SAFE MOTHERHOOD INITIATIVE
PROPOSALS FOR ACTION - CURRENT VERSION
Follow-up

FORM NO. 75
(6-83)

THE WORLD BANK/IFC

ROUTING SLIP	DATE: 4/17/87

NAME	ROOM NO.
Drs. Jagdish & Sai Mmes. De Regt, Domingo, Herz	

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

REMARKS:

Attached is a draft proposal for backstopping national Safe Motherhood Workshops, to be discussed at the first meeting of the SM Working Group at 11 a.m. Tuesday, April 21, 1987 in Room N-550.

I look forward to seeing you on 4/21.

cc: Mr. North

FROM:	ROOM NO.:	EXTENSION:
ARMeasham	N440	61573

FORM NO. 75
(6-83)

THE WORLD BANK/IFC

ROUTING SLIP	DATE: 4/17/87

NAME	ROOM NO.
Drs. Angele Petro-Bavarzian	WHO
Robert Cook Mark Belsey	
Mr. Frank Hartvelt Ms. Katherine Springer	UNDP
Dr. Pierre Severigno	UNFPA

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

REMARKS:

Attached is the draft proposal for national Safe Motherhood workshops, as agreed in our April 6 meeting. Your comments would be appreciated, if possible by May 8, 1987.

Many thanks.

FROM:	ROOM NO.:	EXTENSION:
ARMeasham	N440	61573

A Proposal for Backstopping National Workshops on Safe Motherhood

DRAFT 4/14/87

Introduction

The February 1987 Nairobi Safe Motherhood Conference achieved its objective of placing the problem of pregnancy-related illness and death higher on the priority list of many developing countries, international agencies and NGOs. There has been a substantial increase in ongoing and planned activity on three fronts: advocacy and information dissemination regarding Safe Motherhood with key target groups; operational research to fill major knowledge gaps; and programs and projects to reduce the unnecessary toll of illness and death. This proposal seeks to sustain the momentum achieved in the run up to Nairobi, the Conference itself and its attendant publicity and aftermath, by providing a mechanism for the Bank and other donors to assist countries to develop policies and action plans to make motherhood safer.

Objectives. This proposal seeks to achieve two aims:

a) Assist developing countries interested in strengthening Safe Motherhood activities to develop plans of action; and

b) Assist developing countries in a lesser state of readiness to take action on Safe Motherhood programs or projects, to consider the extent of the problem and what policy and program action might be called for.

The Means. National (and perhaps in some cases sub-regional) workshops provide a potentially cost-effective way to assist interested developing

countries to translate their concerns about maternal health and family planning (here referred to as Safe Motherhood) into concrete policies and programs. Many agencies will be able to provide technical and financial assistance to selected developing countries, e.g. WHO, UNFPA, UNICEF and the Bank, using a variety of mechanisms and channels. WHO/Manila, for example, is helping the Philippine authorities to organize a national workshop with assistance from WHO/Geneva and the Bank. WHO, UNFPA, UNICEF and the Bank all have field offices that can assist in this task. WHO and the Bank have received already requests for technical and financial assistance from approximately twelve countries.

While this proposal seeks to foster local initiative to the utmost, some degree of standardization is desirable for several reasons: to take advantage of the Nairobi materials (papers, videos, etcetera) rather than re-inventing the wheel; to assure systematic treatment of the principal issues (by providing data, experts, etcetera); and, most important, to help countries translate their concerns in this area into implementable and affordable plans of action, that can be evaluated with a view to pooling experience.

Countries fall into several categories as regards their interest in, and need for, national workshops. At least the following criteria need to be taken into account in developing priorities among countries for international technical and financial support:

- maternal mortality rate
- contraceptive prevalence rate

- o size of country
- o level of activity and interest in Safe Motherhood
- o extent of international support, especially from WHO, UNFPA, World Bank
- o need for technical and financial support

In principle, it is likely that there will be a number of countries that require international assistance to hold national workshops in the next two years. We estimate that about 8-10 countries will need such assistance, over and above those that organize activities with or without assistance from other international agencies.

Where the Bank is active, either in sector or project work, it may still be helpful to have a way of providing organizational or logistical support, even where the necessary resources to hold a national workshop are available. Where the Bank is not active, nor are other agencies, a mechanism to provide this support may make the difference in bringing about strengthened Safe Motherhood efforts.

Family Care International, which organized the Nairobi Conference, is interested in principle in assisting other countries to hold national workshop. FCI has both a high degree of competence and the experience to undertake this role. We propose that FCI be contracted by the Bank to assist in this task during the next two years.

Organizational Arrangements

Two mechanisms exist to develop and pursue this proposal. First, the Bank has created a small Save Motherhood Working Group to coordinate follow-up activities after the Nairobi Conference. Second, representatives of WHO, UNFPA, UNDP and the Bank agreed in New York on April 6, 1987, to continue to meet as an informal mechanism to coordinate Safe Motherhood activities, in a manner analogous to the Task Force for Child Survival. UNICEF may be invited to join this multilateral group and other agencies will be involved as appropriate.

Resource Requirements

A notional budget for these activities follows:

	US$
10 National workshops at $25,000 each	$250,000
Subcontractor expenses and administrative costs	$100,000
Miscellaneous costs, e.g. consultants, travel	$ 50,000
	$400,000

The Women in Development (WID) Office has some FY87 funds it can commit immediately. Other possible sources within the Bank are PHN, IPA and the Office of the President. Some bilateral agencies have indicated interest in supporting this effort. In addition, WHO, UNICEF, and UNDP may be able to contribute, or may prefer to fund similar efforts independently.

Next Steps

Comments on this draft proposal are invited, from the Safe Motherhood Working Group, management and other agencies. The proposal will be considered by the Working Group on April 21, at which time country priorities will be discussed.

ARMeasham/cjm

b:proposl.smw

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION
OFFICE MEMORANDUM

DATE: December 30, 1986

TO: Mr. Vittorio Masoni, IRDIO

FROM: David Hodgkinson, PHNDR

EXTENSION: 61568

SUBJECT: Safe Motherhood Conference - Follow-up Activities

1. Thank you very much for your memo of December 17 and the accompanying list of NGOs to receive Safe Motherhood Conference materials.

2. With respect to possible Safe Motherhood follow-up activities, we agree that regional workshops, in LAC and elsewhere, could be most useful. Such workshops would be an excellent vehicle from which to pursue key policy objectives, such as MCH and family planning, and women in development.

3. Tony Measham has suggested that we arrange a small meeting in mid-January with you and the other interested parties, including EDI, to discuss specific "post-Nairobi" regional strategies. I'll contact you next week regarding a convenient time and place for the meeting. Again, many thanks for your assistance.

cc: Messrs. Van Nimmen (EDI), North o/r, Measham, Berg, Liese, Sai, Denning, Schebeck
Mesdames Herz (PPDPR), Schwartz (IPA), Birdsall, Husain, Sanyal

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION
OFFICE MEMORANDUM

DATE: March 19, 1987

TO: Mr. Parvez Hasan, Director, Operations Policy

FROM: Ishrat Husain, Acting Director, PHND

EXTENSION: 61535

SUBJECT: Publication of Safe Motherhood Paper as World Bank Discussion Paper

1. Attached is Form No. 1835 submitting for consideration for publication as a World Bank Discussion Paper, a paper entitled, "The Safe Motherhood Initiative: Proposals for Action," (copy attached) by Barbara Herz and Anthony Measham. I would be grateful if you would approve this submission, encouraged by the Publications Department.

ARMeasham/cjm

cc: Messrs. North (o/r), Sai, Measham
Mmes. Birdsall, Herz, Sanyal

Attachments

FORM NO. 1835
(9–86)

WORLD BANK FACSIMILE PUBLICATIONS
PROPOSAL FOR PUBLICATION

PUB I.D. No.:
DATE:

INSTRUCTIONS: *Complete this form and submit it to the Editorial and Production Division, Publications Department (see Services section of Telephone Directory), with one photocopy of the paper. A Country Study must also be accompanied by a memorandum from the RVP attesting to its quality and affirming approval for publication by the government concerned.*

1. BASIC INFORMATION

a. Proposed title: THE ~~X~~ SAFE MOTHERHOOD INITIATIVE: PROPOSALS FOR ACTION

b. Author(s): Barbara Herz and Anthony R. Measham

c. Originating department: Population, Health and Nutrition Dept. (PHNDR)

d. Persons to liaise with PUB: Primary: Dr. Tony Measham Room No.: N440 Extension: 61573

Secondary: Ms. Barbara Herz Room No.: E 1050 Extension: 76957

2. SERIES FOR WHICH PROPOSED *(Check One)*:

☐ Country Study ☒ World Bank Discussion Paper ☐ Technical Paper

3. BACKGROUND:

a. Derived from Research Project No. *(if any)*: n.a.

b. Has this paper been issued previously, in this or another form, by the World Bank or by another publisher? ☒ Yes ☐ No

c. If yes, when and where? Summary only with Mr. Conable's Nairobi speech

d. Does it contain a unified bibliography or list of references? ☒ Yes ☐ No
Has both a list of references and a bibliography

e. Date completed in its present form *(month/year)*: 1/87

4. VETTING *(Discussion and Technical Papers only; to be completed by the director of the originating dept.; use additional sheets if necessary.)*

a. Was a seminar held to discuss ☐ this paper or ☐ an earlier draft? ☐ Yes ☒ No If yes, who were the participants?

(1) From the originating department: No seminar but two drafts were commented on by approximately 35 people from PHN, PPD, EDI & the Regions. The paper was also discussed at PHN division meetings.

(2) From elsewhere in the Bank *(give affiliations)*:

(3) From outside the Bank *(give affiliations)*:

b. Who else reviewed and commented on the paper? (1) From the originating department:

(2) From elsewhere in the Bank *(give affiliations)*: From the offices of Mr. Shahid S. Husain, Mr. Stern and Mr. Conable.

(3) From outside the Bank *(give affiliations)*: Experts from Kenya, Nigeria, Gambia, WHO, UNFPA, Population Council, Columbia University, Family Health International, London School of Hygiene, USAID, CIDA, etc about 25 individuals

c. Was the draft revised in light of the seminar or other commentary? ☒ Yes ☐ No

d. State briefly what revisions were made: 2 major revisions, numerous minor iterations.

e. Was the paper in its present form reviewed again by some or all previous readers? ☒ Yes ☐ No Attach all written commentaries on the paper in its present form or summarize oral commentaries. Received favorable final review by WHO & other technical experts inside and outside the Bank; commented on favorably by participants in Nairobi Safe Motherhood Conference where paper was distributed.

f. If this paper is not a Country Study but is country or regionally specific, who in the appropriate regional Programs Department has given approval for its publication in its present form?

Typewritten Name: _____ Title: ☐ Director ☐ Acting Director Department: _____

Signature: _____ Date: _____

5. APPROVAL FOR PUBLICATION

This form must be signed either by the Director, Operations Policy (for a paper originating in an Operational Department) or by the Research Administrator (for a paper originating in an ERS Department).

a. Director, Operations Policy
Approved ☐ with ☐ without further vetting I ☐ do ☐ do not wish to see any further reviews acquired.

Typewritten Name: Parvez Hasan Signature: _____ Date: _____

b. Research Administrator
Approved ☐ with ☐ without further vetting I ☐ do ☐ do not wish to see any further reviews acquired.

Typewritten Name: _____ Signature: _____ Date: _____

The World Bank
INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT
INTERNATIONAL DEVELOPMENT ASSOCIATION

1818 H Street, N.W.
Washington, D.C. 20433
U.S.A.

(202) 477-1234
Cable Address: INTBAFRAD
Cable Address: INDEVAS

September 24, 1986

Dear Sarah:

Attached is a draft copy of the paper we are preparing for the Safe Motherhood Conference the Bank is co-sponsoring with WHO, UNFPA and other agencies to be held in Nairobi in February 1987. We would greatly appreciate your critical review and comment on the draft, if possible by October 6, 1986. Please communicate in whatever way would be most convenient - marginal comments, letter or telephone.

Many, many thanks in advance for your assistance.

With kind regards.

for Barbara K. Herz
Adviser on Women in Development
Projects Policy Department

Anthony R. Measham
Health Adviser
Population, Health and Nutrition Department

Ms. Sarah Brown
Institute of Medicine
National Academy of Sciences
2101 Constitution Avenue
Washington, DC 20418

Attachment

The World Bank
INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT
INTERNATIONAL DEVELOPMENT ASSOCIATION

1818 H Street, N.W.
Washington, D.C. 20433
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September 24, 1986

Dear Dr. Corvalan:

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Many, many thanks in advance for your assistance.

With kind regards.

for Barbara K. Herz
Adviser on Women in Development
Projects Policy Department

Anthony R. Measham
Health Adviser
Population, Health and Nutrition Department

Dr. Hugo Corvalan
UNFPA
220 E. 42nd Street
New York, NY 10017

Attachment

The World Bank
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September 24, 1986

Dear Anne:

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Many, many thanks in advance for your assistance.

With kind regards.

for Barbara K. Herz
Adviser on Women in Development
Projects Policy Department

Anthony R. Measham
Health Adviser
Population, Health and Nutrition Department

Ms. Anne Tinker
Chief, Health Services Division
S&T/HEA - Room 714
USAID
Washington, DC 20523

Attachment

The World Bank
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September 24, 1986

Dear Ann:

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Many, many thanks in advance for your assistance.

With kind regards.

for

Barbara K. Herz
Adviser on Women in Development
Projects Policy Department

Anthony R. Measham
Health Adviser
Population, Health and Nutrition Department

Ms. Ann Van Dusen
Deputy Director
SA-18, Room 709
Office of Health
USAID
Washington, DC 20523

Attachment

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September 24, 1986

Dear Dr. Ladipo:

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Many, many thanks in advance for your assistance.

With kind regards.

for Barbara K. Herz
Adviser on Women in Development
Projects Policy Department

Anthony R. Measham
Health Adviser
Population, Health and Nutrition Department

Dr. Ladipo
Dept. of OB/GYN
Ibadan University
Ibadan, Nigeria

Attachment

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September 23, 1986

Dear Kaval:

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With kind regards.

for

Barbara K. Herz
Adviser on Women in Development
Projects Policy Department

Anthony R. Measham
Health Adviser
Population, Health and Nutrition Department

Ms. Kaval Gulhati
President
CEDPA
Suite 202
1717 Massachusetts Ave., NW
Washington, DC 20036

Attachment

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September 24, 1986

Dear Marcia:

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Many, many thanks in advance for your assistance.

With kind regards.

for Barbara K. Herz
Adviser on Women in Development
Projects Policy Department

Anthony R. Measham
Health Adviser
Population, Health and Nutrition Department

Ms. Marcia Griffiths
Manoff Associates
Suite 420, 2001 S Street, NW
Washington, DC 20009

Attachment

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Health Adviser
Population, Health and Nutrition Department

Dr. Richard Wilson
Director
Health Sciences Division
Ottawa, Canada

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September 23, 1986

Dear Brad:

We were sorry you could not be with us for the planning meeting on September 15 but are pleased to report that arrangements for the conference appear to be on track.

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Many, many thanks in advance for your assistance.

With kind regards.

for Barbara K. Herz
Adviser on Women in Development
Projects Policy Department

Anthony R. Measham
Health Adviser
Population, Health and Nutrition Department

Mr. Bradman Weerakoon
Secretary General
International Planned Parenthood
Federation
18-20 Lower Regent Street
London SW1Y 4PW
England

Attachment

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With kind regards.

for Barbara K. Herz
Adviser on Women in Development
Projects Policy Department

Anthony R. Measham
Health Adviser
Population, Health and Nutrition Department

Dr. Ladipo
Dept. of OB/GYN
Ibadan University
Ibadan, Nigeria

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Projects Policy Department

Anthony R. Measham
Health Adviser
Population, Health and Nutrition Department

Ms. Kaval Gulhati
President
CEDPA
Suite 202
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Adviser on Women in Development
Projects Policy Department

Anthony R. Measham
Health Adviser
Population, Health and Nutrition Department

Dr. Richard Wilson
Director
Health Sciences Division
Ottawa, Canada

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With kind regards.

for Barbara K. Herz
Adviser on Women in Development
Projects Policy Department

Anthony R. Measham
Health Adviser
Population, Health and Nutrition Department

Mr. Bradman Weerakoon
Secretary General
International Planned Parenthood
Federation
18-20 Lower Regent Street
London SW1Y 4PW
England

Attachment

July 7, 1986

Dear ^F1^,

As you will recall, we are committed to writing the program strategy paper for the February 1987 Safe Motherhood Conference. We would greatly appreciate your comments and suggestions on the attached outline, if possible by July 21. Please comment in the way that is most convenient to you, by means of marginal comments, a telephone call or written note. We also attach a copy of the conference outline for reference.

Barbara recently returned from Nairobi. The Kenyan authorities are enthusiastic about the conference and the initiative, and everything appears to be on track for Nairobi. We propose to convene another planning meeting in the Bank on Monday, September 15th, to focus on the schedule for the conference, the attendees, the financing, and the key ideas for an initiative that we hope to launch at the conference. By then we will have drafts of the main background papers. We believe that most of a day will be necessary for the meeting, and propose that we meet from 10 a.m. to 4 p.m., September 15, with a working lunch.

We would appreciate an early response regarding your attendance.

Thanks very much. Best regards.

Sincerely,

Barbara Herz
Adviser on Women in Development

Anthony R. Measham
Health Adviser
Population, Health and Nutrition Department

^F2^

Attachment

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

DATE May 15, 1986

TO Mr. S. Shahid Husain, OPSVP

Through: V. Rajagopalan, PPDDR and John North, PHNDR

FROM Barbara Herz, PPDPR and A.R.J. Measham, PHNDR

EXTENSION 76957 and 61573

SUBJECT **Safe Motherhood Initiative**

1. This is a brief update on the safe motherhood initiative, which is being managed jointly by PPD (Office of Women in Development) and PHN.

2. Of every 100,000 women giving birth in Africa, 200-600 die, compared to fewer than ten in developed countries. Yet, as you know, effective approaches exist for reducing maternal mortality and morbidity through community-based health and family planning services. By helping young women reduce the risks of pregnancy, we can establish trust that will also help introduce family planning.

3. We have met with an enthusiastic response from donors, developing country governments, and NGOs to the idea of an initiative to strengthen maternal health care and family planning. The Bank (PPD and PHN) plans to sponsor an international conference next winter to launch the initiative. We hope that the conference will produce a technical consensus on the contents of the initiative (being worked out through background papers and preparatory meetings). It should also launch country programs and demonstration projects financed by the Bank and others. The Government of Kenya will host the conference in Nairobi, February 10-13, for 60-70 participants from developing countries, some NGOs, and the donor community. A draft program outline for the conference is attached. It will be co-sponsored by the Bank, WHO, and UNFPA, in cooperation with IPPF, Ford, Rockefeller, the Population Council, and some bilaterals. Approximately $120,000 would be needed to fund the conference. This funding seems assured. Substantial contributions from various sponsoring and cooperating agencies have been offered though precise amounts are still being discussed. PHN and PPD intend to provide $30,000-$40,000 each if necessary from their FY86 and FY87 budgets.

4. We would appreciate your comments and suggestions. If, as we intend, we achieve consensus before the Conference on the content, impact, and rough cost of a safe motherhood initiative, we would need your help again to persuade Mr. Conable to address the conference. That would emphasize the Bank's commitment and leadership. We expect other agency heads and the leaders of the Government of Kenya to join with us.

Attachment.

cc: Messrs. North o/r, Burki, Amoako, Berg, Denning, Hodgkinson, McGreevey
Mmes. Sai, Birdsall, Husain, Maguire.

BKHerz:ra

Outline for International Technical Conference

on Safe Motherhood Initiative

Objectives

1. Reach consensus among senior technical experts on the most promising and cost-effective approaches to assure maternal survival and improve women's health. (These would include pre- and post-natal care, help with delivery, and family planning.)

2. Develop program strategies, in the form of costed options, for national programs and for small scale projects to test promising ideas.

3. Mobilize national and international support and resources.

Location, Timing

1. Nairobi, Kenya. (The Government of Kenya will host.)

2. February 10-13, 1987

Tentative Program

Day 1 a.m. Opening: Addresses by senior Kenyan official and senior representatives of WHO, UNFPA, and the World Bank.

p.m. Two keynote addresses:

- Assessment of the problem (maternal mortality and morbidity patterns and causes). (Speaker to be identified.)

- Sociocultural context/status of women. (Speaker to be identified.)

Day 2-3 Plenary Overview of Approaches to Reduce Maternal Mortality

Working Groups:

Community level approaches that are well established:

-- Key issues and evidence in care of pregnancy, childbirth, spontaneous and induced abortion, and child-spacing.

-- Integrating family planning with health; contraceptive technology; and childbearing during adolescence and after age 35.

-- "Frontier Technology" for dealing with the principal causes of maternal mortality.

-- Mobilizing the community to help.

Need for hospital services: Alternative approaches to handling high risk and complicated cases and surgical contraception.

Programs Beyond the Health Sector: Building better health through income generation, production for home consumption, improved water and sanitation, and education.

Country Typology: Economic/physical circumstances;
Behavioral/cultural setting;
Health infrastucture;
Causes of maternal mortality;
Possible approaches, resource requirements, and financing.

Day 4 Launching the Safe Motherhood Initiative

a) Conference conclusions: Next steps

b) Project launch - country examples
- donors' views

c) Closing

Day 5 Optional Field Visit

Background Papers - to be circulated one month before conference:

1. Tour d'horizon of problem of maternal mortality and morbidity (WHO).

2. Typology on community-level approaches to "safe motherhood" (Columbia University).

3. Frontier technology for maternal health (Population Council).

4. Family Planning (Rockefeller Foundation)

5. Program Strategy (World Bank -- Herz/Measham)

Press Kit

-- WHO to finance prototype in English and French

-- World Bank/Others to finance production of 500 press kits.

Sponsorship

The World Bank will co-sponsor the conference with WHO, and UNFPA, in cooperation with IPPF, Ford, Rockefeller, the Population Council and other UN agencies (possibly UNDP and UNICEF), NGOs, and bilaterals.

Attendees: 50-60 (definitely under 70)

--* Approximately 20 from multilateral and bilateral agencies.

--* Approximately 10 senior technical experts.

--* Strong developing country participation (at least 50 percent of attendees)

--* Approximately 10 from foundations and NGOs.

-- One or two representatives per country: preferably people with technical backgrounds and substantial program responsibility.

-- Developing countries largely from Africa and Asia to be represented.

Notional Budget

Conference site, arrangements, logistics	$ 40,000
Travel (for 30 maximum) at $1,500 & per diem at $100 a day for 5 days	$ 60,000
Publication of proceedings	$ 10,000
Unallocated	$ 10,000
Total	**$120,000**

*Overlapping categories.

-- PHN and Women in Development to contribute $30,000 to $40,000 each.

-- Expressions of interest from WHO, Ford and Rockefeller Foundations, and some bilaterals.

-- The World Bank has asked IPPF to handle the arrangements for the conference in cooperation with the sponsors and the Government of Kenya.

(In addition, background papers are being supported by USAID, SIDA, Ford, Rockefeller, WHO, and the Bank.)

Outstanding Questions

1. Site in Kenya (probably Intercontinental Hotel, Nairobi).

2. Conference program.

3. Confirmation of specific amounts to be provided by donors.

4. Participation of Mr. Conable, Dr. Mahler, other senior people.

Next Steps

After the international conference, follow-up with donors and developing countries by World Bank/WHO team (and others as interested).

Distribute the proceedings of the internatinal conference, including costed packages for donors and government.

Organize a series of 3-4 EDI seminars for senior policymakers, one each in Asia and Latin American and 1-2 in Africa (1 Anglophone, 1 Francophone).

Develop and monitor several actual projects incorporating the "safe motherhood" approach.

ARMeasham/BKHerz/ra

May 13, 1986

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION
OFFICE MEMORANDUM

DATE: November 5, 1986

TO: Mr. Ernest Stern, SVPOP through Mr. S. Shahid Husain, VPOPS

FROM: John D. North, Director, PHNDR

EXTENSION: 61571

SUBJECT: Safe Motherhood Conference: Nairobi, Speech Outline for Mr. Conable's Approval

1. As you requested, I attach an outline for Mr. Conable's speech together with a brief on Bank lending for health.

2. In the outline you will note that we suggest that Mr. Conable express Bank support for a Safe Motherhood Fund. We intend to submit to you a separate note giving further details for your consideration.

cc: Mr. Hasan
Ms. Herz
Mr. Grenfell
cleared with and cc: Dr. Measham

Attachment

Outline for Mr. Conable's Nairobi Speech on Safe Motherhood

Estimated time - 20 minutes

THE PROBLEM

a. 500,000 women die annually from causes related to childbearing; 99% of maternal deaths in developing countries, where maternal mortality is 100 times developed country levels, infant mortality "only" 10 times. Maternal mortality leading cause of death among young women in many developing countries. Of those who survive millions suffer long-term ill health and disability. Illness and death related to childbearing disproportionately borne by the poor. (Country examples especially from S. Asia and SSA. About 300,000 of the 500,000 deaths occur in S. Asia and 150,000 in SSA.)

b. Other impact:

second-order welfare losses: few of the babies survive and other children die

economic impact: loss of women's productivity and role in child nutrition and education, all of which undermines economic development

c. Bank interest obvious from above:

-Bank goals are economic development and poverty alleviation in order to improve human welfare

-Bank committed to helping countries

(1) strengthen role of women in development

(2) improve health

(3) reduce fertility and rapid population growth

TACKLING THE PROBLEM

a. Reproductive health problems are responsible for major proportion of morbidity and mortality among women in developing countries. Key factors are pregnancies at the extremes of the childbearing period (among teenagers and grand multiparas), unwanted children, babies too closely spaced, etcetera...

b. Affordable, proven technologies exist to assure safe motherhood to the women at highest risk of complications and death, and to prevent unwanted or too closely spaced pregnancies. Their application would bring down the risks of childbearing in developing countries to levels approaching those in the developed world.

c. What is required is a relatively simple system of maternal health care comprising:

(1) basic services at village and community level to assess pregnancy risk, provide preventive care and family planning services and assure safe delivery;

(2) referral care for high risk deliveries and emergency complications; and

(3) ensuring communication and transportation links between the basic service and referral levels. Country and program examples here, e.g. China, Chile, Zimbabwe, Indonesia.

d. This system approach can work, as shown by experience of all industrialized countries and a number of developing countries.

e. These components of the health system are affordable in almost all countries, costing US$1-2 annually per capita, or 10-20% of what most countries spend on health services.

f. Also critical to tackling the problem are female education and education focused on family health. NGOs and the media can make a major contribution here.

g. Stress broader influences and needs: income, especially of women; home production; women's nutritional status; sociocultural factors.

THE ROLE OF THE WORLD BANK

a. Safe motherhood is a feature of more and more projects the Bank helps to finance (about half of the PHN projects approved so far). We are anxious to assist countries to do more in this vital area.

b. We are co-sponsoring this conference with WHO and UNFPA to urge our member countries and other donors, NGOs and private groups, to join in a global Safe Motherhood Initiative. We have the means to prevent most of these tragic deaths at affordable cost. All that is needed is the will, the commitment and action NOW. We believe that the number of women dying as a result of pregnancy can be cut in half by the year 2000, with a concerted, joint effort. Will you join us to make it possible?

Options for strong closing statement. Mr. Conable might announce one or both of the following:

1) the Bank intends to assist at least 20 countries (mainly in SSA and S. Asia), to strengthen substantially safe motherhood activities during the next five years.

2) the Bank would join other donors in support of a "Safe Motherhood Fund" to promote operational research and catalyze the development of Safe Motherhood projects for national, bilateral or multilateral funding.[1]

ARMeasham/BHerz/JDNorth/cjm

11/5/86

[1] Assuming management approval in principle, staff would develop a detailed proposal and explore interest of WHO, UNDP and other donors; Bank would not manage such a fund.

D R A F T
ARM/BH/JDN 11/5/86
Annex 1

Bank Lending for Health

1. Beginning in the early 1970s, the Bank financed health activities within population projects. In 1974 the Bank adopted a formal policy for such investments. The Health Sector Policy Paper of March 1975 concluded that ill health impeded development in many countries and that improving health conditions should be a major development objective. The Bank then began lending for health components in agriculture and rural development, and in urban and education projects. Among other things, these projects financed the construction and staffing of health facilities to provide a delivery system for family planning and nutrition activities, and to provide for the training of health personnel.

2. The Board in 1980 approved the beginning of direct lending for health projects. Within three years of that decision, the Bank became the largest lender for developing country health projects. (Japan and the United States provide an average of $100 million or more a year for health, largely in the form of grants.) The Bank has approved health, population and nutrition projects totaling over $100 million in each fiscal year since 1982, lending some $1,010 million for 35 projects during fiscal years 1981-86 (see Table 1). Health components of projects in other sectors are not included in this amount, nor are water and sanitation investments (which affect health conditions).

3. The shift from lending for health components to direct lending for health projects signaled a change in the Bank's approach, to a broader role in health sector planning and operations, with a view to improving the

management of the health sector as a whole. The Bank initiated direct lending for several reasons: (1) To use its experience in country programming and sector analysis, to help countries design effective national health systems. (2) To help mobilize international financial resources and technical expertise in support of primary health care. (3) To allow the Bank to assist countries in improving the health and productivity of the very poor. (4) To provide opportunities for dialogue on population issues and for supporting family planning services through the health care system.

Nature of projects

4. The Bank supports the concept of primary health care, that is the provision of essential and appropriate health care at the community level, as enunciated by WHO and UNICEF at the 1978 Alma Ata Conference. The 35 PHN projects financed by the Bank over 1981-86 -- the first five years of direct lending for health projects -- have a number of common features: all, except one project in São Paulo, Brazil, are primarily rural projects. Most are designed to expand basic health services. All include a manpower development component, and the majority include a substantial effort to strengthen family planning services. The development of health facilities, involving the construction or rehabilitation of health posts and centers, predominantly at the primary level, figures in all projects and accounts for 40-50 percent of project costs financed by the Bank. About two thirds of health projects include funds to support sector studies, reflecting the paucity of financial and epidemiological data in most countries. A slightly smaller proportion of projects include components that aim to improve

nutritional status. Of 35 projects, 14 include cost recovery for health services or drugs as a project objective.

5. Two other elements are also prominent in most projects: (1) stressing cost-efficiency while minimizing recurrent costs of health projects, and (2) strengthening pharmaceuticals management. The first is evident in all the projects approved since 1981, most notably in Sub-Saharan AFrica, where economic conditions are worst. The need to minimize recurrent costs has been emphasized in various ways. In Jordan and Jamaica, Bank staff have helped national authorities plan health sector investments to reduce items, such as additional hospital beds, that carry high investment and recurrent costs, and have concentrated efforts on low-cost primary care facilities that emphasize prevention as well as treatment of disease. The Bank has also stressed the need to maintain rather than expand infrastructure when resources are very limited, for example, in Ghana and Ethiopia. Rigorous analysis and control over plans to expand health manpower and to introduce expensive new technologies, for example in urban hospital facilities, have helped keep recurrent costs down. Bank staff have suggested methods of cost recovery to increase the efficiency and the effectiveness of investments, as well as permit more rapid and equitable expansion of health services.

6. Shortages of drugs and supplies, and inefficient procurement, storage, and distribution systems are major constraints in most developing countries. In 14 Bank projects, including 8 in Sub-Saharan Africa, strengthening pharmaceuticals management and, in some cases, production, is a major goal. Adoption of the essential drugs policy advocated by WHO is usually the key to more efficient and effective pharmaceuticals management. This policy

emphasizes assuring the availability of a limited number of essential drugs. In several Bank-financed projects, for example in Botswana, Lesotho and Malawi, projected savings on pharmaceuticals resulting from the essential drugs policy and better management of drug distribution, should largely offset the incremental recurrent costs of the projects.

Lending experience

7. Lending for health, population and nutrition accounted for 2.6 percent of total Bank lending in fiscal year 1986, more than double the proportion before direct health lending began. Bank lending for health has increased the awareness within member countries of the need to consider health investments within the context of overall national development programs. The Bank's involvement in the health sector also has contributed to the adoption of clearly defined and well-supported policies on population and family planning in several countries (e.g., Malawi, Nigeria and Senegal). In Nigeria the Bank's involvement helped to make population and family planning an important focal point for discussion and coordination of assistance from other donors.

8. Most of the projects launched since 1980 are still being implemented and evaluated. While they have yielded useful lessons, their overall effectiveness and impact are not yet known. Nevertheless, some lessons for the future are clear from the strengths and weaknesses of Bank-financed health projects to date. While projects to expand basic health services (including family planning and nutrition) will continue to be important, future projects will need to be more sharply defined, given the limited

management capacity in many developing countries. Innovation in project design will be encouraged and careful consideration given to sector and policy-based lending. The Bank will maintain emphasis on cost-efficient models of health-care delivery, minimizing recurrent costs, and encouraging a wide range of institutions (including nongovernmental organizations) to provide health services. Nutrition, and tropical diseases, which have received relatively little support to date, will receive greater attention in the future. Strengthening maternal health care, already a feature of most projects, will also receive additional emphasis in the future, since in many countries it is relatively neglected compared with efforts to improve child survival. Finally, more attention, supported by research and evaluation, will be given to the design of projects to improve the provision and management of health services at the periphery.

Future PHN Lending

9. PHN expects to average about 12 projects per year through FY89, with the exception of a trough in the FY87 program, following the record number of projects (11) and lending total ($404 million) in FY86. Future lending totals should average about $500 million per year.

Table 1: WORLD BANK POPULATION, HEALTH AND NUTRITION PROJECTS APPROVED, BY REGION, FISCAL YEARS 1981-86[1]
(In millions of dollars)

Region	FY81	FY82	FY83	FY84	FY85	FY86
South Asia	0	0	18	70	0	129
East Africa	0	23	7	14	4	11
West Africa	0	0	15	17	61	70
East Asia and Pacific	0	0	27	85	85	98
Middle East and North Africa	13	0	19	0	43	0
Latin America and Caribbean	0	13	34	58	0	96
Total	**13**	**36**	**120**	**244**	**193**	**404**
Number of Projects	1	2	7	7	7	11

Source: World Bank, Population, Health and Nutrition Department.

[1] Bank fiscal year ends June 30.

Safe Motherhood Conference

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION
OFFICE MEMORANDUM

DATE: January 22, 1987

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

FROM: John D. North, Director, PHN and Arturo Israel, Acting Director, PPD

EXTENSION: 61571

SUBJECT: Briefing Note on Safe Motherhood Conference, Nairobi, Kenya, February 10-13, 1987

1. Objective. The purpose of the conference is to increase awareness on the need to improve maternal health and launch a "Safe Motherhood Initiative" in developing countries (see the attached background paper). The specific outcomes sought are:

- o A Safe Motherhood "declaration" to launch the Initiative.
- o Statements by developing countries and donors to commit more resources to Safe Motherhood programs and projects.
- o Announcement of a Safe Motherhood Fund for Operational Research.

2. Sponsors and Participants. The Bank is co-sponsoring the conference with the World Health Organization (WHO) and the United Nations Fund for Population Activities (UNFPA), in association with the Ford and Rockefeller Foundations, Carnegie Corporation, and other agencies.

3. We expect approximately 120 participants, about 50 from developing countries and 70 from donors and other international agencies. About thirty developing country participants are at the ministerial or secretary level, (for example, Drs. Ransome Kuti and Roberto Santos, Ministers of Health of Nigeria and Brazil, respectively) with the remainder mainly internationally known experts. On the donor side, the co-sponsors will have delegations led by Dr. Halfdan Mahler, Director General, WHO; Mr. Rafael Salas, Executive Director of UNFPA; and yourself. In addition, Mr. William Draper III, Administrator of UNDP, will attend. At the opening session, President Moi will make an opening address followed by major addresses from the four agency heads. A list of participants is attached at Annex 1.

4. Conference Program. This is attached at Annex 2. After the opening session Tuesday morning, we will have technical sessions through Thursday morning. On Thursday afternoon we will agree on the Safe Motherhood Declaration. On Friday morning the Conference will close with the issuing of the Declaration, some statements by donors and country delegations, and the announcement of the Safe Motherhood Fund and possibly other specific activities.

5. Press Conferences. There will be a press conference for you, Dr. Mahler, Mr. Salas, and Mr. Draper immediately following the opening session on Tuesday morning, February 10, 1987. The conference will also close with a press conference, but this will not require your attendance. However, a press conference dealing with more general aspects of your visit to Kenya, and to Africa, is presently scheduled at 9 am on Friday, February 13, 1987.

6. On Monday evening the Bank will host a reception for conference participants and Kenyan officials and dignitaries.

7. Other Briefing Materials. Attached as Annex 3 is the background paper for the conference prepared by the Bank. We are also preparing a list of possible "tough" questions and answers for the Tuesday press conference and will send those to you in the next few days.

8. Beyond Nairobi. We hope that developing countries and donors alike will commit substantially more resources to Safe Motherhood after the conference. For the Bank's part, our contributions will be threefold:

- o Financing at least 20 projects with a substantial Safe Motherhood Fund component during the next five years.
- o Providing $1 million towards a $5 million Safe Motherhood Fund for Operational Research to be executed by WHO.
- o Regional and possibly country level workshop and seminars, in collaboration with WHO and other agencies. Within the Bank, EDI, PHN and WID would be mainly responsible for these activities.

9. We are coordinating the conference plans with Judith Maguire here and Jim Adams in Nairobi.

10. We would be pleased to provide any additional information you would like.

Attachments

BHerz/ARMeasham/rmf/cjm
File: SMFbrief

The World Bank
INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT
INTERNATIONAL DEVELOPMENT ASSOCIATION

1818 H Street, N.W.
Washington, D.C. 20433
U.S.A.

(202) 477-1234
Cable Address: INTBAFRAD
Cable Address: INDEVAS

February 19, 1986

Dear Angèle and Robert:

It was a pleasure to see you last week at the meeting on maternal mortality organized by the Population Council and Columbia University. We thought the exchange of views was very useful and believe there is a good deal of momentum behind our collective efforts to draw attention to the neglected problems of womens' health, especially maternal mortality and morbidity.

Attached is a preliminary outline of our thoughts regarding the proposed conference and beyond. We are anxious to have your comments and suggestions on the outline. We believe it would be particularly useful to hold the conference in Africa, where the problem is most severe, for several reasons. We think it is important symbolically to have the meeting in Africa. It would obviously facilitate field visits. In addition, it might be useful to associate the meeting with a particular place, and perhaps have a declaration associated with that place. And it would be easier to obtain media coverage than in Europe. We are grateful of course, for your kind offer of WHO headquarters, and may yet take up that offer!

We would appreciate your help on three points in particular. First, what additional background papers do you think are required for the conference? Second, would you kindly send us a complete set of the background papers for the November WHO meeting. And third, may we have your suggestions regarding technical experts you believe should be invited to the conference?

We are continuing discussions with those at the New York meeting and other multilateral, bilateral and non-government agencies, and the response is encouraging. Later on we will want to convene the planning group and will be back in touch with you on that point.

We look forward to hearing from you.

With best wishes,

Sincerely,

Barbara Herz

Barbara Herz
Adviser, Women in Development

BKH for

Anthony R. Measham
Health Adviser
Population, Health and Nutrition Department

Attachment

Dr. Angèle Petros-Bavarzian
Chief, Family Health Division
Division of Strengthening Health Services
World Health Organisation
1211 Geneva 27
Switzerland

Dr. Robert Cook
Family Health Division
Division of Strengthening Health Services
World Health Organisation
1211 Geneva 27
Switzerland

Outline for Senior Technical Conference on Maternal Mortality and Morbidity

Objectives:

1. To reach a consensus among senior technical experts on cost-effective approaches likely to have the greatest impact in promoting safer births.

2. To develop program strategies, in the form of costed options, for national programs, and for small scale projects to test new approaches.

Location, Timing

-- African venue (? Nairobi, Abidjan, Dakar)

-- October/November 86

-- 3-4 days (? arrive Sunday, leave Thursday), including one day field trip to rural areas and district or rural hospitals.

Sponsorship

IBRD (PHN, Women in Development, ?EDI, ?IPA) with WHO, ?UNFPA, others (IPPF, foundations, ?universities, bilaterals).

IBRD to take the lead, closely consulting with WHO and others.

Attendees 30-40 (definitely under 50).

-- * approximately 20 senior technical experts.

-- * strong developing country participation (at least 50% of attendees).

-- * approximately 20 from multilateral, bilateral agencies.

-- * approximately 10 from foundations, universities.

-- ? maximum 3 from one institution.

-- ? how to choose appropriate developing country government representation - ? only individuals, no "official" representatives.

Notional Budget

Conference site, arrangements, logistics	$ 50,000
Travel (for 30 maximum at $2000) & per diem @ 500	75,000
Publication of proceedings	10,000
Background papers	$ 50,000
Unallocated	$ 15,000
Total	$200,000

PHN and Women in Development to contribute up to $50,000 each. Expressions of interest from Ford and Rockefeller Foundations.

* Overlapping categories

Outstanding Questions

1. Site, dates (decide by 5/1/86).
2. Organizer (? IPPF, FHI, Population Council, other).
3. How to organize program committee.
4. Sources of support.
5. Conference program.

Next Steps

After the senior technical conference, launch initiative at agency heads or meeting with other suitable people, preferably with speech by new Bank president. Distribute proceedings of senior technical conference, including costed package for donors and governments.

Third phase would be a series of 3-4 EDI seminars for senior policy-makers, one each in Asia and Latin America and 1-2 in Africa (? 1 Anglophone, 1 Francophone). Discuss with EDI week of 2/17/86.

ARMeasham:aer
February 19/86

MATERNAL MORTALITY MEETING

Wednesday, February 5
9:30 a.m. - 4:30 p.m.
John D. Rockefeller 3rd Room

LIST OF PARTICIPANTS

Dr. Kenneth Bart, AID Office of Health

Dr. George Brown, The Population Council

Ms. Judith Bruce, The Population Council

Dr. Cook, WHO, Switzerland

Ms. Judy Fortney, Family Health International

Ms. Adrienne Germain, The Population Council

Dr. Scott Halstead, The Rockefeller Foundation

Dr. Oscar Harkavy, The Ford Foundation

Dr. Barbara Herz, The World Bank

Dr. Anrudh Jain, The Population Council

Ms. Barbara Kwast

Ms. Deborah Maine, Center for Population & Health, Columbia U.

Dr. Nimrod Mandara, IPPF Regional Office, Nairobi

Dr. Anthony Measham, The World Bank

Dr. S. Ofosu-Amaah, UNICEF

Dr. Emile Papiernik, Chief, Ob/Gyn, Hopital Antoine Beclere, Paris

Dr. Angele Petros-Barvazian, WHO, Switzerland

Dr. Roger Rochat, Emory U. School of Medicine

Dr. Allan Rosenfield, Center for Population & Health, Colombia U.

Dr. Sheldon Segal, The Rockefeller Foundation

Ms. Jill Sheffield, Carnegie Corporation of N.Y.

Dr. Beverly Winikoff, The Population Council

Dr. George Zeidenstein, The Population Council

* * *

The Population Council

Meeting on Maternal Mortality

Topics for Discussion

Presentation of issues

Nature and extent of problem

Reasons for renewed interest

Possible responses: do we know enough about the problem, its importance and possible responses to design programs now?

Information needs

Action needs

Evaluation needs

Financial considerations

Needs for coordination: donors, policymakers, researchers

Next steps

The Population Council

International Programs

One Dag Hammarskjold Plaza
New York, New York 10017
Cable: Popcouncil, New York
Telephone (212) 644-1300
Telex: 234722 POCO UR

January 8, 1986

Dr. Anthony R. Measham
Health Advisor
The World Bank
1818 H Street, N.W., Room N440
Washington, D.C. 20433

Dear Tony:

At least half a million women a year die unnecessarily from complications of pregnancy, labor, and delivery. Despite all the advances in obstetrics during the last two decades, maternal mortality is still a leading cause of death among young women of reproductive age in developing countries. In contrast, recent attention to high levels of infant and early childhood mortality in the developing world has resulted in the identification of several effective, low-cost interventions. Both policy and program have now been developed incorporating these new insights, and implementation is proceeding in many countries.

Given the growing awareness of the unnecessary tragedy of maternal mortality and the need for action on this problem, it is now appropriate to begin a discussion among health professionals, funding agencies and health scientists on the directions for policy and program in the immediate future.

On February 5, 1986, an informal meeting will be held to discuss strategies to reduce maternal mortality in developing countries during the next decade. This meeting will be co-sponsored by the Center for Population and Family Health of Columbia University and the Population Council. The meeting will be held in the John D. Rockefeller 3rd Room at the Population Council, One Dag Hammarskjold Plaza, New York, New York 10017 (at the corner of 47th Street and Second Avenue). The meeting will start at 9:30 a.m. Lunch will be provided but, unfortunately, we are not able to provide transportation or per diem for participants. We sincerely hope that you will be able to participate in this meeting, however. Please let us know at your earliest convenience whether or not you will be able to attend by telephoning Ms. Christina Dunstan at the Population Council, (212) 644-1332.

Enclosed with this letter are reading materials which present an overview and recent evaluations of approaches to the problem. In addition, we have appended a list of topics for discussion during the meeting on February 5.

Sincerely yours,

Allan Rosenfield, M.D.
Director
Center for Population & Family Health
Columbia University

George F. Brown, M.D., M.P.H.
Vice President
Director, International Programs
The Population Council

Enclosures

February 2, 1987

STRATEGIC PLANNING

I. Introduction:

The World Bank and the World Health Organization are spearheading a global initiative in maternal survival...to increase the safety of childbearing. They have developed financial resources of $10 million to initiate maternal survival projects in countries with maternal mortality rates greater than 400 maternal deaths per 100,000 livebirths.

The purpose of these two sessions is to acquire the skills necessary for strategic planning by learning the components of the strategic planning process and the development of its product the strategic plan. These skills will then be applied to the development of a strategic plan to lower maternal mortality in Bangladesh. The students will be divided into three groups to develop strategic plans for 3 different Bangladeshi organizations. An oral presentation of the strategic plan will be made during the second session. A discussion of each plan will follow the presentation. Students and the invited technical consultants listed below are asked to critique the plans and make useful suggestions for improvement. Each group will then have two weeks to prepare a written version of the plan incorporating any suggestions from the group discussion. Evaluation of the learning process will be based on the quality and substance of the oral presentation and written strategic plan. Please turn in an outline of your strategic plan at the time of your presentation on February 23. The written 8-12 page original paper of each team's strategic plan is due March 9, two weeks after the oral presentation.

Each group will be given a set of the readings for both sessions. It is suggested that each group meet prior to the first session to share the readings and plan for the other meetings that will be necessary to develop a strategic plan, prepare the oral presentation and write the strategic plan report. Readings will include background information on each group's particular organization.

To prepare for the first session, read the assigned materials on strategic planning, maternal mortality and its causes, the essential obstetric functions to prevent maternal deaths, and the goals and plans of the World Bank and the World Health Organization to reduce maternal mortality.

To prepare for the second session, read the available materials on the Ministry of Health and Population Control (MOHPC), your assigned organization in Bangladesh (all students will read the paper on the MOHPC, there is unfortunately no written information on one of the organizations-BAPSA), details about causes of maternal mortality in Bangladesh, and the Bangladeshi environment in which each of these programs must work. (Be sure to read all of the required readings and your choice of optional readings.) With the help of these materials and the readings and lecture of the first session you should be able to develop a comprehensive strategic plan for your assigned organization. Each student in the group is required to participate in the oral presentation and help write the report.

II. Session One February 16, 1987

A. Objectives

At the end of the session students will be able to:

1. Define strategic planning and the components of the strategic planning process as outlined below:

a) The Environment

(1) The Economy
(2) Technology
(3) Society
(4) Politics and Law
(5) Available Resources
(6) Clients

b) The Organization's Mission

(1) History
(2) Distinctive competencies
(3) Environment
(4) Markets
    i) Achievable
    ii) Motivational
    iii) Specific

c) The Organization's Objectives

d) The Organization's Strategies

(1) Market penetration strategies
(2) Market Development strategies
(3) Product Development strategies
(4) Diversification

e) The Organization's Portfolio Plan

(1) Portfolio matrix

2. Specify plausible overall and cause specific maternal mortality rates for the 5 most common causes of maternal mortality in a typical community in the Asian subcontinent. (see below)

a) Rates: 400-800 per 100,000 livebirths.

b) Causes: and Cause Specific Rates:

(1) Hemorrhage
(2) Eclampsia
(3) Sepsis
(4) Abortion
(5) Obstructed delivery

Students to complete with information from the readings

3. To list 3 alternative strategies to lower maternal mortality in developing countries.
(see below)

a) Build hospitals and train physicians for institutional based reproductive health care: to include C-sections, abnormal deliveries, women with serious medical problems, and surgical contraception.

b) Train nurse midwives in home or clinic attended reproductive health care, including management of complicated cases (vacuum, forceps, emergency C-section), MR (menstrual regulation) and family planning.

c) Train traditional birth attendants in safe home attended deliveries; provide "safe delivery kits"; provide safe MRs; screen for high risk deliveries; obtain more skilled assistance for high risk women through referral to residences near medical school training hospitals until they deliver. TBAs should be trained in contraceptive education and promotion and the provision of oral contraceptives and condoms. (e.g. Bangladesh, MOHPC).

4. To specify 3 methods of monitoring the effectiveness of an intervention program in lowering maternal mortality in order to evaluate its impact. (see below)

a) Maternal death monitoring

(1) Vital statistics
(2) Hospital reports
(3) Periodic surveys

b) Maternal morbidity monitoring

c) Health services statistics

B. Reading assignments

1. Each group will receive one copy of each reading unless otherwise noted:

a) Required reading:

(1) Strategic Health Planning (Xerox handout), 24 pp. (Handout given to each student for Feb 2 lecture)

(2) Donnelly, Gibson, Ivancevich, Chapter 6 *Strategic Planning*, pp. 127-150. (Handout given to each student on February 2)

(3) WHO: *Safe Motherhood Conference*, Draft Press Kit, Sept. 1986, 21 pp.

(4) Herz B, Measham AR : *The Safe Motherhood Initiative: Proposals for Action*, World Bank, 1987, 47pp. Focus on the Waterland (Bangladesh) example.

b) Optional reading:

(1) WHO: Essential Obstetric Functions At First Referral Level to Reduce Maternal Mortality; Report of a Technical Working Group, Geneva, 23-27 June 1986, 66 pp.

(2) Rochat RW, *The Magnitude of Maternal Mortality: Definitions and Methods of Measurement.* Chapter in U.Landy,ed. **Prevention and Treatment of Contraceptive Failure**, Plenum Publishing Co., 1987

C. Learning activities

1. Lecture and Discussion on:

a) Strategic planning

b) Maternal Mortality

c) WHO and World Bank strategies to reduce maternal mortality, including a report from the Feb. 9-13 "Safe Motherhood" Conference in Nairobi.

d) Bangladesh and Bangladeshi health care

e) Maternal mortality in Bangladesh

2. Group Work
During this time students will begin work on their strategic plans. Each group will have an advisor/consultant available during this time to consult on maternal mortality and/or their particular Bangladeshi organization.

Students will be divided into the three groups listed below. Each group will develop an organizational approach to lower maternal mortality during a 3 year time period using the strategic planning process. The components of the strategic planning process as listed in the objectives for this session should be used as the basis for both the oral presentation and the written report. The plan should also include a brief explanation of how you would evaluate the success of the strategic plan at the end of 3 years. The three groups will be:

(1) Ministry of Health and Population Control, with government funds and external support from USAID, WHO, the World Bank, and other donors.

(2) Bangladesh Association for the Prevention of Septic Abortion (BAPSA), with private foundation funds.

(3) Medical Mission Hospital in Malumghat, Chittagong District.

3. Closing discussion and questions

III. STRATEGIC PLANNING: SESSION TWO February 23, 1987

A. Objectives

At the end of the session students will have:

1. Demonstrated their ability to present the findings of the strategic planning process.

2. Recorded the useful comments from the critique of their presentation to be used in their written report.

B. Reading Assignment

1. Each group will receive one copy of required and optional readings. (Original books are in Dr. Rochat's office.)

a) Required reading:

(1) National Strategy for a Comprehensive Maternal and Child Health Programme, Report of MCH Task Force, MOHPC, Dhaka, January 1985: Pages ii-22 and 30-37.

(2) Maloney C, Aziz KMA, Sarker, PC: **Beliefs and Fertility in Bangladesh**, ICDDR,B, Asiatic Press, Dhaka, Bangladesh, 1981
Chapt.13: pp. 241-283 (*Conclusion*)

(3) Olsen, Viggo **DAKTAR, Diplomat in Bangladesh**, Moody Bible Institute, 1973 (352 pp.) *(This is the story of Malumghat Hospital and should be read by the team developing a strategy for that hospital.)*
ONLY ONE COPY OF BOOK: Required for team #3 only.

b) Optional reading includes:

(1) The environment:

i) Maloney C et al: **Beliefs and....**
pp.7-13: "Medical systems,...";
pp.72-74: *Parda and Family Planning;*
Chapt. 6, pp. 99-121, *Thoughts on Having Children*,
Chapt. 9: pp. 165-186 *Beliefs Concerning Pregnancy and Childbirth*;
Chapt.10: Pp. 186-211 *Contraception*;
Chapt.11: pp. 213-224 *Abortion and Infanticide;*

ii) Moudod, Hasna Jasimuddin:*O Father Come Let Us Plow*,p.24 and *Kabar*, pp. 43-48 in **Selected Poems of Jasim Uddin,** Oxford University Press, Bangladesh, 1975.

iii) Alam BA, *Women in Nursing, A Study of the Nurses of Dacca Medical College Hospital, pp. 121-153 in* ....**Women for Women, Bangladesh 1975**, University Press Ltd.(Bangladesh), 1975 (248 pp.)

iv) Traditional Childbearing Practices (Should be available by the Feb. 16 session for reference.)

(2) The Maternal Mortality Problem:

i) Rochat RW,Jabeen S, Rosenberg MJ, Measham AR, Khan AR, Obaidullah M, Gould P, *Maternal and Abortion Related Deaths in Bangladesh.* International J Gynaecology and Obstet, 1981, 19:155-164.

ii) Alauddin M, *Maternal Mortality in rural Bangladesh: The Tangail District*, Studies in Family Planning 1986,17(1):13-21

iii) Khan AR, Jahan FA, Begum SF, *Maternal Mortality in Rural Bangladesh: The Jamalpur District,* Studies in Family Planning, 1986, 17(1): 7-12.

iv) Khan AR, Rochat RW, Jahan FA, Begum SF, *Induced Abortion in a Rural Area of Bangladesh,* Studies in Family Planning 1986, 17(2):95-99.

C. Learning Activities.

1. Each student group will present its organization's strategic plan to lower maternal mortality in Bangladesh. (Groups can use overhead transparencies or handouts if desired). Students should plan on a twenty minute presentation.

2. Faculty and students will provide comments on and constructive criticism of the strategic plans. Fifteen minutes will be devoted to each group plan if needed.

3. During the following two weeks students will prepare the written plan report. (If you have questions regarding the report during this time please contact Dr. Rocaht at 727-5724.) It should be about 8-12 pages typed doublespaced..preferably using a word processor-available using the Kaypros at 1552 Clifton.

4. Each of the following has agreed to serve as reviewers and/or technical consultants:

a) Tedd Ellerbrock, MD, CDC obstetrician epidemiologist with 3 years field experience in rural Bangladesh and obstetrical experience with Navajo Indian reservation hospital (available for the March 23 session only).

b) Hani Atrash, MD, MPH, CDC obstetrician epidemiologist with public health experience in the Middle East and U.S.

c) Lisa Koonin, MN, MPH, obstetrical nurse with field experience in rural U.S.

d) Carla Syverson, MN, MPH candidate(Emory) with nurse midwifery experience in the Middle East.

e) Martha Rogers, MD, CDC pediatrician epidemiologist who has worked in Malumghat, Bangladesh.

f) James Buehler, MD, CDC pediatrician epidemiologist who has worked in Bangladesh and is familiar with the work of BAPSA.

tony

this is an exercise I've given my students —
If you have a chance to read & comment this work I'd appreciate it.
In any case, you may enjoy my fumbling attempts to teach management!

Roger

Agenda for Planning Meeting for Safe Motherhood Conference,

Washington, Monday, September 15, 1986, 10 am - 4 pm

1.	Adoption of agenda	10:00 - 10:10
2.	List of invitees	10:10 - 11:30
3.	Financing - closing the gap	11:30 - 11:50
4.	Completion and distribution of background papers	11:50 - 12:10
5.	Invitations	12:10 - 12:30
6.	Lunch	12:30 - 13:30
7.	Conference program	13:30 - 15:50
8.	Other business	15:50 - 16:00

Participants of Safe Motherhood Conference Prep. Meeting
September 15, 1986

	Y/N	
	Y	[1] Dr. Allan Rosenfield Center for Population and Family Health Columbia University 60 Haven Avenue New York, N.Y. 10032 [1] Allan:[4]
2	Y	[1] Ms. Deborah Maine Center for Population and Family Health Columbia University 60 Haven Avenue New York, N.Y. 10032 [1] Deborah:[4]
3	N	[1] Dr. Sheldon Segal Rockefeller Foundation 1133 Avenue of the Americas New York, N.Y. 10036 [1] Shelly:[4]
4	Y	[1] Dr. Roger Rochat International Health Track, WPH Program Emory University 735 Gatewood Road Atlanta, Ga. 30332 [1] Roger:[4]
5	Y	[1] Dr. Robert Cook WHO Geneva 27 Switzerland [1] Robert:[4]
6	N	[1] Dr. Angele Petros-Bavarzian SHO Geneva 27 Switzerland [1] Angele:[4]
7	N	[1] Dr. Mark Belsey WHO Geneva 27 Switzerland [1] Mark:[4]
8	Y	[1] Dr. Marjorie Koblinski ,Ford Foundation 320 E. 43rd Street, New York, NY 10017 [1] Bud:[4]
9	Y	[1] Dr. Judith Fortney Family Health International Research Triangle Park, NC 27709 [1] Judith:[4]
10	N	[1] Dr. George Brown The Population Council One Dag Hammarskjold Plaza New York, N.Y. 10017 [1] George:[4]
11	Y	[1] Dr. Beverly Winikoff The Populaion Council One Dag Hammarskjold Plaza New York, N.Y. 10017 [1] Beverly:[4]
12	Y	[1] Mr. Bradman Weerakoon IPPF 18020 Lower Regent Street London SW1Y 4PW United Kingdom [1] Bradman:[4]
13	N	[1] Dr. Nafis Sadik UNFPA 220 East 42nd Street New York, N.Y. 10017 [1] Nafis:[4]
14	Y	[1] Dr. Duff Gillespie Office of Health, SA-18 USAID Washington, D.C. 20523 [1] Duff:[4]
15	N	[1] Dr. Kenneth Bart Office of Health, SA-18 USAID Washington, D.C. 20523 [1] Ken:[4]
16	Y	[1] Ms. Jill Sheffield The Carnegie Foundation 437 Madison Avenue New York, N.Y. 10022 [1] Jill:[4]
17	Y	[1] Dr. Nestor Suarez Ojeda PAHO 525 23rd Street, N.W. Washington, D.C. 20037 [1] Nestor:[4]
18	Y	[1] Dr. Adetokunbo Lucas Carnegie Corporation 437 Madison Avenue New York, N.Y. 10022 [1] Dr. Lucas:[4]
19	Y	[1] Ms. Mari Simonen UNFPA
20	Y	C. Conable
21	Y	B. Herz
22	Y	A. Measham
23	Y	J. North
24	N	V. Jagdish

17 yes 7 no

Dining Room Reservations for 18 persons: 12:30, H bldg.

August 28, 1986

[I]

Dear [I]

We are delighted that so many can attend the planning meeting for the Safe Motherhood Conference here on September 15th. (It will be held in room N-550, as before, from 10:00 a.m. until 4:00 p.m., including lunch.) The Conference -- and the concept -- seem to be gaining momentum.

To ensure that all goes smoothly in February, we would like to reach closure at the September 15 meeting on:

(a) List of invitees;
(b) Invitation telex;
(c) Conference program;
(d) Completion of background papers;
(e) Financing the conference.

Enclosed are a draft invitation and a list of possible invitees for your reaction. The list is limited to about 70 as we agreed. From the developing countries, we would like more people with program responsibility as well as technical background. From the larger countries we have aimed to find two people, one technical expert and one with program responsibility. To keep to about 70, we have had to select among countries and only included three from Latin America.

Enclosed also is a draft Conference Program for your thoughts. We hope it meets your earlier concerns. It keeps evenings free except Wednesday, which will be the major substantive day. We've tried to focus each day's activity and to lead up to strategy-building on Thursday. We suggest working groups on Thursday to consider action plans for two or three kinds of situations: poor rural, moderately poor rural, and moderately poor urban. To facilitate consensus-building on strategy, we propose to draft and circulate for comments in November a "summary declaration" on a safe motherhood initiative. This will note the main points on need, practical approaches, cost, and impact. It could be refined and distributed at the Conference.

On background papers, by September 15 we will have drafts from Rochat, Rosenfield/Maine, Brown/Winikoff, and Kwast. Shelly Segal will be ready shortly thereafter as will WHO. There may be two or three others. The strategy paper that the Bank is preparing will also be in draft by September 15. The papers should be circulated to invitees before January.

On financing, we need to make decisions. The tentative budget is $150,000 as elaborated on the attachment. That includes about $50,000 in direct conference costs plus $12,000 for publication and press kit, and $88,000 for 40 participants from developing countries (averaging $2,200).

The Bank will provide the $50,000 in direct Conference costs (beyond financing some background papers). The publication costs we can worry about a little later. So we need primarily to decide how to fund the participants.

Dr. Sadik has generously agreed that UNFPA will fund the roughly 10 Asian participants.

Jennifer Sebstad from Ford's Nairobi office has kindly offered to help with the 7-10 East African participants, though we need to work out an appropriate mechanism. (The Kenyan participants will not require funding.) (Ford has also funded a background paper.)

Shelly Segal mentioned that Rockefeller could provide some funding (beyond his own background paper).

Could WHO secure funding for the West African and Latin American participants, perhaps joining forces with Shelly Segal?

Other divisions of labor may be better, of course.

To treat all participants alike, we suggest offering airfare plus $700 (for 7 days' per diem at $100 a day). The per diem must cover the hotel, breakfast, and dinner. Lunch will be provided on Tuesday-Friday, and there may be a reception or two at night.

We have arranged to hold the Conference at the Intercontinental Hotel in Nairobi. The hotel is reserving 75 singles February 8-14 with details to be arranged. The Intercontinental offers those rooms at about $55 daily including tax, so the per diem of $100 should be fine. We need to decide whether participants should get the per diem and settle their own

Jill Sheffield, Family Care International, has agreed to manage the conference arrangements in cooperation with an institution in Kenya to be determined. Jill organized a conference very successfully at Bellagio last year on next steps in women-in-development.

You will receive drafts of our "strategy paper" and the other background papers as soon as we have them.

We are looking forward to September 15 -- and more to February.

Thanks.

Sincerely yours,

Barbara K. Herz
Adviser on Women in Development

Anthony R. Measham
Health Adviser
Population, Health and Nutrition Department

Enclosures.

LIST OF POSSIBLE INVITEES FOR SAFE MOTHERHOOD CONFERENCE NAIROBI, FEBRUARY 1987

DEVELOPING COUNTRY PARTICIPATION

BANGLADESH	Brig. Hedayet Ullah, DG (Health), MOHPC; Col. Abdul Latif Mallik, DG (Pop), MOHPC
BRAZIL	Dr. Joao Yunes, State Secretary of Health, Sao Paulo (asked Dr. Echeverri)
CHINA	Dr. Yen Reng Ling (? affiliation)
COLOMBIA	Asked Dr. Echeverri
COTE D'IVOIRE	Dr. Welfens, Abidjan Medical School Dr. Sangraet (AGR)
EGYPT	??
ETHIOPIA	Head of MCH (need name and address)
GHANA	(Ask Dr. Sai), Dr. Charlotte Gardner, Head of MCH; Dr. Klufio, Univ. of Ghana Medical School
INDIA	Dr. Hacharan Singh, Health Adviser (H), Planning Commission; Mira Sedh, Add. Sec. for H/FP (per Dr. Sadik)
INDONESIA	Dr. Haryono Suyono, Head of BKKBN Dr. Suyono Yahya, Director of Comm. Health Services, MOH
KENYA	Dr. Wilfred Koinange, PS MOH, Dr. John Kigondu, Prof. Mati, Jennifer Mukolwe Dr. Irvine (NGO), Mrs. Ngugi
MALAWI	Dr. John Chipangwe, Head of Ob/Gyn, Queen Elizabeth Hospital
MALI	Dr. Gaoussou Traore, Director of Public Health, MOH
MEXICO	Asked Dr. Echeverri
NIGERIA	Dr. Ransome-Kuti, MOH; Dr. Ladipo, Ibadan; Dr. Kelsey Harrison, Head of Ob/Gyn, Zaria (Planning Commission), Dr. Bilquis Fatma, MCH (Dr. Sadik)
PAKISTAN	Dr. Sirajedin (? affiliation) Dr. Setna, Ster. PSM., Ms. Riadh, new Sec. Women's Div.
SENEGAL	Col. Omar Sylla, Directeur d'Hygiene et de la Protection Sanitaire, MOH

SUDAN	Dr. Baldo (affiliation ?); Dr. Rushwan, U. of Khartoum Medical School
TANZANIA	
THAILAND	Dr. Vitoon Osathanondh, Prof. Ob/Gyn, Ramathibadi Med. School or Dr. Nikon Chulalongkorn
ZAIRE	Ask Fortney/Potts/Bill Bertrand/Jane Pratt; Dr. Lamboray
ZAMBIA	Dr. Njelesane, DMS
ZIMBABWE	Dr. O. Chidede, MOH or Dr. D. Makuto, MOH

DONOR PARTICIPANTS

CANADA	CIDA representative
CARNEGIE	Dr. Addie Lucas
COLUMBIA UNIV	Dr. A. Rosenfield/Maine
EMORY UNIV	Rochat
FHI	Potts/Fortney
FIGO	Dr. M. Fathalla (Egypt)
FORD FOUNDATION	Harkavy/Sebstad
FRANCE	Dr. Emil Papenik
IBRD	Conable, North, Herz, Sai, Measham, Jagdish & Adams
INTL. MIDWIVES FED.	Cowpepper
INTL. NURSES ASSN	
IPPF	Weerakoon/Mukasa
JPIEGO	Ask R. Castadot
MORE WOMEN'S ORGANIZATIONS	
NORWAY	Wahlstrom
POPULATION COUNCIL	Zeidenstein/Brown

ROCKEFELLER FOUNDATION	Segal
SWEDEN	Wahren/Himmelstrand
UNDP/UNIFEM	Peg Snyder
UNFPA	Dr. N. Sadik
UNICEF	Dr. Mary Racelis, Regional Director, Nairobi
USAID	Bart/Gillespie
WHO	Drs. Mahler, Monekosso, Petros-Bavarzian, Cook, Belsey, Kasonde

ARMeasham 8/8/86
BHerz 8/22/86

DRAFT/BKHerz/ra
August 20, 1986

DRAFT TELEX INVITATION:

1. WHILE HEALTH HAS GENERALLY IMPROVED IN RECENT YEARS, THE RISK OF MATERNAL MORTALITY AND MORBIDITY IN SOME DEVELOPING COUNTRIES REMAINS 100 TIMES THAT IN MOST DEVELOPED COUNTRIES. MATERNAL MORTALITY IS IN MANY PLACES THE LEADING CAUSE OF DEATH TO YOUNG WOMEN. THE BURDEN OF MATERNAL MORTALITY AND MORBIDITY FALLS NOT ONLY ON WOMEN BUT ON THEIR FAMILIES -- IN LOSS OF LIFE, LOSS OF PRODUCTION, LOSS OF CARE, (MOST YOUNG CHILDREN WHO LOSE THEIR MOTHERS DIE SOON AFTER.) YET EFFECTIVE AND AFFORDABLE APPROACHES EXIST TO IMPROVE MATERNAL HEALTH BEFORE, DURING, AND AFTER CHILDBEARING. THE TIME HAS COME TO ACT -- TO HELP PUT SUCH APPROACHES MORE WIDELY IN PLACE.

2. YOU ARE CORDIALLY INVITED TO ATTEND THE INTERNATIONAL "SAFE MOTHERHOOD" CONFERENCE FEBRUARY 10-13 AT THE INTERCONTINENTAL HOTEL IN NAIROBI. THE CONFERENCE WILL BE HOSTED BY THE GOVERNMENT OF KENYA AND SPONSORED BY THE WORLD BANK, WHO, AND UNFPA IN ASSOCIATION WITH IPPF, THE FORD AND ROCKEFELLER FOUNDATIONS. THE POPULATION COUNCIL AND OTHER DONORS AND NGOS. IT WILL INVOLVE ABOUT 70 SENIOR OFFICIALS AND EXPERTS SELECTED FOR THEIR OUTSTANDING COMPETENCE AND INTEREST FROM INTERNATIONAL AND NATIONAL PUBLIC AND PRIVATE INSTITUTIONS. ITS AIM IS TO

FORGE A STRATEGY AND LAUNCH AN INITIATIVE TO REDUCE MATERNAL MORTALITY AND MORBIDITY AND OTHERWISE PROMOTE WOMEN'S HEALTH THROUGH STRONGER HEALTH AND FAMILY PLANNING SERVICES AND OTHER MEASURES TO ASSIST WOMEN. IT THUS BUILDS ON INTERNATIONAL COMMITMENTS TO PRIMARY HEALTH CARE AND TO BETTER OPPORTUNITIES FOR WOMEN ENUNCIATED OVER THE PAST DECADE AT UNITED NATIONS FORA.

FOR DEVELOPING COUNTRY PARTICIPANTS: YOUR AIRFARE AND PER DIEM WILL BE PROVIDED BY ONE OF THE SPONSORING OR ASSOCIATED AGENCIES.

PLEASE TELEX OR OTHERWISE INFORM US BY OCTOBER 15 WHETHER OR NOT YOU CAN ATTEND THE CONFERENCE. PLEASE RESPOND AND ADDRESS ANY QUESTIONS YOU MAY HAVE TO ANTHONY MEASHAM, HEALTH ADVISOR, OR BARBARA HERZ, ADVISOR ON WOMEN IN DEVELOPMENT, AT THE WORLD BANK IN WASHINGTON. IF YOU PLAN TO ATTEND, WE WILL ADVISE YOU ON DETAILED ARRANGEMENTS SOON.

WE HOPE YOU CAN ATTEND. REGARDS. SHAHID HUSAIN, VICE PRESIDENT, WORLD BANK.

SAFE MOTHERHOOD CONFERENCE

SUMMARY

	Tuesday Feb. 10	Wednesday Feb. 11	Thursday Feb. 12	Friday Feb. 13
Morning	Opening (VIP speeches)	Users' views Health System Approaches	Role of NGOs Develop Strategy via Working Groups	Recommendations & Closing
Afternoon	Define the Problem	Specific Measures a. Community & Clinical b. Frontier Technology	Working Group and Consensus Building	Press Conference
Evening	Free (possible reception)	Hold	Free	Free

DETAILED VERSION

	Tuesday	Wednesday	Thursday	Friday
Chair	Koinange (Kenya)	Ransome-Kuti; MOH, Nigeria	Ullah or Mallik, BD	Chidede, PS, Zimbabwe
Morning	09:30-09:45 Welcome 09:45-10:15 Pres. Moi 10:15-10:30 Coffee 10:30-10:50 Mahler 10:50-11:10 Sadik 11:10-11:30 Werakoon 11:30-11:50 Conable 12:00-12:15 Arrangements	09:00-09:15 Arrangements 09:15-10:00 Women's Views 10:00-10:15 Coffee 10:15-12:00 Health System Approaches	09:15-10:15 Role of NGOs 10:15-10:30 Coffee 10:30-12:00 Strategy Working Groups	09:15-10-45 Present Recommendations & Declaration 10:45-11:00 Coffee 11:00-12:00 Closing
Lunch	12:30-1:45 pm	12:00-1:45 pm	12:00-1:45 pm	12:00-1:45 pm
Afternoon	2:00-3:00 Keynote 3:00-3:30 Coffee 3:30-5:00 Define Problem WHD a. Extent b. Impact c. Immediate Causes	1:45-2:45 Community-level Measures in MH/FP 2:45-3:45 Clinical/Referral Measures 3:45-4:00 Coffee 4:00-6:00 Frontier Technology & Innovative Approaches a. 4:00-5:00: MH b. 5:00-6:00: FP	1:45-3:30 Reports of Strategy Working Groups 3:30-4:00 Coffee 4:00-6:00 Forge Consensus on Recommendations and Strategy	3:00-4:30 Press Conference
Evening	Free (possible reception)	Hold if needed for spillover from afternoon	Free	

SAFE MOTHERHOOD CONFERENCE

I. Conference Budget

A. Direct Conference Costs

1.	Misc. materials such as pads, pencils, flipcharts, etc. (hotel to provide some).	$ 500
2.	Translation	$ 4,000
3.	Lunch for 70 people for 5 days = 350 lunches at $10, plus an equal amount for coffee, etc.	$ 8,000
4.	Providing and mailing invitations for 70 people	$ 500
5.	Duplicating and distributing background papers, rapporteurs' notes, press releases	$ 1,500
6.	Making travel arrangements and hotel reservations and issuing per diem (not including travel costs and per diem) and other staff time at $1,000 per week	$ 25,000
7.	Transport to and from airport	$ 2,500
8.	Contingency	$ 8,000
	Subtotal	**$ 50,000**

B. Participants' Costs

Airfare @ $1,500 plus 7 days per diem at $100
= $1,500 + $700
= $2,200 for 40 participants from development countries — **$ 88,000**

C. Press Kit and Publishing Costs — **$ 12,000**

Grand Total — **$150,000**

II. Sources of Funds

A.	World Bank	$ 50,000
B,	UNFPA (Asian Participants)	$ 25,000
C.	Rockefeller (verbal indication)	$ 20,000
D.	Ford - Nairobi (verbal indication) (East African participants)	$ 15,000
E.	Gap	$ 40,000
		$ 150,000

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION
OFFICE MEMORANDUM

DATE: January 22, 1987

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

FROM: John D. North, Director, PHN and Arturo Israel, Acting Director, PPD

EXTENSION: 61571

SUBJECT: Briefing Note on Safe Motherhood Conference, Nairobi, Kenya, February 10-13, 1987

1. Objective. The purpose of the conference is to increase awareness on the need to improve maternal health and launch a "Safe Motherhood Initiative" in developing countries (see the attached background paper). The specific outcomes sought are:

- o A Safe Motherhood "declaration" to launch the Initiative.
- o Statements by developing countries and donors to commit more resources to Safe Motherhood programs and projects.
- o Announcement of a Safe Motherhood Fund for Operational Research.

2. Sponsors and Participants. The Bank is co-sponsoring the conference with the World Health Organization (WHO) and the United Nations Fund for Population Activities (UNFPA), in association with the Ford and Rockefeller Foundations, Carnegie Corporation, and other agencies.

3. We expect approximately 120 participants, about 50 from developing countries and 70 from donors and other international agencies. About thirty developing country participants are at the ministerial or secretary level, (for example, Drs. Ransome Kuti and Roberto Santos, Ministers of Health of Nigeria and Brazil, respectively) with the remainder mainly internationally known experts. On the donor side, the co-sponsors will have delegations led by Dr. Halfdan Mahler, Director General, WHO; Mr. Rafael Salas, Executive Director of UNFPA; and yourself. In addition, Mr. William Draper III, Administrator of UNDP, will attend. At the opening session, President Moi will make an opening address followed by major addresses from the four agency heads. A list of participants is attached at Annex 1.

4. Conference Program. This is attached at Annex 2. After the opening session Tuesday morning, we will have technical sessions through Thursday morning. On Thursday afternoon we will agree on the Safe Motherhood Declaration. On Friday morning the Conference will close with the issuing of the Declaration, some statements by donors and country delegations, and the announcement of the Safe Motherhood Fund and possibly other specific activities.

5. Press Conferences. There will be a press conference for you, Dr. Mahler, Mr. Salas, and Mr. Draper immediately following the opening session on Tuesday morning, February 10, 1987. The conference will also close with a press conference, but this will not require your attendance. However, a press conference dealing with more general aspects of your visit to Kenya, and to Africa, is presently scheduled at 9 am on Friday, February 13, 1987.

6. On Monday evening the Bank will host a reception for conference participants and Kenyan officials and dignitaries.

7. Other Briefing Materials. Attached as Annex 3 is the background paper for the conference prepared by the Bank. We are also preparing a list of possible "tough" questions and answers for the Tuesday press conference and will send those to you in the next few days.

8. Beyond Nairobi. We hope that developing countries and donors alike will commit substantially more resources to Safe Motherhood after the conference. For the Bank's part, our contributions will be threefold:

- o Financing at least 20 projects with a substantial Safe Motherhood Fund component during the next five years.
- o Providing $1 million towards a $5 million Safe Motherhood Fund for Operational Research to be executed by WHO.
- o Regional and possibly country level workshop and seminars, in collaboration with WHO and other agencies. Within the Bank, EDI, PHN and WID would be mainly responsible for these activities.

9. We are coordinating the conference plans with Judith Maguire here and Jim Adams in Nairobi.

10. We would be pleased to provide any additional information you would like.

Attachments

BHerz/ARMeasham/rmf/cjm
File: SMFbrief

Outline for International Technical Conference

on Safe Motherhood Initiative

Objectives

1. Reach consensus among senior technical experts on the most promising and cost-effective approaches to assure maternal survival and improve women's health. (These would include pre- and post-natal care, help with delivery, and family planning.)

2. Develop program strategies, in the form of costed options, for national programs and for small scale projects to test promising ideas.

3. Mobilize national and international support and resources.

Location, Timing

1. Nairobi, Kenya. (The Government of Kenya will host.)

2. February 10-13, 1987

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Day 1 a.m. Opening: Addresses by senior Kenyan official and senior representatives of WHO, UNFPA, and the World Bank.

p.m. Two keynote addresses:

- Assessment of the problem (maternal mortality and morbidity patterns and causes). (Speaker to be identified.)

- Sociocultural context/status of women. (Speaker to be identified.)

Day 2-3 Plenary Overview of Approaches to Reduce Maternal Mortality

Working Groups:

Community level approaches that are well established:

-- Key issues and evidence in care of pregnancy, childbirth, spontaneous and induced abortion, and child-spacing.

-- Integrating family planning with health; contraceptive technology; and childbearing during adolescence and after age 35.

-- "Frontier Technology" for dealing with the principal causes of maternal mortality.

-- Mobilizing the community to help.

Need for hospital services: Alternative approaches to handling high risk and complicated cases and surgical contraception.

Programs Beyond the Health Sector: Building better health through income generation, production for home consumption, improved water and sanitation, and education.

Country Typology: Economic/physical circumstances;
Behavioral/cultural setting;
Health infrastucture;
Causes of maternal mortality;
Possible approaches, resource requirements, and financing.

Day 4 Launching the Safe Motherhood Initiative

a) Conference conclusions: Next steps

b) Project launch - country examples
- donors' views

c) Closing

Day 5 Optional Field Visit

Background Papers - to be circulated one month before conference:

1. Tour d'horizon of problem of maternal mortality and morbidity (WHO).

2. Typology on community-level approaches to "safe motherhood" (Columbia University).

3. Frontier technology for maternal health (Population Council).

4. Family Planning (Rockefeller Foundation)

5. Program Strategy (World Bank -- Herz/Measham)

Press Kit

--* WHO to finance prototype in English and French

-- World Bank/Others to finance production of 500 press kits.

Sponsorship

The World Bank will co-sponsor the conference with WHO, and UNFPA, in cooperation with IPPF, Ford, Rockefeller, the Population Council and other UN agencies (possibly UNDP and UNICEF), NGOs, and bilaterals.

Attendees: 50-60 (definitely under 70)

--* Approximately 20 from multilateral and bilateral agencies.

--* Approximately 10 senior technical experts.

--* Strong developing country participation (at least 50 percent of attendees)

--* Approximately 10 from foundations and NGOs.

-- One or two representatives per country: preferably people with technical backgrounds and substantial program responsibility.

-- Developing countries largely from Africa and Asia to be represented.

Notional Budget

Conference site, arrangements, logistics	$ 40,000
Travel (for 30 maximum) at $1,500 & per diem at $100 a day for 5 days	$ 60,000
Publication of proceedings	$ 10,000
Unallocated	$ 10,000
Total	**$120,000**

*Overlapping categories.

-- PHN and Women in Development to contribute $30,000 to $40,000 each.

— Expressions of interest from WHO, Ford and Rockefeller Foundations, and some bilaterals.

-- The World Bank has asked IPPF to handle the arrangements for the conference in cooperation with the sponsors and the Government of Kenya.

(In addition, background papers are being supported by USAID, SIDA, Ford, Rockefeller, WHO, and the Bank.)

Outstanding Questions

1. Site in Kenya (probably Intercontinental Hotel, Nairobi).
2. Conference program.
3. Confirmation of specific amounts to be provided by donors.
4. Participation of Mr. Conable, Dr. Mahler, other senior people.

Next Steps

After the international conference, follow-up with donors and developing countries by World Bank/WHO team (and others as interested).

Distribute the proceedings of the internatinal conference, including costed packages for donors and government.

Organize a series of 3-4 EDI seminars for senior policymakers, one each in Asia and Latin American and 1-2 in Africa (1 Anglophone, 1 Francophone).

Develop and monitor several actual projects incorporating the "safe motherhood" approach.

ARMeasham/BKHerz/ra

May 13, 1986

OPERATIONAL RESEARCH IN MATERNAL HEALTH

Some examples of priority subjects

(N.B. The list is not exhaustive. It does address all the main causes of maternal death except septic (illegal) abortion, as well as the research and evaluation of improved organization of prenatal care and care in childbirth generally. Details of the criteria which will be used for evaluation are not given here, but have been considered for each subject individually).

Two levels are under consideration here. The community-level which includes both the home and the aid post, dispensary, health centre in or near the community; and the first-referral level, usually a small peripheral district hospital with maternity beds which can (or should) provide the most essential items of obstetric care. Whilst we are not listing subjects by level, it is clear that some of these interventions or changes are applicable usually to one level or the other or, very often, to both, i.e. they require some action at community level combined with some at first-referral level.

1. Prevention of puerperal sepsis. Evaluation of the effects of routine antibiotic cover for all women who have not delivered within 12 hours of rupture of membranes.

2. Prevention of severe anaemia. Using simple technology for discrimination between under and over 8 gm haemoglobin per cent already tested in collaboration with WHO, determine the impact of routine malaria prophylaxis compared with and combined with haematinics, on proportion of women entering ninth month of pregnancy with Hb less than 8gm.

.../2....

3. Prevention of eclampsia at community level. As well as the development and evaluation of better schemes during regular prenatal care for detection and effective referral of hypertensive disease of pregnancy, introduction and evaluation also of early treatment at the periphery of imminent eclampsia. The criteria of success would be the reduction in the number of women admitted to hospital actually with convulsions, and in the percentage these represent of all emergency admissions.

4. Prevention and management of post-partum haemorrhage. Evaluation of the following four interventions in combination and singly:

   (a) catheterization of the bladder by TBAs;

   (b) routine use of oxytocics by all birth attendants after delivery of anterior shoulder;

   (c) manual removal of placenta at health centre, in emergency and with antibiotic cover; and,

   (d) the use of plasma substitutes to replace blood loss in shock.

5. The use of plasma substitutes (as currently available - the development of new plasma substitutes is a piece of basic research) with iron replacement subsquently is in fact a wider subject in obstetric care - and, indeed, in surgery and traumatology - than for post-partum haemorrhage. A suitable operational research subject is to explore the limits of safety and effectiveness of plasma substitutes plus iron throughout midwifery/obstetrics. This has always been a subject of much potential value in developing country obstetrics and is now made much more so by the threat of HIV transmission through blood products.

6. The above include or imply the delegation of functions to more peripheral levels and to less specialized health workers. The evaluation of the safety, effectiveness and feasibility of such delegation is a general theme of operational research in maternal care and a specific theme at first-referral level in several other important functions. An important example is Caesarean Section being carried out by general medical officers, by clinical officers/medical assistants, and by senior midwives, all of them specially trained for this function, as has been pioneered in a few countries already. Other examples include surgical support to Family Planning (IUD insertion, vasectomy, tubal ligation) which would be done mainly by HRP who have already experience in this field. Another function which needs to be researched is the possibility of diagnosing ectopic pregnancy earlier and dealing with it more peripherally using skills similar to those required for Caesarean Section plus plasma substitutes/blood transfusion including auto-transfusion. (There is a suspicion that many deaths occur from ruptured ectopic pregnancy which are never ever diagnosed as such).

7. The organization of prenatal care within primary health care, the best use of community effort and support, and the evaluation of such improvements in management, is a fruitful field for research. It includes not only improved training of staff and volunteers and health education of the public and their evaluation, but also the evaluation of improved methods of supervision and support. The subject has a wide scope, but the criteria are quite clear and feasible to measure, a change in the proportion, in the pattern and in the severity of emerging admissions.

8. Prenatal screeing and referral of high-risk patients for hospital delivery is one important line of defence. There are two others which require operational research.

8A evaluation of maternity waiting areas, or annexes near to the hospital where high-risk patients from remote areas go a few days before labour begins. There is much anecdotal evidence about the effectiveness of this sort of scheme in avoiding many emergency admissions or deaths en route, but virtually no evaluations. It may be however that such evaluations would provide evidence so convincing that such facilities (community supported, at low cost, self-sustaining) would become a regular feature of all regions (and there are many) where death en route to hospital in emergency is a common occurrence.

8B The last line of defence is at least to improve the system so that a maternal emergency is more quickly diagnosed and acted on (e.g. wider use of partograph) causing, in effect, an alarm signal, and communication with transport elsewhere to fetch the woman, or transportation of the woman herself, is improved.

Evaluation criteria for 8A and 8B are fairly obvious.

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

→ Tony Measham
3 copies

DATE August 25, 1986

TO Mr. Barber Conable, President
THRU: Mr. Ernest Stern, SVPOP
FROM Hans-Eberhard Köpp, Acting OPSVP and John D. North, PHNDR

EXTENSION 73592 and 61571

SUBJECT Safe Motherhood Conference, Nairobi, Kenya, February 10-13, 1987

1. The Bank has organized and is co-sponsoring this Conference with WHO and UNFPA, in cooperation with the Rockefeller and Ford Foundations, the International Planned Parenthood Federation, the Population Council and other agencies. The purpose of the Conference is to launch an initiative to reduce maternal mortality and morbidity--now the leading threat to the life and health of young women in the developing world. Recent studies show that maternal mortality can be reduced by half or more through the provision of basic and affordable health and family planning services.

2. We believe that this initiative is worthy of the Bank's strongest support. If convenient for your schedule, we propose that you address the Conference. This would show the strength of Bank support and guarantee the successful launching of the Safe Motherhood initiative. We expect that Mr. Daniel arap Moi, the President of Kenya, and Dr. Halfdan Mahler, Director-General of the World Health Organization, will also address the Conference.

3. Please let us know what you decide on this so that we may start making the necessary arrangements.

4. We attach a memorandum to Mr. S. Shahid Husain giving more details on the Conference.

Attachment

cc: Mr. Burki, IRDDR

BHerz/mpv

OFFICE MEMORANDUM

DATE May 15, 1986

TO Mr. S. Shahid Husain, OPSVP

Through: W.V. Rajagopalan, PPDDR and John North, PHNDR

FROM Barbara Herz, PPDPR and A.W. Measham, PHNDR

EXTENSION 76957 and 61573

SUBJECT Safe Motherhood Initiative

1. This is a brief update on the safe motherhood initiative, which is being managed jointly by PPD (Office of Women in Development) and PHN.

2. Of every 100,000 women giving birth in Africa, 200-600 die, compared to fewer than ten in developed countries. Yet, as you know, effective approaches exist for reducing maternal mortality and morbidity through community-based health and family planning services. By helping young women reduce the risks of pregnancy, we can establish trust that will also help introduce family planning.

3. We have met with an enthusiastic response from donors, developing country governments, and NGOs to the idea of an initiative to strengthen maternal health care and family planning. The Bank (PPD and PHN) plans to sponsor an international conference next winter to launch the initiative. We hope that the conference will produce a technical consensus on the contents of the initiative (being worked out through background papers and preparatory meetings). It should also launch country programs and demonstration projects financed by the Bank and others. The Government of Kenya will host the conference in Nairobi, February 10-13, for 60-70 participants from developing countries, some NGOs, and the donor community. A draft program outline for the conference is attached. It will be co-sponsored by the Bank, WHO, and UNFPA, in cooperation with IPPF, Ford, Rockefeller, the Population Council, and some bilaterals. Approximately $120,000 would be needed to fund the conference. This funding seems assured. Substantial contributions from various sponsoring and cooperating agencies have been offered though precise amounts are still being discussed. PHN and PPD intend to provide $30,000-$40,000 each if necessary from their FY86 and FY87 budgets.

4. We would appreciate your comments and suggestions. If, as we intend, we achieve consensus before the Conference on the content, impact, and rough cost of a safe motherhood initiative, we would need your help again to persuade Mr. Conable to address the conference. That would emphasize the Bank's commitment and leadership. We expect other agency heads and the leaders of the Government of Kenya to join with us.

Attachment.

cc: Messrs. North o/r, Burki, Amoako, Berg, Denning, Hodgkinson, McGreevey , Sai, Schebeck
Mmes. Birdsall, Husain, Maguire

BKHerz:ra

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ARMeasham/BKHerz/ra

May 13, 1986

Sri Lanka glbs. No.	1950	51	52	53	54	55	56	57	58	59	60	61	62	
Births.	304635	313662	323522	321217	303899	325538	325067	339135	335690	356336	361702	363677	370762	3
Deaths														
Heart (117)	362	357	353	299	326	292	319	292	340	384	315	269	304	
Tax (116)	486	518	504	418	400	402	345	378	343	292	271	224	269	
Syph (115)	341	408	449	342	234	233	217	162	184	130	125	103	67	
Other (120)	745	495	495	468	395	349	307	366	387	355	353	327	435	
Total														
Abo (118-9)	28	32	17	31	33	38	36	36	40	46	30	31	22	
T. Rel.	1592	1810	1818	1558	1388	1319	1224	1239	1294	1207	1094	949	1097	

Sri Lanka – from WHO data bank.

60	61	62	63	64	65	66	67	68	69	77	80	81	82	83
361702	363677	370762	365812	361572	369437	369153	369531	384198	372771	389522	418373	426215	407164	403741
315	264	304	241	143	251	229	197	215	(113) 142		(390) 62			
271	224	263	277	227	238	222	172	163	(112) 105		(391) 77			
125	103	67	87	143	86	84	33	76	(116) 34		(—) 85			
353	327	435	265	309	288	256	198	208	(117) 68					
											(39) 224			
30	31	22	27	35	21	28	24	27	114-15 32		(35) 34			
1094	949	1097	897	1007	884	879	630	685	381		397			
									70	71	79			
									368262	382490	417966			

MRC
Medical Research Council

Medical Research Council Laboratories
Fajara, near Banjul
The Gambia, West Africa

telephone Serrekunda 2442/6
cables TROPMEDRES, Banjul, The Gambia

Your reference

Our reference

26th November, 1986

Dr Anthony R. Measham
Health Adviser
Population, Health and
Nutrition Department
The World Bank
1818 H street N.W.
Washington DC 20433
USA

Dear Dr Measham,

I have been waiting to reply to your letter of July brought back by Phil Gowers until I had some data on maternal mortality on paper to send to you. Enclosed is a copy of a paper which has been accepted in principle by the Bulletin of the World Health Organization although they still want some modifications made. I hope that this helps.

Yours sincerely,

Brian Greenwood

B M GREENWOOD

Enclosure

A PROSPECTIVE SURVEY OF THE OUTCOME OF PREGNANCY IN A RURAL AREA OF THE GAMBIA, WEST AFRICA

Alice Greenwood,[1] B.M. Greenwood,[2] A.K. Bradley,[3] K. Williams,[4] Fiona Shenton,[5] S. Tulloch,[6] P. Byass,[7] F.S.J. Oldfield,[8]

1. Epidemiologist, Medical Research Council (MRC) Laboratories, Fajara, Banjul, The Gambia.

2. Director, MRC Laboratories, Fajara, Banjul, The Gambia.

3. Epidemiologist, MRC Laboratories, Fajara, Banjul, The Gambia.

4. Senior technician, MRC Laboratories, Fajara, Banjul, The Gambia.

5. Research officer, MRC Laboratories, Fajara, Banjul, The Gambia.

6. Computer manager, MRC Laboratories, Fajara, Banjul, The Gambia.

7. Computer manager, MRC Laboratories, Fajara, Banjul, The Gambia.

8. Director of Medical Services, Medical and Health Department, Banjul, The Gambia.

ABSTRACT

The outcome of pregnancy was recorded in 672 women studied over a 1-year period in a rural area of The Gambia with few medical resources prior to the introduction of a primary health care programme. Maternal mortality was very high (22 per 1,000); post-partum haemorrhage and infections were the main causes of maternal death. Stillbirth and neonatal death rates were also high (35 and 65 per 1,000 respectively). Prematurity and infections were the main causes of death in neonates. First or late pregnancies, an age of under 20 years or over 40 years and multiple pregnancies were all asociated with a poor outcome of pregnancy. Women in these groups should be encouraged by traditional birth attendants and by the staff of rural ante-natal clinics to deliver in a health centre.

INTRODUCTION

It is recognised widely that in rural Africa pregnancy is a hazardous time for both mother and child (1) but there are few data quantitating the degree of risk. In Africa, most information about maternal mortality has come from hospital-based surveys but in many rural areas few women deliver in a hospital or health centre, even when complications of pregnancy occur. In such communities most stillbirths and early neonatal deaths occur at home. Where such conditions prevail information on the outcome of pregnancy can be obtained only by asking women about their past obstetric history or, more accurately, by making direct observations on the outcome of pregnancy. Few such prospective studies have been undertaken. In Macharkos, Kenya, direct observations on the outcome of pregnancy were made in 4,716 rural women studied over a 4 year period from 1975 - 1978. The outcome of pregnancy was relatively favourable in these women and maternal mortality was low (2). In The Gambia, demographic records have been kept in two villages, Keneba and Manduar, since 1951. A high perinatal mortality was observed in both villages which changed little during a 25-year period of observation from 1951-1975 (3). Since 1975 a paediatrician and a mid-wife have lived and worked in Keneba and infant and childhood mortality have declined dramatically (4). Keneba and Manduar no longer reflect the situation that prevails in most rural areas of the country.

In 1980 the Medical and Health Department of the Government of The Gambia embarked upon an ambitious primary health care programme which will establish a village health worker (VHW) and traditional birth attendant (TBA) in every village with a population of 400 or more. To provide the background for an assessment of the effects of this programme on the outcome of pregnancy and on mortality in infancy and early childhood we have carried out a survey of the course and outcome of pregnancy in women living in a rural area of The Gambia with few medical resources prior to the introduction of the primary health care programme. We have also tried to identify risk factors for a poor outcome of pregnancy which could be used by TBAs and the staff of rural antenatal clinics to identify pregnant women who require special care.

MATERIALS AND METHODS

Study Area

The study was undertaken in 41 villages and hamlets near to the town of Farafenni, North Bank Division, The Gambia. The nearest village was 12 km from Farafenni, the most distant 35 km. There are no tarred roads in the area but all study villages are accessible by laterite roads throughout the year. An occasional taxi travels between larger villages and Farafenni town but residents of more isolated villages can reach Farafenni only by foot, bicycle, horse or donkey cart. The geographical and climatic features of the area are described elsewhere (5).

In 1982/1983, when this survey was undertaken, the medical resources of the Farafenni area were very limited. The medical facilities of the town comprised a government-run dispensary, manned by a dresser-dispenser and a midwife, one private medical practitioner and a number of small pharmacies. Fortnightly maternal and child health clinics were held at two villages 16 km to the west and 20 km to the east of Farafenni respectively. Expectant mothers had to travel up to 20 km to reach one or other of these clinics. Patients seen at Farafenni dispensary who required further treatment had to be sent across the river by ferry to Banjul, a journey of nearly 200 km., likely to take several hours.

Study Population

The population of the study area belong to 3 main ethnic groups, Mandinka, Wollof and Fula with Mandinka predominating. Household heads are mainly subsistence farmers. Women are responsible for most rice-farming, an occupation which places great demands on them during the latter part of the rainy season. A house-to-house enumeration undertaken during November and December 1981 indicated that the total population of the study villages and hamlets was 12,313 of whom 2,800 were women aged 15 - 45. Only 4% of women in the child-bearing age had had any formal education.

Identification of Pregnant Women

Two methods were used to identify pregnant women.

a. An individual was identified in each village and hamlet who was responsible for recording all births and deaths in his or her village and for identifying all pregnant women. This information was given to one of a team of MRC-employed field assistants who were each responsible for data collected in a group of villages and hamlets.

b. At the onset of the surveillance period (April 1982 - March 1983) urine samples were collected for pregnancy testing from all women in the reproductive age group 15 - 45 years excluding those who had delivered during the preceeding 12 months. Approximately 90% coverage was achieved. Urine tests were repeated in September 1982 before the second clinical survey.

Once a woman had been identified as pregnant she was visited by a field worker and an initial ante-natal questionnaire, which asked about her previous obstetric history, was administered. Birth intervals and the proportion of children surviving were calculated from data collected retrospectively in this way.

Monthly Surveillance

Each woman identified as pregnant was visited once a month by a field worker and a morbidity questionnaire administered. Information was sought about current complaints and about visits to a health facility during the preceeding month. On completion of the questionnaire oral temperature was measured, using an electronic thermometer, and a blood film was obtained if this was 38.0°C or higher. If a woman was found to have delivered during the period since the last visit a final questionnaire was completed which enquired where the delivery had occurred, who had assisted with the delivery and its outcome.

Clinical surveys

On two occasions, once during the dry season (March 1982) and once at the end of the rainy season (October/November 1982), all women who were known to be pregnant were examined in their village by the same physician. Women were weighed and their height was recorded. Completion rates of over 95% were obtained for each survey. A finger-prick blood sample was collected for parasitological, haematological and serological measurements and a urine sample was collected for chemical analyses. Treatment was given for any illness identified during the survey. All women found to have a positive serological test for syphilis were treated with penicillin.

Identification of Maternal and Infant Deaths

Abortions, stillbirths, early neonatal and maternal deaths were recorded by field assistants at the time of administration of the post-natal questionnaire. Deaths later in the neonatal period were detected during the course of a survey into the causes of infant and early childhood deaths in the study area. When a stillbirth, maternal or infant death was reported to the project epidemiologist a visit to the household was made by a physician and a detailed history obtained from the family of the events that had led up to the death. This information, supplemented by any clinic records that were available, was used to try to determine the most likely cause of death.

Laboratory Methods

Urine was tested for protein and sugar using Labstix (Ames). Pregnancy tests were carried out using a miniaturised version of a commercial latex agglutination test (Prognosticon, Organon). By using only 20 ul of each reagent, dispensed with a micropipette, it was possible to carry out approximately 40 - 50 tests with each 1 ml of reagent. Thick blood films were stained with Giemsa; 100 high power fields were scanned before a film was considered to be negative. The packed cell volume (PCV) was measured with a microhaematocrit centrifuge. Sera were tested for syphilis using an RPR card test (Hynson, Westcott and Dunning) as a screening procedure. Sera found positive by the RPR test were tested by the

more specific TPHA test (Burroughs Wellcome). Agglutination at a dilution of 1:80 or more was considered positive in the TPHA test. Tetanus antibodies were measured by a passive haemagglutination assay. Antibodies to rubella were determined by a radial haemolysis assay (Rubascreen, Northumbria Biologicals). Sera which gave an area of haemolysis equal to or greater than that of the positive control were considered positive. Antibodies to cytomegalovirus were determined by immunofluorescence using MRC 5 cells infected with the AD 169 strain of virus. An anti-whole immunoglobulin fluorescein conjugate was used. In this assay sera which gave fluorescence at a titre of 1:2 or greater were considered positive. Antibodies to malaria and to toxoplasma were measured by ELISA tests. For the malaria assay an antigen prepared from placentae infected with Plasmodium falciparum was employed. An IgG peroxidase conjugate was used. For the toxoplasma test a commercial antigen preparation was employed (Virion) and both IgG and IgM alkaline phosphatase conjugates were used. Sera which gave an absorbance of 0.2 or greater in an ELISA were considered positive. Sera were screened for hepatitis B surface antigen using a haemagglutination assay (Burroughs Welcome).

RESULTS

OUTCOME OF PREGNANCY

During a 1 year period, April 1982 - March 1983, 789 pregnant women were identified. One hundred and eight women were still pregnant at the end of the survey and a further 9 women moved out of the study area. Thus, the outcome of pregnancy was known for 672 women. Maternal deaths, stillbirths and neonatal deaths were all frequent (Table 1). Only a few abortions were recorded but this figure is almost certainly an under-estimate as few women reported their pregnancy until after the first trimester.

MATERNAL DEATHS

Fifteen women died from a cause that was probably related to pregnancy. The mean age of the mothers who died 28.5 + 8.0 years was very similar to the mean age of 657 pregnant women who survived (27.3 + 6.4 years). Death occurred more frequently among primagravidae (2/7)(26 per 1,000) and among women who had had 5 or more previous pregnancies (8/176)(45 per 1,000) than among women who had had 1 - 4 previous pregnancies (5/420)(12 per 1,000)(x^2 = 6.5;2 df;$P<0.05$). Only one woman died in hospital; 2 women died on the way to hospital and the remainder died at home. Eleven women had attended an antenatal clinic at least once during their pregnancy. Likely causes of maternal death are shown in table 2. Post-partum haemorrhage was the most important, being

responsible for 5 deaths (33%). Infections were responsible for another 4 deaths and sudden collapse at or shortly before delivery for a further 3. Eight women gave birth to a live child, including one pair of twins. All these 9 children died before reaching the age of 1 year.

STILLBIRTHS AND NEONATAL DEATHS

Twenty-three stillbirths and 41 neonatal deaths were recorded. Figure 1 shows stillbirths and neonatal deaths by month of death. The stillbirth rate showed little change with season but significantly more neonatal deaths occurred during the 6 months of the rainy season and immediate post-rainy season (June - November) (32/343 live births) than during the dry 6 months of the year (December - May)(9/288 live births) (x^2 = 8.9;1 df;$P<0.01$). Twenty-four of the 41 neonatal deaths occurred in males; 17 in females.

Information on the circumstances of death was obtained for 38 of the 41 infants who died during the neonatal period. Only 7 (18%) died in a hospital or health centre and only 11 (29%) had received any form of western medicine for their final illness. Presumptive causes of death established by post-mortem questionnaire and by examination of record cards are shown in Table 3. Prematurity was the main cause of death in 12 infants, including a pair of twins and a set of triplets. Nine of these 12 infants died within the first 48 hours of life. Feeding problems accoun-

ted for the deaths of 5 further infants. Infections were the main cause of death among infants who survived the first week of life (10/15 deaths). A total of 13 neonates proably died from an infection; 5 probably had pneumonia, 4 a generalised septicaemia associated with septic skin lesions, 1 meningitis, 1 neonatal syphilis, 1 acute gastroenteritis and 1 neonatal tetanus. The mother of the latter child had not been immunised.

FACTORS INFLUENCING THE OUTCOME OF PREGNANCY

Four of 672 women had multiple pregnancies, comprising 3 sets of twins and 1 set of triplets. Only 4 of these 9 infants survived the neonatal period and only 2 reached the age of 1 year.

Factors influencing the outcome of pregnancy were assessed for 649 women with a singleton pregancy whose outcome was known, excluding those who had an abortion or intra-uterine death. The results of these comparisons are summarised in Table 4. The outcome of pregnancy was influenced by both age and parity. A poor outcome (stillbirth or neonatal death) was recorded significantly more frequently in women aged less than 20 years and in those 40 years old or more than in women aged 20 - 39 years (x^2 = 10.9;3 df;$P<0.05$). Neonatal mortality was especially high in those aged 40 years or more (5/24). A poor outcome was recorded more frequently in primagravidae and in multigravidae than in those with 1 - 4 previous pregnancies (x^2 = 11.7;2 df;$P<0.01$). The outcome of pregnancy was not influenced by ethnic group. A

higher proportion of women whose pregnancy ended in a stillbirth had a history of a previous stillbirth than did women whose pregnancy ended in a live birth (7/16 compared with 135/458) but this difference is not statistically significant (x^2 = 2.4;1 df;NS). The mean duration between the onset of the index pregnancy and the previous pregnancy was similar in women with a bad outcome of pregnancy (41.2 + 14.7 months) and in those with a good outcome (38.0 + 14.9 months). However, 29 women whose previous child had died had a significantly shorter birth interval (26.6 + 12.7 months) than did 357 women whose previous child was still alive (mean birth interval was 38.0 + 14.9 months)(t = 4.0;P<0.001).

The proportion of women who had an antenatal card and who were known to have visited an antenatal clinic on at least one occasion during their pregancy did not differ significantly between women with a good outcome of pregnancy (436/590)(74%) and those with a bad outcome (41/59)(69%). Ninety percent of women who had an ante-natal card had a record of administration of at least 1 dose of tetanus toxoid during the current or previous pregnancies; the level of tetanus immunization did not differ between the 2 groups. An antenatal card record of chloroquine administration during the current pregnancy was noted significantly more frequently for women with a bad outcome of pregnancy (8/41) than for women whose child survived the neonatal period (26/436) (x^2 = 8.4;1 df;P<0.01).

Field workers completed an average of 2.9 monthly morbidity questionnaires for both women with a good outcome of pregnancy and for those with a bad outcome. Complaints were frequent in both groups (fever, abdominal pain, weakness, swelling of the feet and dysuria in descending order of frequency) but no symptom differed significantly in prevalence between the two groups. An oral temperature of 38.0°C or greater was recorded at the time of administration of morbidity questionnaires on only 8 of the 1813 times when temperature was recorded. Only 2 of these women had malaria parasitaemia. All 8 febrile women had a good outcome of pregnancy.

A cross-sectional clinical survey of all pregnant women in the study area carried out on two occasions during the study period was not helpful in identifying risk factors for a poor outcome of pregnancy. An abnormal foetal position was detected in 26 of 307 women with a palpable foetus but only 1 of these 26 pregnancies had a bad outcome. Oedema was noted in 11/35 women (31%) with a bad outcome and in a similar proportion of women with a good outcome (155/433)(36%). Systolic hypertension (BP 140 mm/Hg or greater), diastolic hypertension (BP 90 mm/Hg or greater) and proteinuria were all found infrequently and were recorded in 17, 26 and 11 of 475 women respectively. Only 3 women had hypertension and proteinuria; 1 had a stillbirth. Glycosuria was not detected. Trends towards a higher stillbirth rate in women 1.5 m or less and towards a higher neontal death rate among women in the heaviest decile were observed but overall the outcome of

pregnancy was not influenced significantly by height or weight.

Blood was collected for haematological, parasitological and serological determinations durinmg each clinical survey. Malaria parasitaemia was found in 3/37 women (8%) with a bad outcome of pregancy and in 29/422 (7%) of those with a good outcome. The mean PCV of 31 women with a poor outcome of pregnancy (32.8% + 3.6%) was very similar to the mean PCV of 353 women with a good outcome (32.2% + 4.4%). No difference between groups was found when the comparison was restricted to the 155 women seen during the last trimester. All 25 women with a PCV of 25% or less had a good outcome of pregnancy.

The results of serological investigations carried out on 237 blood samples obtained from 254 pregnant women during the first clinical survey are shown shown in Table 5. Few diferences were observed between women with a good outcome of pregnancy and those with a bad outcome. A higher IgM titre of toxoplasma antibodies was found in the mothers of infants who died in the neonatal period but no other significant differences were found. Although positive serological tests for syphilis were frequent these did not predict a bad outcome to pregnancy. Because of this rather suprising finding these tests were also caried out on a further 221 samples collected during the second clinical survey. Once again no correlation with the outcome of pregnancy was found. The prevalence of HB_s antigen was about twice as high in women with a poor outcome of pregnancy as in those with a good outcome but

numbers are small and this difference is not statistically significant. Mean titres of toxoplasma, malaria and CMV antibodies did not differ between women with a poor outcome of pregnancy and those with a good outcome.

Information on the circumstances of delivery was obtained by questionnaire for 59 women with a bad outcome of pregnancy and for 590 women with a good outcome. The percentage of women who had been delivered by a mid-wife in a health centre or hospital was low and was similar in each group (5% and 4% respectively). Histories of prolonged labour, excessive bleeding and tearing were all given more frequently by women with a bad outcome of pregnancy than by women with a good outcome but none of the differences between the two groups is statistically significant.

DISCUSSION

In this study we tried to identify all pregnant women in a group of 41 villages and hamlets in North Bank Division of The Gambia throughout a one year period and to determine the outcome of their pregnancies. We believe that by using a combination of registration methods and by urine testing all at-risk women very few pregnancies were missed. We recorded depressingly high maternal, stillbirth and perinatal death rates. We have found few other comparable sets of data, collected during the course of community surveys in Africa, with which to compare our findings. In a comprehensive survey of the relationship between fertility,

birth intervals and foetal mortality Armagnac and Retel-Laurentin (6) recorded an abortion rate of 210 per 1,000 and a stillbirth rate of 50 per 1,000 respectively in a rural area of Burkina Faso. In the relatively prosperous Macharkos area of Kenya, Voorhoeve et al. (2), using survey techniques similar to our own, found a stillbirth rate of 30 per 1,000, a neonatal death rate of 23 per 1,000 and a maternal death rate of only 0.8 per 1,000, a figure 30 times lower than that recorded in our study. In The Gambia, a study carried out in the villages of Keneba and Manduar over a 25 year period from 1951 - 1975 gave stillbirth rates of 64 and 89 per 1,000, neonatal mortality rates of 85 and 50 per 1,000 and maternal mortality rates of 11 and 10 per 1,000 respectively (3). Thus, our data suggest that there has been little or no improvement in the outcome of pregnancy in rural areas of The Gambia during the past few years. The maternal death rate in the Farafenni area is about 200 times greater than that recorded in industrialised countries, the neontal death 5 - 10 times higher and the stillbirth rate about 3 times higher.

The maternal mortality rate recorded in our study is very high, even by the standards of developing countries, for example a mortality of 1 per 1,000 live births in Jamaica (7). Caution is required in making generalisations from the findings obtained in a restricted population during a survey period of only one year but our findings suggest that in rural Gambia as many as 1:8 women still die in pregnancy or in childbirth. Only 2 of the 15 women who died had been seen in a hospital or health centre

during their final illness so that maternal death rates based on hospital or health centre records would have grossly underestimated the size of the problem. Even before the introduction of a new primary health care programme, rural health services in The Gambia were relatively effective, as shown by the high proportion of pregnant women seen in our study who had attended an antenatal clinic and who had received tetanus immunisation. It is likely that in some other parts of Africa where rural health programmes are less well developed, maternal mortality is at least as high as in The Gambia.

To try to determine ways in which maternal deaths might have been prevented as much information as possible was obtained about each woman who died. In 11 of the 15 cases death occurred either before or within 4 hours of delivery and was associated with haemorrhage or sudden collapse. Because of lack of transport and the lack of resuscitation facilities at the nearest dispensary it is difficult to see how these deaths could have been prevented. It is possible that some of the women who died had an obstetric abnormality which could have been detected at an antenatal clinic and which would have led to their referal to a health centre or hospital. However 11 of the 15 women who died had been seen at least once at an antenatal clinic but none had been referred for health centre delivery.

The stillbirth rate among Farafenni women was not especially high and similar to that reported in the more prosperous community of

Macharkos, Kenya (2). A history of a previous stillbirth was obtained more frequently from women whose pregnancy ended in a stillbirth than in women with a successful outcome of pregnancy and it is our clinical impression that in the study community there are a small number of women who experience recurrent stillbirths. A number of possible infective causes of stillbirth were considered. It is unlikely that malaria was important because no seasonal variation in the incidence of stillbirths was observed and, in The Gambia, malaria is very seasonal. Although a high prevalence of positive antibody tests for syphilis was found this infection did not appear to be a significant cause of stillbirths as has been noted in rural Burkina Faso (6) and in urban Zambia (8).

Deaths among neonates fell into two main groups. Prematurity was the main cause of death in infants who died during the first few days after birth and infections were the main cause of death in neonates who survived the first week of life. A history suggestive of death from neonatal tetanus was given by only one family, a finding in keeping with the high prevalence of tetanus antibodies in pregnant Farafenni women. Maternal death was an important cause of neonatal and infant mortality. All 9 children born to mothers who died failed to reach the age of 1 year. A maternal death is thus, almost inevitably, a double tragedy.

We tried to identify risk factors that might help traditional birth attendants and mid-wives working in rural anetenatal

clinics with few facilities to identify pregnant women at risk who might benefit from delivery in a health centre. Because our sample size was relatively small only risk factors exerting a strong effect would have been detected. As expected, we found that primagravidae, women with 5 or more previous pregnancies, women over the age of 40 years old or women with multiple pregnancies were all at risk. Our attempts to detect other risk factors were unsuccessful. Monthly administration of morbidity questionnaires by field staff, together with the measurement of temperature, did not provide any helpful indicators. Examination of each pregnant woman by a physician on one occasion during pregnancy was also unhelpful; very few women had any signs of pre-eclampsia or other recognised risk factors. Determination of the PCV and serological tests for a variety of infections known to cause congenital infections were, in the main, unhelpful although a tendency to a poorer outcome was noted in women who were HB_s antigen positive. Thus, it is likely that in the Farafenni area that the outcome of pregnancy is determined largely by obstetric factors and that infections such as malaria and syphilis, which might be amenable to specific interventions, do not play a major role in causing stillbirths or neonatal deaths. Reviewing Table 2 it is clear that many maternal death were due to catastrophic episodes which the attendants at delivery had no possibility of alleviating in the home situation. Transport from outlying villages is extremely difficult to obtain in an emergency and at the time of this study, Farafenni Health Centre had inadequate staff and facilities to deal with obstetric

disasters. The Government Hospital in Banjul, the nearest place where blood transfusion and obstetric services are available is reached only after a journey of several hours, including a ferry crossing of The River Gambia. Consequently the importance of identifying the at-risk mother well before delivery should be emphasised and training given to the TBA's and to visiting midwives who conduct antenatal clinics in Health Centres to assist them in this selection. Mothers at risk must be encouraged to attend the Health Centre nearest to them for delivery, transport facilities should be improved and a place made available for mothers to stay near a Health Centre prior to delivery. Whenever possible major health centres should be upgraded to include blood transfusion facilities and the services of an obstetrician.

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Table 1. The outcome of pregnancy in 672 women in a rural area of The Gambia during the period April 1982 - March 1983.

Outcome	Number	Rate per 1,000
Maternal death	15	22.3
Intra-uterine death	4	-
Abortion	15	-
Stillbirth	23	34.9
Early neonatal death (< 1 week)	26	40.9
Perinatal death	49	74.5
Late neonatal (1 - 4 weeks)	15	23.6
Total neonatal death	41	64.6

The stillbirth and perinatal death rates are calculated per total births (658), the neonatal death rates per live births (635). Maternal deaths are defined as deaths during pregnancy, delivery or within 6 weeks of delivery which were related to the pregnancy.

TABLE 2. FEATURES OF MATERNAL DEATHS IN 15 RURAL GAMBIAN WOMEN

NUMBER	AGE IN YEARS	PARITY	A.N.C. VISITS	PROBABLE CAUSE OF DEATH	ASSISTANT AT DELIVERY	PLACE OF DELIVERY	PLACE OF DEATH	TIME AFTER DELIVERY	OUTCOME
1	33	3	2	Post-partum haemorrhage	Untrained T.B.A.	Home	Home	4 hours	Stillbirth
2	22	2	0	Amenorrhoea 3/12 severe abdominal pain, collapse	No one	-	Roadside	-	I.U.D.
3	40	6	3	Post partum haemorrhage	Relative	Home	Home	1 hour	Live born, died 3/52
4	36	5	2	Post-partum haemorrhage with retained placenta	Relative	Next door compound	Next door compound	1 hour	Live born, died 3/52
5	28	6	3	Sepsis and jaundice	Relative	Home	Home	4 days	Live born, died 3/52
6	30	8	1	Anaemia, heart failure, chronic renal failure	Trained midwife	Hospital	Home	8 weeks	Twins, liveborn, die 1/12 and 3/12
7	26	6	2	Hepatic coma	Trained midwife	Hospital	Home	5 days	Live born, died 10/7
8	30	6	4	Tuberculosis	Relative	Home	Home	2 weeks	Live born, died 6/1
9	41	12	1	Post-partum haemorrhage	Relative	Home	Home	4 hours	Stillbirth
10	21	3	1	Premature delivery convulsions	Relative	Home	Home	5 weeks	Stillbirth
11	34	5	1	24/52 Gestation, acute toxic illness? S.typhi	No one	-	Home	-	I.U.D.
12	34	3	2	36/52 Gestation. Sudden severe abdominal pain	No one	-	Home	-	I.U.D.
13	21	1	0	36/52 Gestation. Sudden weakness and collapse	Untrained T.B.A.	-	Roadside	-	I.U.D.
14	16	0	0	Sudden death at delivery ? Amniotic fluid embolus	Untrained T.B.A.	Home	Home	Instant of delivery	Live born, died 6/52
15	16	0	0	Post-partum haemorrhage	Untrained T.B.A.	Home	Home	1 hour	Live born, died 1/12

(A.N.C. - antenatal clinic, T.B.A. = traditional birth attendant, I.U.D. = intra - uterine death)

Table 3. Presumptive cause of death in 41 infants who died during the first month of life.

Cause of death	Number
Prematurity and death < 1 week	12
Nutritional problems and failure to thrive	5
Birth trauma	1
Congenital abnormalities	1
Infection	13
No obvious cause	6
No information obtained	3
Total	41

Table 4. Risk factors for a poor outcome of pregnancy (stillbirth or neonatal death) in 649 women with a singleton pregnancy.

Statistically significant risk demonstrated	Data suggestive but no statistically significant	No risk demonstrated
First pregnancy	Previous stillbirth	Symptoms in pregnancy
5 or more previous pregnancies	Short stature	Oedema
Age < 20 years	weight	BP
Age > 40 years	Prolonged labour	PCV
Chloroquine Administration in pregnancy		Malaria parasitaemia
		Positive serology for syphilis

Table 5. The results of serological tests in 237 pregnant women in relation to the outcome of their pregnancy.

Antibody test	Outcome of pregnancy					
	Child alive at 1 month		Stillbirth or early neonatal death		Late neonatal death	
	no.	%	no.	%	no.	%
Syphilis						
RPR	57/214	27	3/16	19	1/7	14
RPR +TPHA	29/214	14	1/16	6	1/7	14
Toxoplasma						
IgG	133/195	68	7/15	47	6/6	100
IgM	24/195	12	1/15	7	3/6	50
CMV	200/209	96	13/15	87	6/6	100
Rubella	197/208	95	15/16	94	6/6	100
Malaria	213/214	100	16/16	100	6/6	100
HB Ag	30/193	16	4/16	25	2/6	33

LEGEND TO FIGURE

The number of stillbirths and neonatal deaths recorded in 672 pregnant Gambian women by month of year.

SUMMARY

The outcome of pregnancy was recorded in a rural area of The Gambia with few medical resources prior to the introduction of a rimary health care programme to identify risk factors for a poor outcome of pregnancy which might be used by traditional birth attendants and by the staff of rural antenatal clinics to identify pregnant women who require special care.

During a one-year-period the outcome of pregnancy was recorded in 672 women resident in 41 villages and hamlets near to the town of Farafenni on the north bank of the river Gambia, 100 km from the coast. Pregnant women were identified by village reporters and by urine testing all women aged 15 - 45 years on two occasions during the study period. It is unlikely that many pregnant women were missed. Pregnant women were visited monthly by a field worker until they delivered and, on two occasions during the year, all available pregnant women were examined in their village by a physician.

The maternal death rate recorded was very high, 22 per 1,000. Primagravidae and women with 5 or more previous pregnancies had an increased risk of death. Haemorrhage and infections were the main causes of maternal death. Nine live children were born to 15 women who died; all of these children died before reaching the age of 1 year.

Twenty-three stillbirths and 41 neonatal deaths were recorded (stillbirth rate 35 per 1,000 and neonatal death rate 65 per 1,000). Prematurity and its complications was the main cause of death in infants who died during the first week of life. Infections were the main cause of death in infants who survived beyond this period.

Factors that influenced the outcome of pregnancy were determined for 649 women with a singleton pregnancy. The outcome of pregnancy was influenced by both age and parity, a poor outcome (stillbirth or neonatal death) being noted most frequently in the very young and the old. Morbidity surveys were unhelpful in identifying women at risk and few abnormalities were detected during cross-sectional surveys undertaken by a physician. Outcome was not related to packed cell volume. A high prevalence of positive serological tests for syphilis and hepatitis B surface antigen was found. A trend towards a poor outcome was observed in women who were HB_s antigen positive but this was not the case for a positive serological test for syphilis.

It is likely that in the study area the outcome of pregnancy is determined largely by obstetric factors and that infections such as malaria and syphilis, which are amenable to specific interventions, are not a major cause of stillbirths or neonatal deaths.