice make it difficult to develop precise answers to a simple question: What are the global financial trends in support of maternal health? Despite the efforts to collect information the diversity of statistical methods and practices affect the reliability of the mailed questionnaire. The alternative to periodic special studies is for members of the Meeting of Interested Parties to establish a consensus on statistical objectives and methods of measurement.

F. *Developing Country Data*

Efforts to track global health trends face enormous problems of methodology, staffing, and training. A basic statistical method in government budgeting is to categorize budget functions by such traditional components as personnel, transport, allowances, and equipment. While special studies permit disaggregation into specific functions, such as primary health care, maternal health care, and nutrition, the absence of functional accounting does not permit disaggregation as a general practice. WHO has recently encouraged health ministries to establish accounting formats that identify the principal sources of income and specify the principal distribution of that income, by function and over time (Mach and Abel-Smith, 1983). Without functional accounting, health ministries find it difficult to attribute the total costs (manpower, equipment, facilities) to, say, primary health care or other subsectoral components.

To measure progress toward improved maternal health, financial trend analysis is an important -- but limited -- tool to supplement the more direct measurement of change in maternal mortality and morbidity.

Estimated Trends in Direct & Indirect External Financing for Maternal Health in Developing Countries by Source of Financing, 1986-1988

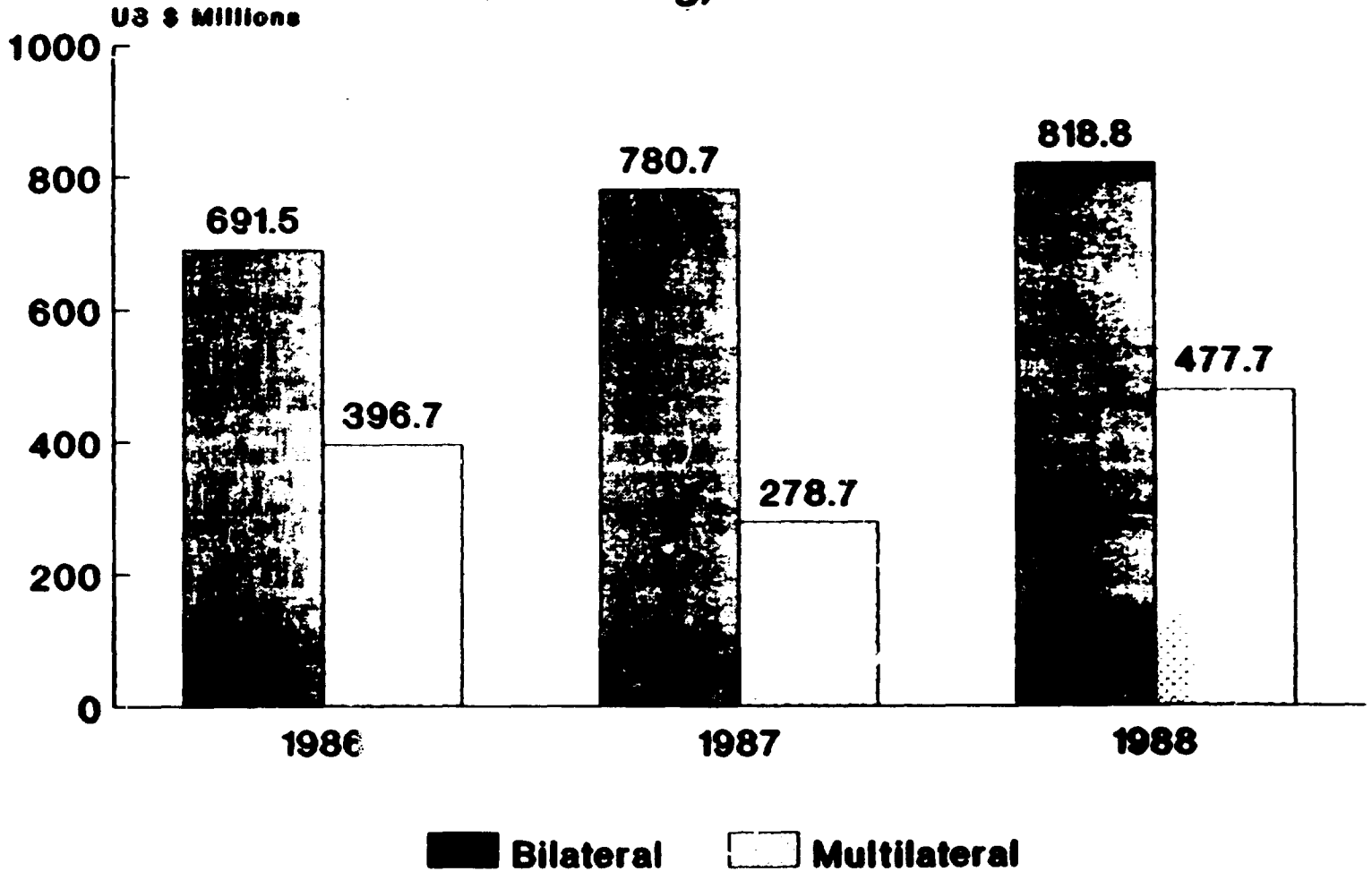

Figure 1

Estimated External Financing for Maternal Health In Developing Countries by Project Category & Source of Financing, 1988

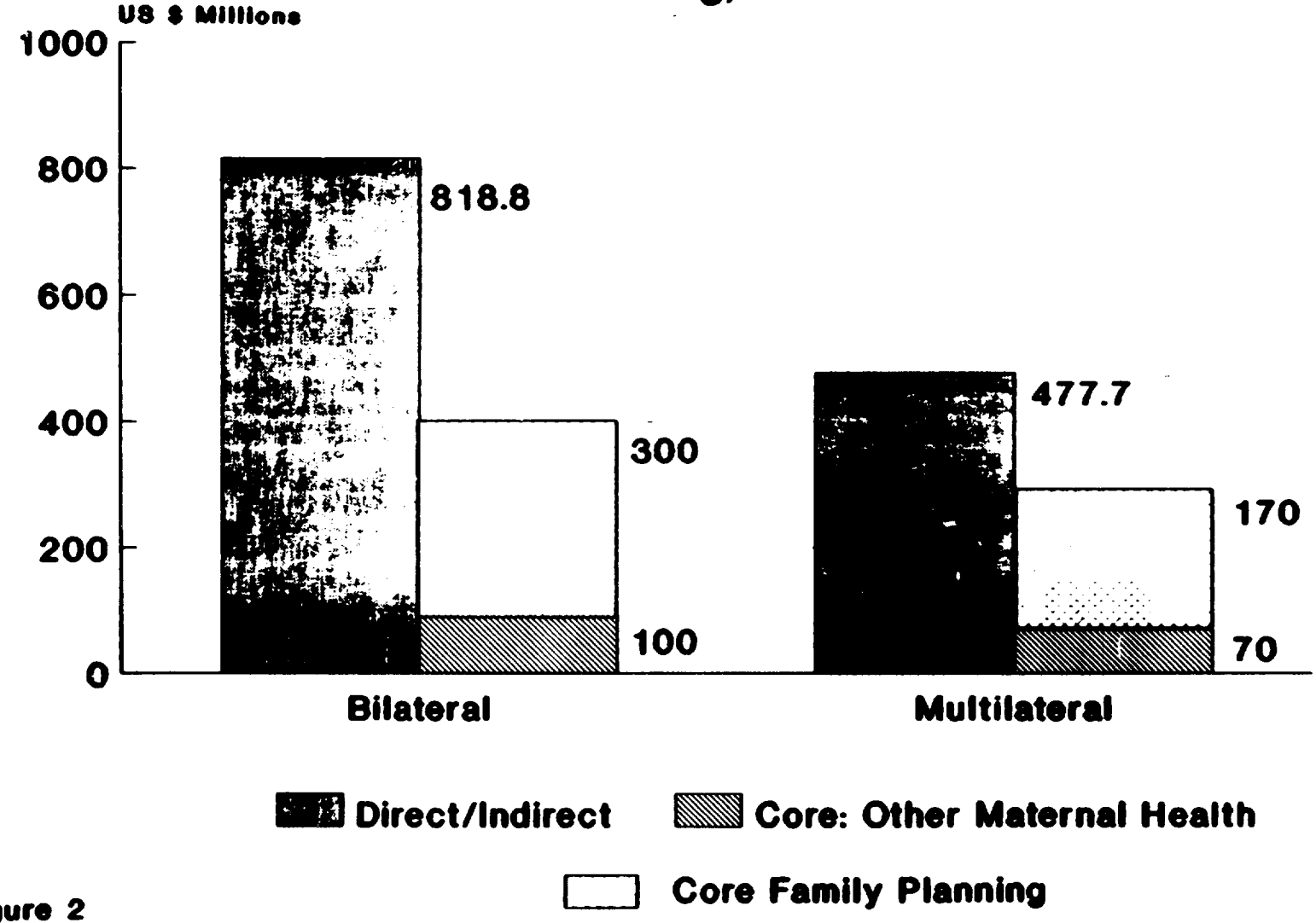

Figure 2

II. INTERVIEW NOTES: SUMMARY

A. *Summary of Donor Financial Trends*

Since bilateral data include government contributions to multilateral and United Nations organizations,[3] expenditures from both sources cannot be added to provide an annual total. The available data are not sufficient to provide a precise disaggregation of programs, particularly those that apply to high-risk births and the complications of pregnancy. The data do, however, offer a baseline on the status of the current information. Donor organizations should seek a consensus on the need to strengthen the statistical criteria and establish procedures for future measurement.

1. Bilateral Financial Trends

For the 17 major bilateral sources, including the European Community, the net trend from 1986 to 1988 shows a gradual increase in current dollars for Safe Motherhood ($691.5 to $818.8 million) and for comprehensive health, population, and nutrition ($2.221 to $2.863 billion). Projects with direct and indirect effects on maternal health improvement represent about a third of all bilateral financing, including family planning[4], primary health care, nutrition, training, and disease control (Figure 1). Both multilateral and bilateral data exclude the formal water supply and sanitation sector. If these expenditures were added, the level of total health funding would double. Water and sanitation are not excluded where they are essential parts of an integrated health project.

In 1988 financing for projects with direct maternal health benefits (core financing) included an estimated $300 million for family planning and $100 million for other core maternal health programs (Figure 2). The trends mask specific contributions by Belgium, the European Community, France, Italy, and Japan to upgrade or provide secondary or tertiary facilities to treat the complications of pregnancy. All donors support the objective of Safe Motherhood and at least seven donors have instituted new policies and plans for SM-specific projects starting 1989. Other bilateral donors observe that it is too soon to expect to see major global progress.

2. Multilateral Financial Trends

For the six multilateral agencies reviewed here, sectoral spending in 1988 ($1.632 billion) was 17 percent above 1987's level but below 1986's, suggesting fluctuations in disbursements of World Bank loans. SM components in 1988 were approximately 40 percent higher than 1987, largely because of increased programing by the Bank and UNFPA. A marked increase is planned in 1989 in World Bank lending for health, population, and nutrition, of which an estimated 50 percent contains SM components. This amount would represent a tripling of SM components over the previous year (see Figure 1).

The $477.7 million spent in 1988 for all direct and indirect maternal health financing includes an estimated $170 million in family planning services and $70 million for other programs with direct maternal health benefits, or $240 million for SM (see Figure 2).

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[3] Contributions by bilateral, multilateral, and nongovernmental organizations, for example, account for almost half of the annual expenditures of WHO and PAHO.

[4] Bilateral population programs cost $472 million in 1985.

In 1988 and 1989 WHO's funds for maternal health will amount to about 6 percent of the agency's total expenditures. This estimate excludes other programs, such as primary health care, nutrition, training, malaria, and health education, all of which also contribute to maternal health. Constitutionally, WHO does not serve as a major resource for financial transfers. The major resource is a global network of technical personnel who work on behalf of developed and developing countries.

B. *Safe Motherhood Financing by Developing Countries*

The following list describes the current status of data collection on expenditures for maternal health.

- WHO's Maternal and Child Health Offices do not maintain global data on local currency expenditures for maternal health at the country level. At the World Bank's request, WHO is distributing a questionnaire to selected WHO country representatives to solicit this information. In Latin America and the Caribbean, PAHO estimates that about a sixth of national health expenditures may be attributed to maternal care, including hospital expenditures.

- One of the few studies available was conducted by Sri Lanka's Marga Institute (1985). Based on 1982 data, health expenditures accounted for 3.7 percent of total government public sector expenditures and 1.4 percent of GNP. In the health sector, Rs. 976 million, or 20.7 percent, was directed to family health, of which Rs.72 million (64 percent) was spent on maternal health care. The study suggests that government expenditures for MCH are doubled by household expenditures. Approximately a third of all maternal and child health expenditures are related to transport. The study does not state the criteria for attribution.

- UNICEF Country Situation Analysis reports do not specify maternal health costs.

- Detailed WHO-sponsored health care financing studies on Jamaica, Costa Rica, and Mali do not contain information on maternal care.

- WHO Country Resource Utilization reports give only limited details on maternal health expenditures. The accounting categories are general -- salaries, transport, and drugs -- rather than by programs.

- A report on Malawi (1983) attributes about 4 percent of government health expenditures to "maternities" and "dispensary/maternities."

- A study on Liberia (1988) indicates that 90 percent of the health budget funds "curative medicine," of which the major cost is salaries. Within these costs, however, approximately 30 percent of hospital beds are used for pregnancy and its complications (40 percent in the John F. Kennedy Hospital in Monrovia). In addition, the study documented an extensive nonsalaried network of trained traditional birth attendants (approximately 2,500).

1. Trends in National Financing for Maternal Health

Global monitoring of maternal care financing is not likely to emerge without a specific agreement by the various health ministries. The problem is not unrelated to the difficulties of monitoring general health sector expenditures. Only 20 developing countries report to the United Nations system on national accounts. WHO has attempted to encourage functional accounting following the Mach and Abel-Smith (1983) "Manual on Financial Planning for Developing Countries." But acceptance of this procedure has been very slow and, in effect, has inhibited the ability of governments to document their progress in the health sector.

Short of improving the entire health statistical system in developing countries, there will need to be an agreed effort among Ministries of Health and their resident external cooperation advisers to gather maternal health information according to agreed criteria. Given the program overload imposed on health ministry personnel and their WHO colleagues, how is the work to be done? The issue merits the attention of the Meeting of Interested Parties. Is this an area that would benefit from joint financing and technical cooperation, beginning with a limited number of developing countries and expanding over a period of several years? The process of attracting financing suggests that data collection may be one of the prerequisites for effective financial mobilization in that it documents demand and justifies the need for additional financing. For purposes of program justification, gross estimates are less persuasive. For example, 72 percent of 40 least developed countries responding to a WHO survey spend less than 5 percent of GNP on health (WHO EB/83/2). Half of another 88 "other developing" countries also spend less than 5 percent. The high number of countries that did not respond to the survey (50 percent) suggest that average GNP health percentage is lower -- possibly 2 to 4 percent. The 1987 DAC chairman's Annual Report provides a global GNP estimate of $2,585,260 million. At the 3 percent level, public sector health expenditures would approximate $77.4 billion. Assuming a 1:3 ratio of public to private expenditures, health expenditures by developing countries may reach $221 billion. If a tenth of this expenditure is attributed to maternal health, the global total would approximate $22 billion.

This type of global estimate is meaningless for practical purposes. How much maternal health does a given unit of currency purchase? To make reasonable progress in this direction, it is critical to encourage the practice of functional accounting.

III. *CONCLUSIONS*

A. *Statistical Methods*

Ideally, each country and region should keep data on the costs of direct and indirect programs to improve maternal health. Although mortality, morbidity, accessibility, and service data are available on a country-by-country basis, there is limited information on financial flows at the country level. Budget and accounting procedures most often follow traditional expenditure categories rather than disaggregating funds by program. This has made it extremely difficult to calculate support for targeted activities. Unless statistical and accounting methods are improved, the supply of funds to maternal health activities will continue to be measured by attributing a certain percentage of the project to these programs. At the country level, this task calls for a statistical training program for government and non-government staff. For external financial sources, the problem is different. In contrast to the specific maternal health orientation of health organizations, bilateral and multilateral donors vary in their perceived need for maternal health data. Development organizations are primarily country- or region-oriented. Consequently, specific health expenditures place additional demands on their statistical systems.

Although the principal donors have been exceptionally cooperative in estimating expenditures for this study, donor data are unlikely to serve as the most precise source of information on financial flows. It is at the country level that the relevant financial information -- the level of financing negotiated in relation to the level of maternal risk -- will be maintained

The factors that influence maternal health have been well-defined by Herz and Measham (1987). The use of arbitrary percentages in this paper is useful only as a starting point for future refinement. As better measures and criteria are identified, it should be feasible to improve the measurement of expenditures that contribute to risk reduction without relying on an extended multisectoral definition of safe motherhood. While it is true that direct and indirect benefits are the result of general development activities, not every component has the same effect. Some donors maintain that family planning and primary health care -- in combination with general development programs -- are a sufficient and appropriate approach to reducing maternal mortality. Other donors recognize the explicit need to address the risks and complications of pregnancy as the causes of mortality and morbidity, and point out that these risks will continue to exact high mortality rates unless donors intervene with targeted "core" programs. To encourage international financing, to cooperate with developing countries in more targeted programs, and to provide a better tool for program and financial measurement, the Meeting of Interested Parties will need to sharpen the definitions and strategy of the Initiative.

Such measurements become particularly important in justifying and mobilizing financing for maternal health. How is this task to be accomplished? The issue is a suitable topic for the agenda of the Meeting of Interested Parties. More specifically, the issue is how the Initiative co-sponsors can offer professional and financial resources to developing countries to help define financial flows and to accelerate a more targeted program to reduce maternal risk.

B. *Financial Trends*

For the 17 major bilateral sources, including the European Community, funds for SM programs increased (in current dollars) from $691.5 million in 1986 to $818.8 million in 1988 (see Figure 1). Approximately half of this amount was for so-called core activities, primarily family planning services (see Figure 2). General health, population, and nutrition sector flows for the same period increased from an estimated $2,221 million to $2,863.6 million. These trends were positive for 13 sources, unchanged for three, and negative for one.

Of the six multilateral sources, SM totals for 1988 were $477.7 million, a 41.7 percent increase over 1987 and a 17 percent increase over 1986 (see Figure 1). Half of this goes to core programs, again primarily family planning services (see Figure 2). Sectoral health, population, and nutrition totals for 1988 ($1,632 million) are 17 percent higher than 1987 ($1,348.9 million) but lower than 1986 -- a reflection of differences in the annual volume of World Bank loan approvals.

Estimated World Bank SM expenditures in 1989 are triple the previous year's total as a result of the projected doubling of loans for health, population, and nutrition. New SM activities are beginning to emerge in the form of specific care for the complications of pregnancy, improvement of tertiary facilities, training, and promotional workshops. While the data suggest positive early trends, a better assessment will emerge during the next four to five years.

While developing country expenditures for SM are the subject of a special questionnaire issued by WHO/Geneva, limited data indicate that these expenditures may be an average of 3 percent of GNP for the health sector, or approximately $77 billion for public expenditures, $221 billion for public and private expenditures, and $22 billion (10 percent) for maternal health.

C. ***Policies***

All 22 of the interviewed financial sources (plus the OPEC Fund) endorse the objectives of the Initiative, although there are differences in perceptions of objectives and the mechanisms with which to achieve them. The 17 DAC bilaterals, with few exceptions, stress that national projects and programs are eligible for financial cooperation where the demand is included in national proposals.

With estimated net flows of Official Development Assistance amounting to $48.1 billion in 1987 (OECD 1988) and estimated ODA flows for health $4 billion (Howard 1989), the supply of external finance exceeds the current official demand by developing countries. The term "official demand" is carefully chosen. Informally expressed needs are of little effect until that need is articulated in a formal proposal that has the support of the sponsoring government or private agency. Indeed, at the level of official negotiation, financing cannot be processed or committed without the project preparation and approval process. Although acceleration of financing for health purposes in developing countries may be encouraged by external cooperating partners, the priority attached to the health sector in developing countries, compared with other sectors, reflects the limitation of professional skills to develop, justify, and negotiate proposals for health priorities.

Donors recognize that there is no global system to assist developing countries in identifying and formulating financing proposals for priority health areas. Consequently, programming for safe motherhood depends more on the developing countries' ability to identify SM-related problems and external financial requirements than on donor views. (Except in the sense that not all donors cooperate with all developing countries.) In principle, this response capability should be an inherent function of WHO, and indeed, limited efforts have been made since 1981 to assist selected countries through the Country Resource Utilization Review (CRU) process. In comparison with WHO's well-used technical services, the CRU process has received limited emphasis and organizational attention.

Additionally, there are externally influenced international priorities that may impede new sector initiatives. An informal view among donors is that a limited number of current global programs absorb so large a part of external financing, national local currency, and administrative energy that officials find it difficult to develop new initiatives.

There is an almost uniform consensus that SM objectives should be supported through multiple programs, channels, and sectors rather than through a new vertical international program. This consensus is based on prevailing official development policies that place the responsibility for program initiatives with the requesting governments. In view of the limited number of resident country technical and professional health personnel available to the donor community, with the exception of the United Nations organizations and possibly four bilateral agencies, there is no consensus on ways to support developing countries in the identification of maternal health priorities or the formulation of proposals.

A review of program options suggests that donors have a growing interest in channeling increasing financial support through the Women in Development program. Particular interest has been shown by WID offices in Bonn, The Hague, and in the Scandinavian countries. Although WID program budgets are not separately established, developing countries are eligible for WID financing provided there is an appropriate proposal. Donors should examine the options for cooperating with developing countries to help them identify problems that could be supported by the WID program.

In conclusion, it is clear that policies to support maternal health are widely endorsed. Persistent maternal mortality, however, at an estimated level just short of 500,000 deaths per year in developing countries, and an equivalent mortality among infants of deceased mothers, calls for improved operational strategies to increase financial flows for SM programs. The effectiveness of donor financing may require far greater attention to two special problems:

a. Improving the Data on SM Financial Trends

- Establishing a consensus on definitions.
- Seeking a consensus on financially measurable program or project categories of SM.
- Defining methods for the systematic collection of donor and recipient country data on financial trends.

b. Strengthening Recipient Countries' Capacity to Articulate Project Demand

- Providing specific training
- Providing technical advisory assistance
- Providing operational guidelines to mobilize financial resources.

These strategies for external financing do not replace the equally important responsibility of developing countries to establish their own financial priorities and improve the efficient use of available national financing. External cooperation, nevertheless, draws on a critical resource to accelerate change in the tragic picture of maternal death and illness.

IV. ENDNOTES

1. The Conference was co-sponsored by the World Bank, the World Health Organization (WHO), and the United Nations Fund for Population Activities (UNFPA), with the cooperation of the United Nations International Children's Fund (UNICEF), the United Nations Development Program (UNDP), the Carnegie Corporation, the Pathfinder Fund, and the Rockefeller Foundation.

2. South and West Asia, 300,000; Africa, 150,000; Latin America, 34,000; East Asia, 12,000.

3. While NGOs are known to be actively and extensively involved in maternal health, financial data from the estimated 1,500 international NGOs on maternal health activities over the past few years would be very difficult to obtain.

V. REFERENCES

Primary sources for this report were interviews with 74 officials of 25 international org. nizations (See Methodology), written communications, and official annual or periodic reports of bilateral and multilateral organizations.

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