Safe Motherhood
A Review
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This report is the result of collaborative efforts and contributions from a range of individuals and partner agencies.

Family Care International is grateful to the World Bank for its financial support, with special thanks to Elizabeth Lule for initiating the development of this report.

Ann Starrs, Executive Vice-President, FCI and Rahna Reiko Rizutto, Consultant, kicked off this project with a wealth of ideas, insights, and inspiration.

Rebecca Casanova, Communications Consultant, carried out in-depth interviews with experts and the review of international agreements for safe motherhood (section III) and conducted the media analysis from 2000–2005 (section IV).

Karuna Chibber, Consultant, developed the country questionnaire guide for the national reports (section VII) and carried out in-depth interviews with development and donor agency representatives (section V).

National consultants carried out the research at the country level and drafted the reports: Alexia Escobar, Alberto De La Galvez Murillo Camberos, and Oscar Viscarra (Bolivia) Widi Wibisana (Indonesia) Rebecca Ramos (Lao People’s Democratic Republic) Valentino Lema (Malawi) Mountaga Toure (Mali) Nikubuka Shimwela (Tanzania)

Researchers at the Netherlands Interdisciplinary Demographic Institute (NIDI) provided invaluable support and assistance in the analysis of financial data related to safe motherhood (section VI). Special thanks to UNFPA for permission to use the UNFPA/UNAIDS/NIDI resource flows database.

FCI staff contributed critical technical feedback, suggestions, and support throughout the research and writing process: Jill Sheffield, Ann Starrs, Martha Murdock, Cristina Puig, Ellen Brazier, Ellen Themmen, Fatima Maiga, Rehema Mwateba, and Lauren Goddard. The report was coordinated by Shafia Rashid and designed by Patricia Quintero. Adrienne Atiles, with assistance from Luz Barbosa, managed the design and production of the publication.

FCI also wishes to thank the many colleague agencies who contributed their time and thoughts to this project.
The year 2007 will mark 20 years since the launch of the global Safe Motherhood Initiative (SMI), an international effort to raise awareness of the scope and dimensions of maternal mortality and to galvanize commitment among governments, donors, UN agencies, and other relevant stakeholders to take steps to address this public health tragedy. The forthcoming twentieth anniversary of the SMI provides a timely opportunity to take stock of how safe motherhood has fared within the health and development agenda, and assess the Initiative’s achievements and shortfalls.

In 1987, when health experts, development professionals, and policymakers gathered in Nairobi to inaugurate the global Initiative, maternal mortality was not a major national or international priority. In fact, it was often the overlooked component of maternal-child health programs, as noted by Maine and Rosenfield in their seminal 1985 article, “Where is the M in MCH?” At the Nairobi meeting, a group of international agencies launched a global movement, the Safe Motherhood Initiative, whose aim was to reduce the burden of maternal death and ill-health in developing countries. Later that year, the Safe Motherhood Inter-Agency Group (IAG) was established to realize the goals of the Initiative. As a group and as individual organizations, these agencies raised international awareness about safe motherhood, set goals and programmatic priorities for the Initiative, stimulated research, mobilized resources, and shared information to make pregnancy and childbirth safer.

In the 21st century, safe motherhood has achieved greater prominence on the international agenda, with increasing visibility, resources, and attention being directed toward it. Many agencies and organizations now have dedicated programs focusing on maternal health; donors have prioritized safe motherhood in their funding programs; governments have developed national strategies and programs to reduce maternal mortality; and there is greater knowledge and awareness of the problem and how to address it. There is broad agreement that good-quality maternal health services need to include skilled care for both routine and complicated cases, including emergency obstetric services for life-threatening complications, and a functioning referral system to ensure timely access to appropriate care.

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2 The founding members of the IAG were the World Bank, World Health Organization, UNFPA, unicef, and UNDP. In October 1987, the group expanded to include the International Planned Parenthood Federation (IPPF) and the Population Council. In 2000, the International Confederation of Midwives, the International Federation of Obstetrics and Gynecology (FIGO), the Regional Prevention of Maternal Mortality Network (Africa), and the Safe Motherhood Network of Nepal joined the IAG. Family Care International served as the secretariat until January 2004, when the Partnership for Safe Motherhood and Newborn Health was established.
Progress has been achieved on a number of key indicators, including the proportion of pregnant women receiving antenatal care, and the proportion of births attended by a skilled birth attendant. Since 1990, coverage of antenatal care in developing countries has increased by 20%, and more than 50% of women receive at least the four recommended antenatal visits. Between 1990 and 2003, the presence of a skilled attendant at delivery increased significantly, from 41% to 57% in the developing world as a whole.

Despite these achievements, the Safe Motherhood Initiative has fallen short of the goal that it set almost 20 years ago: to reduce maternal mortality by 50% by the year 2000. While a few countries have experienced sustained reductions in maternal mortality, little or no progress has been achieved in those countries with the highest levels of mortality, and in some countries, it appears that they have worsened. Maternal mortality remains high even in some countries where utilization of maternal health care (such as antenatal and delivery care) has improved; this underscores the importance of improving not just the availability of care, but its quality.

Why has the Initiative not achieved its goals? Faltering political commitment, inadequate funding, and a lack of clear technical priorities have hampered progress.

**Safe Motherhood in Perspective**

“...Maternal health rarely gets the priority or attention that it deserves. Partly that's because the victims tend to be faceless, illiterate women who carry little weight in their own families, let alone on the national or world agenda.”


Each year, more than half a million women die during pregnancy and childbirth—making pregnancy-related complications among the greatest killers of women of reproductive age in developing countries. Of all the health data monitored by the World Health Organization, maternal mortality demonstrates the greatest disparity between poor and rich countries: the lifetime risk of a woman dying during pregnancy or childbirth is much higher in the poorest countries than in the richest (one in 12 for women in east Africa compared with one in 4,000 in northern Europe). Within countries, poor, uneducated, and rural women suffer disproportionately compared to their educated, wealthy, and urban counterparts: in Kenya, for example, just over 23% of women in the lowest wealth quintile have access to skilled assistance during childbirth, while almost 78% of women in the highest wealth quintile are attended by a doctor or a nurse/midwife. Urban–rural differences also affect

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4 State of the World Population 2005 Report, *The Promise of Equality: Gender Equity, Reproductive Health and the Millennium Development Goals*. New York: UNFPA, 2005. At the regional level, the most marked improvements took place in South-Eastern Asia (from 34 to 64%) and Northern Africa (from 41% to 76%). In sub-Saharan Africa and Western Asia, the indicator increased by only 1 percentage point between 1990 and 2003.
6 Personal communication, Khama Rogo, World Bank.
whether a woman receives adequate care during pregnancy and childbirth: in Peru, over 80% of urban women have a skilled provider attend their delivery, whereas less than 20% of rural women receive such care.\(^9\)

In addition to the risk of dying during pregnancy and childbirth, women can suffer from short- and long-term maternal disabilities and illnesses. According to the 2005 *World Health Report*, 20 million women each year will experience maternal disability, which can range from fever and depression to severe complications such as obstetric fistula and uterine prolapse.\(^10\)

The exact magnitude and scope of maternal morbidity is unclear, due to underreporting, poor recordkeeping systems, and definitional/classification problems.

Investing in maternal health saves individual women’s lives and safeguards their well-being. It also affects the health and well-being of entire societies. Research indicates that the health of newborns is closely linked with the health of their mothers. About 30–40% of neonatal and infant deaths result from poor maternal health and inadequate care during pregnancy, delivery, and the critical immediate postpartum period. Data also suggest that a mother’s death affects the overall well-being of her surviving children: in Bangladesh, the surviving children of a deceased mother are three to ten times more likely to die within two years.\(^11\) In Tanzania, children living in homes in which an adult woman died during the previous 12 months spent half as much time in school as other children. The impact on children’s health and survival was not significant when an adult male died.\(^12\)

In addition to the impact on infants and children, a woman’s death affects her family’s well-being and society as a whole. After a woman dies, her family is less able to care for itself, and forfeits any paid/unpaid wages she contributed to the household. Her death increases the chances of her family facing poverty and malnutrition. Data suggest that the death of an adult woman has a significant effect on household consumption in the poorest households for at least a year following her death.\(^13\)

Investing in maternal health provides long-term benefits for the entire health delivery system. Elements that are essential for effective maternal health care, such as adequate human resources, effective communications and referral mechanisms, and an efficient supply of equipment, drugs, and consumable goods such as gloves and syringes, also have a positive impact on a range of non-obstetric services, including the handling of accidents, trauma, and other emergencies. In addition, pregnancy and childbirth are often the first point of contact for a woman in the health system; antenatal care can provide an opportunity to address other reproductive health concerns, such as family planning and STIs, as well as other illnesses or conditions including tuberculosis, malaria, and HIV/AIDS.

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\(^10\) Obstetric fistula refers to holes in the birth canal caused by prolonged or obstructed labor. Consequences include: vaginal incontinence, pelvic and/or urinary infections, pain, infertility, and early death. The social repercussions are often severe, resulting in abandonment and ostracization. Uterine prolapse is the falling or sliding of the uterus from its normal position in the pelvic cavity into the vaginal canal.


Finally, safe motherhood investments are cost effective. According to the 1993 World Bank *World Development Report*, safe motherhood is among the most cost-effective strategies for low-income countries. In 2005, researchers assessed the costs and benefits of interventions for maternal and newborn health, and determined that strategies at the community and primary care levels (community-based newborn care, antenatal care, and skilled care during childbirth) to lower maternal and newborn deaths are highly cost-effective.\(^\text{14}\)

Safe motherhood is fundamentally a matter of human rights; all women are entitled to good health and high-quality health services. Maternal deaths are linked to women’s low status in society, and their lack of decision-making ability and economic power. In order for women to be able to enjoy safe pregnancy outcomes, they need to be accorded the same opportunities to health, education, and employment as their male counterparts.

**What This Report Contains**

This report reviews the impact of the global Safe Motherhood Initiative, and assesses progress in the safe motherhood field since its launch in 1987. Specifically, the report examines how the field has evolved in terms of international advocacy and media attention; development agency and donor commitment to safe motherhood; financial trends and allocations; and the development of national policies and programs for safe motherhood.

- **International advocacy and media relations:** The report reviews how media attention for safe motherhood has changed over time, and analyzes how and why maternal mortality has been identified as a key priority in international meetings and processes. The analysis reviewed relevant press coverage of safe motherhood to identify trends in coverage and regional or topical trends. In addition, in-depth interviews were conducted with key actors from select international meetings to ascertain the influence of global safe motherhood events.

- **Development and donor agency commitments:** To assess shifts in emphasis, priority, and commitment within selected donor and development agencies, a series of in-depth interviews were carried out with program representatives (see Annex I for a listing of agencies included in the analysis).

- **Financial trends for safe motherhood:** Financial trends since 1987 were analyzed using three different data sources: a World Bank–commissioned report on funding for safe motherhood following the launch of the SMI; the UNFPA/UNAIDS/NIDI financial resource flows database of donor funds via bilateral, multilateral, and foundation channels; and interviews with selected donor officials on trends within their agencies and in the field as a whole.

- **National policies, programs, and budgetary commitments:** In order to examine the development of national maternal health priorities/programs and allocations in several countries in Africa, Asia, and Latin America, in-country consultants conducted document research and carried out interviews with government officials, donor representatives, and NGOs. Countries highlighted in this analysis include: Bolivia, Indonesia, Lao People’s Democratic Republic, Mali, Malawi, and Tanzania.

The past 20 years have witnessed dramatic shifts in how maternal health is framed and conceptualized at the international level. Safe motherhood has evolved from a neglected component in maternal and child health programs to an essential and integrated element of women’s sexual and reproductive health. In the late 1970s through the mid 1980s, while safe motherhood was acknowledged as a key priority area for attaining the health and development of women, it was neglected in the development priorities of governments and funding agencies, and maternal and child health programs tended to focus on the needs of the child and not the mother. In 1987, in an effort to redress this situation, a global movement was launched to bring attention to the silent tragedy of women dying during pregnancy and childbirth.

Over the next 15 years, largely a result of this landmark worldwide initiative, safe motherhood became a central component for the achievement of women’s health and rights. At the International Conference on Population and Development (ICPD), maternal mortality was identified as a core component of women’s sexual and reproductive health, and at the Millennium Development Goal (MDG) Summit it was situated within the broader context of poverty reduction efforts and overall development efforts.

This section traces how maternal health has figured within the broader development framework and identifies key events that shaped its role at the international level.

The UN Decade for Women (1976–1985)

At the first conference on women held in Mexico City in 1975, the United Nations declared the period 1976–1985 as the United Nations Decade for Women in an effort to raise international attention on the health, rights, and development priorities of women. In July 1985, at the third UN conference on women, a series of “Forward Looking Strategies for the Advancement of Women” was adopted by delegates to review and appraise the achievements of the United Nations Decade for Women.

Focusing on the themes of equality, development, and peace, the consensus document framed maternal health within the context of women’s health and rights, and supported a reduction of maternal mortality by the year 2000. The Strategies also called for:

- equal access to health services.
- adequate health facilities for mothers and children.
- every woman’s right to decide on the number and spacing of her children, and access to family planning for every woman.
- discouragement of childbearing at an early age.
- improvement of sanitary conditions, including drinking water supply.

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The Launch of the Safe Motherhood Initiative (1987)

In 1987, when the Safe Motherhood Conference was held in Nairobi, Kenya, the scope and dimensions of maternal health were not well known or understood. There was little evidence available concerning the technical and programmatic interventions most effective for improving maternal health.

To generate awareness and stimulate commitment among governments and funding agencies to address this public health problem, WHO, the World Bank, and UNFPA brought together a range of stakeholders, including government officials, NGO representatives, health providers, and donor representatives at a conference in Nairobi. The conference underscored the relative neglect of maternal mortality in the development priorities of governments and funding agencies, and urged concerted action to prevent women from dying during pregnancy and childbirth.

The conference situated maternal health within the context of improving women’s status in the economic, social, and political spheres, and outlined specific strategies for safer motherhood:

• strengthening community-based health care by improving the skills of community health workers and traditional birth attendants, and screening high-risk pregnant women for referral for medical care;
• improving referral-level facilities to treat complicated cases and serve as a back-up to community-level care;
• developing an alarm and transport system to serve as a link between community and referral care.

For the first time ever, the international development community focused on the plight of women dying during pregnancy and childbirth, and issued a specific goal for maternal mortality reduction: to reduce maternal mortality by 50% by the year 2000. From here on, “safe motherhood” was coined as the “catch phrase” for maternal health.

Following the Nairobi conference, a series of regional and national meetings was held in Africa, the Arab region, Asia, and Latin America in an effort to generate recognition of poor maternal health and stimulate commitment to address this public health problem among national decision-makers, health providers, and NGOs. Annex II provides a summary of the meetings and conferences the Inter-Agency Group organized, and the publications and reports it produced since 1987.

The Children’s Summit (1989)

In 1989, world leaders, joined by the heads of UN agencies and senior representatives of the international development community, gathered in New York to attend the World Summit for Children. The conference reviewed key areas related to the survival, protection, and development of children and issued a plan of action for the next ten years. Maternal mortality was identified as critical to the health and survival of children, and as one of the major goals of the Summit, which specifically called for a reduction of maternal mortality by half between 1990 and 2000. Maternal health was framed largely as a means to ensure childhood survival, rather than an end in itself.  

17 See note on page 4.
The International Conference on Population and Development (1994)

The International Conference on Population and Development (ICPD), held in Cairo, Egypt, was a watershed event for women’s health and rights. Reframing population and development from a focus on meeting demographic goals to securing the reproductive health and rights of men and women of all ages, the ICPD put forward a far-reaching plan for achieving progress in health and development.

Maternal health was situated within the context of the comprehensive approach to reproductive health. Specifically, the ICPD Programme of Action called for:

“[Maternal health] services, based on the concept of informed choice, [which] should include education on safe motherhood, prenatal care that is focused and effective, maternal nutrition programmes, adequate delivery assistance that avoids excessive recourse to Caesarian sections and provides for obstetric emergencies; referral services for pregnancy, childbirth and abortion complications; post-natal care and family planning…”

Governments agreed to cut the number of maternal deaths by half by the year 2000, and in half again by 2015. In 1995, the Fourth World Conference on Women (FWCW) in Beijing gave substantial attention to maternal mortality and reiterated the commitments made at the ICPD.

The ICPD and Beijing commitments also reinforced the position that maternal deaths and disability are violations of women’s human rights, and are strongly tied to women’s status in society and economic dependency. At a fundamental level, women have a right to health services that promote their health and survival during pregnancy and childbirth.

Tenth Anniversary of the SMI (1997–1998)

To commemorate the tenth anniversary of the Initiative, the members of the Safe Motherhood Inter-Agency Group executed a wide-ranging program with the following objectives:

• invigorate national and international commitment and action for safe motherhood among a range of audiences, including policymakers, donors, and health providers; and
• bring together existing knowledge and research on the most effective interventions into a set of clear technical messages for guiding programs and policies on the ground.

The Safe Motherhood Tenth Anniversary program consisted of a comprehensive set of activities, including a technical consultation held in Colombo, Sri Lanka in October 1997 to forge consensus on the most cost-effective strategies for safe motherhood; a World Heath Day media event in April 1998 to generate high-level attention to the problem of maternal mortality among developing country policymakers and donors; and a far-reaching media strategy and communications

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campaign to widely disseminate the findings and messages to interested parties all over the world.

The Tenth Anniversary program has been by far the single largest effort to advance safe motherhood within the international and national arenas. Selected products and outcomes included:

• increased media attention on the dimensions and consequences of maternal mortality.
• a set of ten priority action messages reflecting consensus on the key policy and program strategies for improving maternal health (see Annex III for a summary of the ten action messages for safe motherhood).
• a range of communications tools and resources, including a Web site, fact sheets, public service announcements, a brochure, and a pocket card.

The ten priority action messages profoundly transformed the conception, design, and implementation of safe motherhood programs and policies. Two program interventions that the Initiative itself had advocated ten years earlier at the Nairobi conference (training of traditional birth attendants and risk screening for pregnant women to identify those most likely to develop obstetric complications) were deemed to be ineffective for reducing maternal mortality, and not to be promoted as priority strategies. Instead, the ten action messages emphasize the need to address the broad social, economic, and political context that contributes to women’s risks of dying during pregnancy and childbirth, and promote access to essential obstetric care to prevent or treat serious obstetric complications.20

Millennium Development Goals (2000)

In 2000, at the UN Millennium General Assembly in New York, 189 countries from around the world adopted specific international development goals with the aim of reducing poverty and promoting human development. Building upon the agreements and commitments made at the series of world conferences held in the 1990s, the Millennium Development Goals (MDGs) offer a blueprint for reducing poverty and hunger, and addressing poor health, gender inequality, lack of education, lack of access to clean water, and environmental degradation. Millennium Development Goal 5 calls for an improvement in maternal health and a reduction in maternal mortality by 75% by 2015 from 1990 levels.

The identification of maternal health as one of the eight MDGs firmly situates it as central to poverty reduction and overall development efforts. Its inclusion has resulted in increased international attention to maternal mortality, and provided a mechanism for monitoring progress on maternal health and improving access to skilled attendants at deliveries (the key indicator for measuring progress for Goal 5). With the MDGs now widely accepted as the framework for assessing progress on overall health and development at the national and international levels, safe motherhood can figure more prominently in country programs and in development agencies’ priorities.

For each of the Goals and targets, a task force was established to provide governments and members of civil society with a concrete plan for achieving progress on health and development. The Task Force on Child Health and Maternal Health issued a set of nine recommendations for realizing improvements in maternal health and child mortality (Goal 4 calls for a reduction by two-thirds of the under-five child mortality rate).

In its report, the Task Force outlined the central challenge for maternal and child health: developing and strengthening functioning health systems through which evidence-based interventions can be delivered and scaled-up to the full population. In particular, the report highlighted the unequal distribution of power and resources, and a range of social, economic, cultural, and political inequities, as the main impeding factors for achieving progress in maternal and child health.

**An Expanded Global Partnership for Maternal Health (2005)**

In September 2005, a partnership bringing together three existing global health coalitions on maternal, newborn, and child health (the Partnership for Safe Motherhood and Newborn Health, which itself evolved from the Safe Motherhood Inter-Agency Group; the Healthy Newborn Partnership; and the Partnership for Child Survival) was launched. The Partnership for Maternal, Newborn, and Child Health (PMNCH) aims to strengthen global advocacy and leadership in an effort to raise the profile and visibility of maternal, newborn, and child health; develop and promote a continuum of care for mothers and children; and coordinate country-level support and action. It builds on the expertise, experience, lessons learned, and membership of the predecessor partnerships, with a major focus on working effectively at the country level to achieve improvements in maternal, newborn, and child health.
Beginning in the 1990s, the United Nations sponsored a series of international conferences to develop a framework for achieving progress on population, health, and development. Safe motherhood, including maternal mortality reduction, has been consistently identified as a key development goal at all of these major global conferences.

In order to examine how safe motherhood came to be highlighted as a critical area for action at the international level, and the reasons underlying its inclusion, a set of key informant interviews were carried out with individuals from multilateral organizations and NGOs who played a role in negotiating or otherwise influencing the outcomes of international declarations. The major meetings and outcomes included in this analysis are: the International Conference on Population and Development (1994); the Fourth World Conference on Women (1995); the Millennium Declaration (2000); and the Children’s Summit (2002). What follows is a summary of the findings.

The 1994 International Conference on Population and Development represented a paradigm shift on approaches to population, women’s rights, and sexual and reproductive health. Prior to the ICPD, most leaders in the population community were concerned primarily with achieving demographic targets, rather than meeting individuals’ needs for health services and information.

The ICPD Programme of Action was a watershed for safe motherhood: for the first time, a UN document defined a time-bound and measurable goal for maternal health: to reduce maternal deaths by 75% by the year 2015. The safe motherhood commitment included in the ICPD Programme of Action has been reaffirmed by several major global agreements negotiated since the ICPD, including the Platform for Action of the Fourth World Conference on Women, the outcome documents from the UN General Assembly Special Session on HIV/AIDS, the UN General Assembly Special Session on Children, and the Millennium Declaration.

21 NB: The overwhelming majority of content in this section discusses the ICPD. With the exception of one sub-paragraph on eliminating punitive measures for women who obtained illegal abortions, the FWCW document’s safe motherhood language was basically identical to that of the ICPD. Additionally, the informants noted that the group of countries that opposed language on family planning and unsafe abortion at the ICPD made the same objections at the FWCW and, as at the ICPD, eventually joined the consensus, albeit with reservations.  

22 While the 1990 World Summit for Children “Plan of Action for Implementing the World Declaration on the Survival, Protection and Development of Children in the 1990s” included a goal to reduce maternal mortality by 50% by 2000, it did so in the larger context of a set of quantitative goals focused primarily on child and infant health and well-being. The ICPD Programme of Action placed maternal health in the reproductive health framework; in addition, at the ICPD, the international community pledged financial and other resources to realize this promise.
The informants reported unanimously that the inclusion of an explicit goal on safe motherhood was a precedent-setting event that elevated safe motherhood from an overlooked public health problem to a central development goal. This section discusses the factors that led to the inclusion of safe motherhood in the ICPD Programme of Action and how this commitment has been reaffirmed and expanded upon in subsequent international agreements.

• Regional conferences organized by the Safe Motherhood Initiative in the Arab region, Southern and Francophone Africa, South Asia, and Latin America in the late 1980s and early 1990s, as well as a range of national workshops and conferences, raised the profile of safe motherhood, and helped to pave the way for the inclusion of a holistic approach to safe motherhood in the ICPD Programme of Action. Because of these meetings, there was familiarity with and support for safe motherhood when the preparatory ICPD meetings took place. For example, many of the ICPD Preparatory Committee and regional meeting governmental delegations included ministry of health staff and parliamentarians who had participated in the SMI regional meetings, and they were strong advocates for safe motherhood. Further, the SMI’s wide dissemination of messages and other outcomes from the regional SMI meetings helped to raise awareness of safe motherhood among policymakers, NGOs, and the media.

• The leadership of the ICPD secretariat (UNFPA) and key individuals played a critical role in securing commitment to safe motherhood at the Cairo Conference. One informant noted that, since its first decade, UNFPA has been involved in efforts to improve maternal health and that UNFPA dedicated a significant portion of the time allocated to the ICPD regional preparatory meetings to discussions of the centrality of safe motherhood to reproductive health and development. In addition, Dr. Fred T. Sai’s strong leadership as ICPD Chair and his long history of involvement in maternal health played a critical role in securing the safe motherhood goal.

• During the ICPD preparatory process, a large coalition of NGOs focused on sexual and reproductive health, eventually numbering more than 1,000 organizations from all regions of the world, concentrated its efforts on lobbying for strong commitments to a comprehensive approach to sexual and reproductive health, of which safe motherhood was an intrinsic element. One informant noted that much of the draft language contained in the coalition’s proposals was incorporated verbatim into the ICPD Programme of Action. The NGO coalition, along with European and African governmental delegations, worked with the conference secretariat to highlight the importance of a strong agreement that took a life-cycle approach to reproductive health, population, and development.

All informants reported that, given the awareness of safe motherhood that was raised prior to the ICPD, the Programme of Action’s safe motherhood goal enjoyed near-universal support. However, achieving consensus on addressing a leading cause of maternal death—unsafe abortion—was

23 One informant recalled the Holy See being the only delegation that opposed the goal to reduce maternal deaths by 75% by 2015. This was based on the Catholic Church’s long-standing proscription against “artificial methods” of family planning, which were recognized as being key to reducing unintended pregnancies and, by extension, maternal deaths.
among the most hotly-contested issues at the ICPD and FWCW. Several informants recalled that a small, vocal minority of delegations from conservative member states made a sustained effort to prevent consensus on language calling for action on unsafe abortion and on making reproductive health services available on a universal basis.

Finally, it was noted that safe motherhood served an important political purpose for addressing some of the more controversial issues in the Programme of Action. Framing the reproductive health agenda as critical to reducing maternal mortality made it possible to discuss and achieve agreement on issues that were sensitive or controversial, such as unsafe abortion, and enabled delegates to embrace the comprehensive approach to reproductive health.

Second, the safe motherhood goal was seen by some as a “substitute” for the reproductive health goal. One informant recalled that the dynamic of the Millennium Declaration process was markedly different from that of the ICPD and FWCW. Unlike the conferences of the mid-1990s, NGOs were provided little access to the Summit, limiting the possibility of advocacy. Another difference was the format of the negotiations: the overwhelming majority of the Declaration’s text had been negotiated through informal diplomatic discussions well in advance of the Summit itself, further limiting advocacy efforts. A small minority of conservative governments threatened that, if the reproductive health goal was included as one of the Millennium Development Goals, they would block the consensus. However, these governments also indicated that a goal on maternal health would be an acceptable substitute.

Thus, the inclusion of an explicit Millennium Development Goal on improving maternal health was driven by the recognition of its centrality to development and poverty alleviation in general, as well as by political compromise.

The UN General Assembly
Special Session on Children

The UNGASS on Children, held in 2002, was a ten-year review of the World Summit for Children. It aimed to assess progress on improving children’s lives and to identify additional interventions necessary to achieve the goals of the World Summit.

One informant recalled that commitments to safe motherhood were included in the draft outcome document draft prepared by UNICEF (the UNGASS secretariat). The draft document framed safe motherhood as necessary for improving women’s health and infant and child survival, and included key actions on priority areas such as increasing access to skilled care during childbirth. This was a very effective strategy: although the most powerful governmental delegation—that of the United States—attempted to weaken the discussion of maternal health by equating safe motherhood with abortion, all other delegations reiterated their commitment to safe motherhood, leading the United States to retreat. The informant recalled that, by the time of the UNGASS on Children, safe motherhood was widely accepted as a key development goal; governments were focused on identifying and implementing maternal health interventions and were not interested in revisiting old debates. Additionally, the informant recalled that a number of delegates referenced materials prepared by the SMI when making statements on recommending strong safe motherhood language in the document.
This section assesses how media attention for safe motherhood has changed over time, specifically analyzing the impact of the Safe Motherhood Tenth Anniversary media campaign. In addition, trends in press coverage between 2000 and 2005 were analyzed to ascertain how safe motherhood has fared in national and international media outlets.

**Safe Motherhood at 10**

As part of the Safe Motherhood Tenth Anniversary programme, a media campaign was carried out to reach influential media in donor and developing countries. Elements of this campaign, which was launched following the Technical Consultation in October 1997, included:

- development of story ideas, press releases, and features;
- media training for potential safe motherhood spokespeople in both developed and developing countries;
- identification of a “circle” of 100 journalists from important print and broadcast outlets;
- a media-only Web site for information (also called a virtual press office);
- event-related press relations;
- a master press kit to help partners in developing countries extend the media attention on key safe motherhood issues; and
- development and distribution of public service announcements (PSAs).

Considerable coverage was generated by the Safe Motherhood Tenth Anniversary events (the Call to Action on World Health Day in particular) and by the PSAs, which were disseminated to over 350 TV and 200 radio outlets in more than 80 countries. The PSAs were shown frequently by such outlets as CNN International, CNBC Europe, Star TV, and MTV (North and South), as well as national television stations in Malaysia, Bangladesh, the Czech Republic, Lesotho, Pakistan, Zimbabwe, and Uganda. In a survey of country-level participants from the Technical Consultation, 70% of respondents felt that local media coverage about safe motherhood had increased during the campaign, though no formal country-by-country evaluation was conducted.

The impact of the campaign was assessed through an analysis of press coverage generated around World Health Day 1998 events in Washington, DC and around the world. Press coverage was tracked for the period covering September 1997 to October 1998, which encompassed the Technical Consultation on Safe Motherhood in Sri Lanka and World Health Day, on April 7, 1998.25 One hundred fourteen articles were analyzed across 15 markets: Australia, Canada, China, France, India, Israel, Malaysia, Russia, Singapore, South Africa, Sri Lanka, Thailand, Turkey, the United Kingdom, and the United States. Key findings are presented on the following page.

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25 The media analysis was limited to articles featuring the World Health Organization within the context of the IAG’s World Health Day activities, since World Health Day coverage was extensive and beyond the financial means and study of the communications analysis.
**Story Placement:**

• The greatest number of articles appeared in the United States (55) and the United Kingdom (17). India follows with ten articles, Sri Lanka with eight, then Malaysia and South Africa with four each. Reasons for the heightened interest in these countries include: the location of the World Health Day events and the Technical Consultation, use of local speakers and local issues, and the attendance of national figures at the events.

• A variety of wire services covered safe motherhood; they were responsible for 29% of the press. Most prominent were Associated Press, PressWire, Agence France Presse, and Reuters.

• National print was responsible for 43% of coverage. The *Daily News* (Sri Lanka) had the most articles (three) focused on the Colombo conference. The UK publications the *Daily Telegraph* and the *Financial Times* also contributed one item each. Other national print channels included the *Jerusalem Post*, the *New Straits Times* (Malaysia), and the *Straits Times* (Singapore).

**Story Sources:**

• Seventy-four of the published articles analyzed were news items, 36 were opinion pieces, three were editorials, and one was a letter. The source of the coverage was broken down as follows: interviews or press briefings (62%); third party (i.e., WHO, unicef) (19%); press releases (11%); and spontaneous coverage (3%).

• Press briefings and interviews with key spokespersons proved to be very effective; they generated good coverage of key messages both in terms of volume and favorability. Each market took a keen interest in their own leading figures, and also in the keynote figures at World Health Day in Washington.

**Story Focus and Content:**

• Media attention overwhelmingly cited World Health Day (66%). Family planning was the focus of 19 articles (driven by Hillary Clinton’s call for family planning to prevent unsafe abortion); there were also ten mentions of funding (again driven by Mrs. Clinton’s criticisms of the U.S. Congress).

• The most common messages mentioned in the media coverage were: safe motherhood is a human right (26); safe motherhood is a vital economic investment (13); and greater funding is required (6).

• Offering facts and figures in press releases and other materials helped ensure clear and consistent reportage of the extent and the medical causes of maternal mortality. Coverage of the socioeconomic and political factors was much more diverse, reflecting differing political and economic contexts for each media market.

**Media Coverage Since 2000**

This section analyzes how the media has covered safe motherhood issues since 2000, and identifies regional as well as issue-based trends in press coverage. Media reporting from January 2000 to June 2005 was reviewed for coverage of safe motherhood issues. Research was limited to English-language press sources included in the NEXIS academic universe database. To identify coverage addressing safe motherhood issues in developing countries, keyword searches were conducted using the following search terms: maternal health, maternal death, Safe Motherhood Initiative, and safe motherhood. In addition, more detailed searches were conducted for articles that had the terms “maternal health” and “Millennium Development Goals” within 25 words. The following NEXIS news libraries...
were examined: Major Papers; World News: European sources, North and South American sources, Asia and Pacific Sources, and Africa and Middle East Sources. Additionally, a compilation of news coverage on the Bush Administration’s decision to withhold the U.S. government’s contribution to UNFPA was reviewed for safe motherhood content.

Observations and Trends

Increase in Maternal Health Coverage and the Impact of the MDGs

Perhaps the most striking finding in this analysis was a progressive increase, during the first five years of the new millennium, in the number of articles referencing “maternal health.” This trend, which holds for media outlets in each region, is strongly correlated with the adoption of the MDGs in late 2000. In years 2001 through 2005, MDG reporting increased references to maternal health by a significant margin.

From January 1, 2001 until June 1, 2005, maternal health was mentioned in 561 articles from Middle Eastern and African sources in the World News library (see graph below). Two hundred thirty-one (41%) of these articles focused on the MDGs (the remainder of the articles reported on a range of safe motherhood issues such as new maternal mortality estimates, the impact of unsafe abortion on women in the region, and donor funding for national or regional maternal health interventions). In comparison, from June 30, 1996 until December 31, 2000, maternal health was mentioned in just 172 articles from Middle Eastern and African sources.
As the graph below illustrates, similar trends appear in the Asia and Pacific region. From January 1, 2001 until June 1, 2005, maternal health was mentioned in 813 articles; 212 (26%) of which were focused on the MDGs (the Asia and Pacific region includes Australia; 89 of the non-MDG articles identified in this search discussed domestic Australian maternal health issues). In comparison, from June 30, 1996 until December 31, 2000 just 290 articles from the Asia and Pacific region mention maternal health.

While the MDG-related articles were numerous, most of them did not dedicate significant attention to maternal health. Frequently, maternal health appeared merely in a summary of goals within an article that examined a country’s effort to achieve one of the other goals, such as reducing poverty or increasing primary school enrolment. Overwhelmingly, MDG-focused articles that were maternal health specific either lauded a country’s success in improving safe motherhood or lamented the likelihood that the country would fail to meet the maternal health goal by 2015. Regional differences in whether the coverage was slanted toward “lauding” or “lamenting” maternal health were striking.

In Asia, in safe motherhood “success story” countries such as Sri Lanka and Malaysia, the governments garnered media attention for their assertion that they had met the goal of reducing maternal mortality by 75%. Interestingly, the Chinese government asserted that, while progress had been made, they needed to work harder to meet their MDG on maternal health and noted that expanding access to skilled care during childbirth was key to achieving a 75% reduction in maternal mortality by 2015.
In Africa, most of the maternal health-specific MDG coverage lamented the prospect that key countries would not achieve the maternal health MDG by the 2015 target. Country-specific coverage included articles from Zambia, Kenya, and Ghana. Additionally, several articles from African (Pan-African News Agency) and other regional press outlets (such as Deutsche Press-Agentur and Xinhua News) reported that maternal mortality was increasing in countries affected by civil unrest and/or armed conflict such as Zimbabwe and Sierra Leone.

Overall, while the MDG process appears to have raised the media’s awareness of maternal health issues, much of the coverage to date has been superficial. This suggests that there is a need for press outreach that emphasizes the centrality of the maternal health goal to the achievement of poverty alleviation and sustainable development as a whole.

**Other Trends**

**Reframing of Maternal Health Issues**

Media coverage of maternal health has generally focused on the numbers or rates of women who die each year from pregnancy-related causes, with the release of maternal mortality estimates by the UN agencies approximately every five years garnering significant press attention. In the last 5–6 years, media coverage has broadened to discuss effective interventions, in part reflecting efforts by the press offices of technical and funding agencies (such as WHO, unicef and UNFPA) to frame maternal mortality as a problem with known solutions, requiring political will and resources. For example, 14 of 15 articles on UNFPA’s efforts in October and November 2001 to provide health care to women refugees from Afghanistan mentioned either safe birthing kits or the importance of giving birth with a skilled attendant.

**Mother’s Day**

The use of Mother’s Day as a news “hook” has helped generate coverage when coupled with the release of new information or data. For example, in the United States in 2000 and 2001, just two columns focused on safe motherhood; once Save the Children began to release its “Save the Mothers” report on Mother’s Day, Mother’s Day press coverage of safe motherhood issues increased significantly. In 2003, 2004, and 2005, 20 Mother’s Day articles featuring the “Save the Mothers” report were identified. This report focuses on a different aspect of safe motherhood every year and also includes the popular “Mothers Index,” a compilation of country-level data on key maternal health indicators.

**Coverage of Unsafe Abortion**

During the analysis period for media coverage (January 1, 2000 through June 1, 2005), unsafe abortion was cited more frequently than any other single cause of maternal death and disability. Unsafe abortion was cited in 993 news articles from the World News library in NEXIS. Twenty-eight percent of these articles discussed the causal relationship between unsafe abortion and maternal death, many citing the toll of unsafe abortion in a specific country (such as Kenya, the Philippines, and Colombia). Additionally, 17% of the coverage focused on the impact of the Bush Administration’s policies on reproductive health and referenced how such policies were having a negative effect on efforts to reduce unsafe abortion.
Additionally, the Safe Motherhood Inter-Agency Group meeting on unsafe abortion, held in Kuala Lumpur in September 2003, generated national attention in Malaysia, where Bernama (the Malaysian National Press Agency) published an article that was made available via the Financial Times’s Global News Wire and reprinted in at least four newspapers around the world.

Lessons Learned

The prominence of the MDGs in the media presents an important opportunity to ensure that MDG-related press highlights safe motherhood. To this end, it is important to consider special MDG press outreach focused on maternal health. Such outreach could include media-friendly case studies of success and challenge countries.
Since the launch of the SMI in 1987, the landscape of agencies working in the field of maternal and child health has changed significantly. The number of development agencies with dedicated safe motherhood programs has grown dramatically, and safe motherhood has received increasing priority. Donor agencies’ funding commitments to safe motherhood have also risen, in response to international mandates such as ICPD and the MDGs. However, funding remains inadequate to achieve the Initiative’s goals.

A review of organizations and agencies working in health and development just prior to the launch of the Safe Motherhood Initiative in 1987 revealed that few (approximately six agencies) had specific programs focusing on maternal health. In 1992, five years after the SMI launch, the number of agencies with safe motherhood as a priority increased to 26 (including multilateral organizations) as part of an analysis conducted in preparation of a meeting of Partners for Safe Motherhood, which reviewed progress and prospects for safe motherhood between 1987 and 1992.

The agencies that had identified safe motherhood as a priority issue around the 1987 conference included:

- **The World Bank:** As one of the longest and most consistent supporters of the global Initiative, the Bank has used its financial clout to increase investment in maternal health policies and programs. In the ten years following the SMI launch in Nairobi, World Bank–funded projects for safe motherhood increased substantially—from ten to 150 projects. The Bank has also been a critical partner in the Safe Motherhood Inter-Agency Group, through its periodic role as chair and its financial support of the secretariat.

- **The World Health Organization:** As one of the co-sponsors of the Nairobi Safe Motherhood Conference, the World Health Organization (WHO) has long identified safe motherhood as a core priority area. WHO has provided technical leadership in the design, implementation, and evaluation of programs to governments, and has worked in collaboration with NGOs and health professional groups, among others, to strengthen the provision of maternal health services. The clinical guidelines, policy briefs, training modules, and research reports and methodologies it has produced on maternal health have been widely used and adapted.

- **UNFPA:** Following the ICPD in 1999, UNFPA’s focus on maternal health increased dramatically. Its current strategy for preventing maternal mortality includes family planning to reduce unintended pregnancies; skilled care at all births; and emergency obstetric care for women who develop complications. At the country level, safe motherhood features prominently in UNFPA’s programs, and the agency’s experience working in safe motherhood in over 140 countries has provided a wealth of programming lessons for the maternal health community.

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• **Family Care International**: Family Care International (FCI) was one of the earliest NGOs to situate maternal health as central to its organizational mission. At the safe motherhood conference in Nairobi, FCI played a critical role in setting the agenda, coordinating the meeting logistics, and documenting and disseminating the conference findings. In its role as secretariat to the Safe Motherhood Inter-Agency Group (IAG, 1987–2004), FCI helped shape the global landscape for safe motherhood; the materials produced with and on behalf of the IAG, as well as the conferences it organized, influenced the policy agenda at the global and national levels, set technical priorities, and raised awareness around this public health tragedy.

• **MotherCare (a USAID-funded project implemented by John Snow International)**: From 1990 to 2000, MotherCare was USAID’s flagship project on maternal health (subsequently superseded by the Maternal & Neonatal (MNH) Program and ACCESS). With the aim of improving the health, nutrition, and survival of women and newborns through a continuum of care, it provided evidence-based programmatic approaches through needs assessments, monitoring and evaluation, and policy dialogue. The lessons and experiences gleaned from MotherCare’s work in over 25 countries had a significant influence on the design, planning, and implementation of safe motherhood programs in the decades to come.

• **The Safe Motherhood Inter-Agency Group**: Founded in 1987 following the Nairobi conference, the Safe Motherhood Inter-Agency Group was launched in an effort to redress the gross neglect of maternal mortality and morbidity in the priorities of development agencies, within the national plans of developing country governments, and in the mindsets of the general public. Bringing together UN agencies and civil society partners, the IAG was an unprecedented partnership of organizations united by a common goal: to halve the maternal mortality ratio. While its impact on the global SMI is difficult to determine in quantitative terms, it is clear from informal feedback and a general assessment of trends that the IAG has made substantial inroads for maternal health on the policy, advocacy, and technical fronts.

• **Columbia University, Prevention of Maternal Mortality Program**: From 1988 to 1996 researchers at Columbia University, New York, collaborated with a network of eleven multi-disciplinary teams in West Africa (based in Ghana, Nigeria, and Sierra Leone), called the Prevention of Maternal Mortality (PMM) Network. These teams carried out operations-research projects on maternal mortality, collected a body of information on the design and evaluation of such programs, and produced analytical work that significantly influenced program design (such as the “three delays” model, which analyzed the factors that prevent women from receiving essential care, and their focus on the importance of emergency care for life-threatening complications). Their experiences have provided the safe motherhood community with solid evidence on the types of interventions that have the greatest impact on reducing maternal death and disability.
Beginning in the 1990s and continuing into the new millennium, a number of large, visible, and relatively well-funded projects and programs aiming to reduce maternal mortality were launched. These included the Averting Maternal Death and Disability (AMDD) program, implemented by Columbia University and partner agencies; the Initiative for Maternal Mortality Programme Assessment (IMMPACT) project which is coordinated through the University of Aberdeen; FCI’s Skilled Care Initiative; and the USAID-sponsored MNH Program and ACCESS housed at JHPIEGO. These projects/programs are a testament to the increasing visibility and import accorded to safe motherhood as an issue area over the last decade.

• AMDD was launched in 2000 as a large-scale demonstration project focusing on implementing emergency obstetric care interventions in low resource developing countries through a human rights–based approach. Implemented in over 50 countries, the program has achieved high impact, high visibility, and is well-regarded by governments, international development agencies, and civil societies.

• IMMPACT is a global research initiative that aims to provide rigorous evidence of the effectiveness and cost-effectiveness of safe motherhood interventions, specifically in terms of equity and sustainability. Funded by a range of development aid agencies, IMMPACT plans to develop a series of tools and methodologies, among other activities, by the end of 2007.

• FCI’s Skilled Care Initiative is an innovative five-year project being implemented in three rural, underserved districts in Burkina Faso, Kenya, and Tanzania to improve women’s access to skilled care during pregnancy and childbirth. The project examines the feasibility, cost, and impact of implementing a comprehensive approach to skilled care during childbirth in low-resource settings.

• ACCESS is USAID’s flagship program on maternal health. Building on the work of the MotherCare and MNH projects, ACCESS aims to improve the availability, access, and use of maternal health and newborn services in select countries around the world. ACCESS works at the clinical and community levels (from the facility to the household) in an effort to bring care as close as possible to women and their families.

In order to assess how safe motherhood has fared at the policy, program, and budgetary levels within development and donor agencies, interviews were held with selected representatives between May and July 2005. The objectives of the research were to:

• Assess agency trends in policy commitment to safe motherhood over the last ten years.
• Track agency trends in funding for safe motherhood/maternal health over the past ten years.
• Identify the main factors that have shaped development agencies’ commitment to and investment in safe motherhood.
• Evaluate general trends and events that have influenced funding for and progress toward achieving safe motherhood goals.
Sixteen representatives from major international development agencies based in the U.S. and Europe were interviewed for this report. Responding to a pre-set questionnaire, representatives shared information regarding their agencies’ commitment, funding, and technical priorities related to safe motherhood.

The majority of development agency representatives (13 out of 16) participating in the survey reported that over the past ten years safe motherhood has remained a consistent priority within their agency. Safe motherhood was often classified as one of the priorities within the larger gamut of sexual and reproductive health or broader development issues such as gender and violence, and many representatives identified specific aspects of safe motherhood (skilled care during childbirth, postabortion care, and malaria in pregnancy) as key priority areas over the past ten years.

The factors that contributed to the inclusion of safe motherhood as an agency priority were varied. For some agencies, it was driven entirely by internal push factors—individuals interested in promoting safe motherhood—while others were influenced by external factors such as research, evidence from the field, and global conferences on maternal health.

The majority of agencies felt that maternal health would continue to be a priority in the future in some capacity or the other: 13 of the 16 respondents explicitly identified maternal health as a future priority area for their agency. The clear trend was integrating safe motherhood with other areas: specifically, agencies planned to develop linkages between safe motherhood and HIV/AIDS, given the increasing importance of preventing mother-to-child transmission. Another proposed area of integration is maternal health and newborn health.

“Safe motherhood will become a bigger part of our work in the next few years. One reason for this change is the new approach to working with mothers and newborn care….With new money from foundations, there is a lot of energy around newborn health.”

One representative noted that newborn health programs typically have different strategies and priorities than those focusing on maternal health. For example, they place considerable emphasis on community-based care, including hygienic delivery, cord care, breastfeeding, kangaroo care, etc.; emergency obstetric care, abortion-related care, and addressing obstetric fistula are not typically part of newborn care programs. With more and more donor funding focusing on integrating newborn and maternal health, it may become challenging to marry the varying priorities.

28 Participating agencies included: Academy for Educational Development; Alan Guttmacher Institute; American College of Nurse Midwives; Care International (USA); EngenderHealth; Family Health International; Global Health Council; International Planned Parenthood Federation; Ipas; International Rescue Committee; IntraHealth International; Pathfinder International; Population Reference Bureau; Program for Appropriate Technologies in Health; Save the Children; Women’s Commission for Refugee Women and Children.
The trend toward integrating safe motherhood with other development issues stems from addressing the entire continuum of women’s health issues. In addition, several representatives noted that safe motherhood is gaining greater prominence with other relevant development issues:

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The role of safe motherhood is evolving within HIV/AIDS; for example, looking at the safety of contraception and prevention of unwanted pregnancy for HIV-positive women is increasingly being encompassed in HIV/AIDS work. So aspects of safe motherhood are expanding to cover new areas.
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Representatives were asked to reflect on shifts in programmatic and technical areas within their agencies over the past ten years. Commonly recurring themes include the following:

- **A shift from primarily emphasizing facility-level work to building capacity at the community level.**
- **Focusing on the entire health system,** which involves strengthening capacity at all levels of the health care infrastructure, from primary to referral levels, and engaging community members in service provision. Specific programmatic areas of focus include: improving referral and transfer to higher-level facilities; improving communication systems; strengthening skills in emergency obstetric care at all levels.
- **Increased advocacy** for all sexual and reproductive health issues, including increasing women’s access to safe abortion services (where not against the law) and the health consequences of unsafe abortion. One respondent noted that advocacy efforts need to be supported by clear, evidence-based interventions with demonstrated impact.
- **Increasing emphasis on the “rights framework”** which situates safe motherhood as an essential human right, and includes the right to receive basic health care services.
- **Emphasizing skilled assistance at childbirth and emergency treatment for complications.** Representatives noted that there has been growing consensus that skilled care at the time of childbirth, along with emergency obstetric care to handle complicated cases, is a critical intervention for reducing maternal mortality.

These changes in programmatic and technical emphasis were attributed to two broad areas:

- **The impact of international conferences and discussions, global partnerships, and global advocacy initiatives for maternal health:**

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International dialogue tells us what is important. We are constantly informed by what is happening internationally. For example, recently WHO has emphasized safe motherhood and newborn care to be looked at collectively, and this has influenced our thinking.
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- **Lessons learned from the field:**

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We are influenced by programming in the field. The lessons learned are adapted into our programs.
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Representatives emphasized the importance of operations and field research in providing evidence for the design and development of program interventions. For example, the recent focus on neonatal mortality reduction rose in large part from evidence illustrating that simple, home-based interventions can reduce neonatal deaths. Research in particular can identify what the gaps are and what can be done to address them.

Some representatives also discussed the influence of donors and specifically noted that agencies’ programming priorities were shaped by what donors wanted and were willing to fund.

Data on annual health expenditure was available from 12 of the 16 representatives interviewed for this survey. Among the 12, only five agencies specifically earmarked funds for maternal health, and their maternal health budgets ranged from 10–60% of their total annual health budget; seven agencies do not earmark funds by topical area, or they no longer allocated specific parts of their health budget to maternal health activities. Of the latter, some agency representatives explained that they did not receive funds specifically for safe motherhood (or other areas), but rather funding was country-specific and for a specific project or program. Another agency representative said that until 2000 they received funding specifically for safe motherhood; this is no longer the case, and now they receive lump sum funds for a range of reproductive health issues, with maternal health programs included in this package.

Among those who reported expenditure information, the majority (7 out of 12 representatives) reported that their agencies’ maternal health budget as a proportion of the total annual health budget had increased. They attributed this increase to a recent heightened emphasis on safe motherhood and other reproductive health issues, as well as the rise in funding for specific aspects of safe motherhood such as postpartum care, skilled assistance, etc. Further, with the integration of safe motherhood and newborn health—an area of growing importance—more funding was becoming available for safe motherhood activities.

**Donor Agency Trends**

All donor agency representatives participating in the survey reported that over the past ten years, safe motherhood had consistently been a priority area for their agency. Reasons cited for its inclusion as a priority area included: the influence of the 1987 Safe Motherhood conference and the ICPD conference in 1994; the identification of maternal health as a goal in the MDGs; and the beliefs of individual members within the agency.

“Reaching the MDGs and poverty reduction is our first goal, yet maternal health has become increasingly important since it has become a milestone in the MDGs.”

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29 Donor agencies participating in this review included: The Bill & Melinda Gates Foundation; Department for International Development (DFID), UK; Department for Development Aid Cooperation, Finland; MacArthur Foundation; Swedish International Development Cooperation Agency (Sida); United Nations Population Fund (UNFPA); United States Agency for International Development (USAID); The World Bank; and World Health Organization.
All but one representative felt that safe motherhood would continue to be a priority area in the future, and the majority (five out of nine respondents) felt that its importance would increase. With the MDG goals of improving maternal health and reducing childhood mortality, many representatives felt that safe motherhood was now back on the map and gradually regaining importance. Some respondents also pointed out that their agencies were integrating maternal and newborn health, and hence in terms of priority and budgets safe motherhood would become increasingly important in the future.

Many of the representatives interviewed identified a dramatic shift in funding strategies and priorities in the health field in general, and safe motherhood specifically. Most agencies are now shifting from a piecemeal approach to a health systems approach. This encompasses all aspects of the health system such as upgrading communications systems, strengthening the capacity of health workers, setting up referral systems, etc. Since maternal health depends upon a working health system, many donors identify safe motherhood as a barometer of the overall health system.

- With the identification of maternal health as one of the MDGs, donors feel their energy is invested less on funding service delivery programs or projects, but on scaling-up operations in an effort toward achieving broad development goals.

- There is increased emphasis on financing mechanisms. Donors now consider it important to have a public health system with detailed data on costs for each health service. This level of detail is considered critical for efficient fund allocation, and in order to measure success. Sector-wide approaches (SWAps) are increasingly being pushed and endorsed by more donors, and they are aiming to advocate for increased maternal health allocation in SWAp budgets.

A discussion of financial trends for safe motherhood is provided in section VI.

“We, unlike other agencies, which may say they work on emergency obstetric care, are working at improving national-level health systems. We are also trying to influence technical reform and decentralization of health care delivery.”
To provide an assessment of financial flows for safe motherhood since 1987, several data sources were used:

- A World Bank–sponsored report, *Supporting Safe Motherhood: A Review of Financial Trends*, assessed funding levels related to official development assistance (ODA) for three years (1986–1988). The review employed data sets from this time period, supplemented with interviews with donor representatives and official annual reports from bilateral and multilateral agencies. The study included the following project/program categories: those specifically labeled “safe motherhood activities”; projects categorized as maternal health programs; family planning and population programs; general health system projects with components that contribute to improving maternal health; nutrition programs; IEC programs; women in development projects; and intersectoral programs that benefit women of reproductive age through improvements in education, employment, rural development, or agriculture.

- The UNFPA/NIDI resource flows database, covering a time span of 1996–2002, was developed following ICPD to track resources for the “costed package,” a set of reproductive health interventions and services (including family planning, basic reproductive health, STD and HIV/AIDS prevention, and research policy analysis). Maternal health care is included under the basic reproductive health category. The database assesses financial flows for population via bilateral, multilateral, and private-sector channels, as well as from development banks.

- A series of interviews with key safe motherhood bilateral and multilateral donors to assess changes in funding priorities for reproductive health generally and safe motherhood specifically, and to identify future funding directions for safe motherhood.

While these sources provide a snapshot of how funding for safe motherhood has fared over time, they do not yield a complete analysis of financial trends since the launch of the Initiative. Since the data sets are not comparable, information from one source cannot be used in conjunction with the other, resulting in data and time gaps. Efforts to collect data from individual donor agencies regarding safe motherhood expenditures were problematic, primarily for two reasons:

- lack of electronic information systems (and dedicated staff) that have kept track of funding data since the mid-1980s;
- tendency to aggregate safe motherhood into broader reproductive health and/or population programs, thereby making it difficult to isolate how much is actually spent on safe motherhood projects and programs.

### Funding for Safe Motherhood Following the SMI

In May 1990, the World Bank commissioned a report to assess how financial flows for maternal health changed since the launch of the global Safe Motherhood Initiative. Focusing specifically on ODA (and not other funding sources, such as foundations or NGOs), the analysis estimated trends in external financing for safe motherhood in developing countries.
According to the report, for the 17 bilateral sources, assistance for safe motherhood increased from US$691.5 million in 1986 to US$818.8 million in 1988 (in current dollars); for the six multilateral agencies, spending increased as well, from US$396.7 million (1986) to US$477.7 million (1988).  

Interviews with the major bilateral and multilateral agencies were held to assess individual agencies’ commitment to safe motherhood and respective funding expenditures to developing countries. Covering the period from 1985 to 1988, all 17 bilateral donor representatives and six multilateral agencies included in the survey reported a gradual increase in current dollars for safe motherhood and indicated plans to increase financial support for safe motherhood in the future.

**Funding for Safe Motherhood following the ICPD**

As noted above, the ICPD provided cost estimates for the implementation of a set of services needed to achieve universal access to reproductive health by 2015 (the ICPD “costed package”), and initiated a mechanism for tracking donor expenditures toward this goal. Initially, the majority of expenditures (70%) were on family planning and reproductive health services, with the latter including information and routine services for prenatal, delivery, and postnatal care; abortion and postabortion care; and complications of pregnancy and delivery. Trends in the ICPD categories over time, as outlined in the graph below, point to a sharp increase in expenditures toward STIs and HIV/AIDS in response to the escalating AIDS crisis. Expenditures for basic reproductive services, which include maternal health, appear to have remained fairly constant between 1996–2004, with small spikes and declines from one year to the next.

![Graph showing donor expenditures on ICPD costed-population package categories](http://www.resourceflows.org/index.php/articles/c78/)


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30 Since bilateral data can include government contributions to multilateral and United Nations agencies, expenditures from both categories cannot be summed to yield an annual total. The financial data represent donor allocations for a specific year.
In addition to examining trends in broad categories of the ICPD costed package, a word search of safe motherhood–related terms was conducted to obtain expenditures specific to maternal health between 1996–2002. The analysis revealed that the total amount of funds spent on safe motherhood projects increased steadily from US$74.75 million in 1996 to US$182.63 million in 1999; from 1999 to 2002, however, there was a gradual decline in the amount of funds, to US$177.93 million. It is interesting to note that the amount of funding peaked in 1999, the period corresponding with the tenth anniversary of the Safe Motherhood Initiative.

As the next graph outlines, the number of safe motherhood projects and programs illustrates a rising trend, with an increase from 366 programs in 1996 to 468 in 2002.

Geographic distribution of funds for safe motherhood between 1996 and 2002 provides insight into how donor priorities have shifted over time: in 1996, the region receiving the largest number of funds was Asia and the Pacific, followed by Global/Inter-regional, with Western Asia and North Africa rounding out the top three. In 2002, regional priorities related to safe motherhood shifted, such that Global/Inter-regional received the largest share of donor funds, Asia and Pacific the second largest share, and sub-Saharan Africa the third largest. With data unavailable for 2003 and 2004 at the time of publication, it is unknown how these regional allocations have changed; however, there are indications that more funds are being directed toward sub-Saharan Africa, in large part a result of stagnating, and even rising, maternal mortality levels.

Donor Funding Trends for Safe Motherhood

Interviews were carried out with nine key safe motherhood donor agencies, representing bilaterals, multilaterals, and foundations31 (see Annex I for full list of agencies), in an effort to assess past and

31 Donor agencies participating in this review included: The Bill & Melinda Gates Foundation; Department for International Development (DFID), UK; Department for Development Aid Cooperation, Finland; MacArthur Foundation; Swedish International Development Cooperation Agency (Sida); United Nations Population Fund (UNFPA); United States Agency for International Development (USAID); The World Bank; and World Health Organization.
future funding trends for safe motherhood. Data on annual health investments (from 2004 or the last fiscal year for which data were available) were made available by all donor representatives interviewed for this survey: most indicated that funds for maternal health had increased in their agencies in the past ten years.

With regard to overall trends in maternal health funding, donors had mixed views as to whether funding has increased or decreased. Half the respondents felt that the total funds available for maternal health had increased in the recent past with additional funds coming in from new donors such as the Gates Foundation and DFID. Representatives noted that, as a result of the identification of maternal health as one of the MDGs, donor commitment and collaboration had increased. They hoped that this would translate into more money for maternal health in the near future.

We can say that with the MDGs, maternal health is now on the map and it has now become an issue of knowing what to do and how to scale it up. It is less about getting people’s attention, but of actually setting things in place.

Others felt that there had been no change in funding for maternal health, and if anything, funds had slightly decreased. Although overall donor commitment to reproductive health seems to have increased, it was difficult to tease out the impact on maternal health. Measuring funding levels for maternal health is likely to become even more difficult in the future, with donors and foundations moving toward a more integrated or basket approach to funding using channels such as SWAps and Poverty Reduction Strategy Papers (PRSPs).

Donor agency views on whether global concern about HIV/AIDS has resulted in funds being shifted from safe motherhood varied, reflecting at least in part different internal mechanisms and funding flows. Four donor representatives stated that in their view the impact has been negative, since in their agencies funds for maternal health and HIV/AIDS were drawn form the same pool.

...donors need to fund the Global Fund initiative, and this is normally quoted as the reason why funding in other areas is not going.

In cases where HIV/AIDS funds do not necessarily come from the same pool, donor representatives indicated that “it would be incorrect to say that HIV/AIDS is taking money away from maternal health.” One representative noted that, “The whole pie has increased, so not sure it is an issue of sucking funds away from one area to the other.”

A handful of donor representatives also felt that despite the fluctuations in the past, things were beginning to change, and that money would be coming back to maternal health.

The fund committed to HIV/AIDS has already been allocated, and now new money is available to maternal health.

Donor representatives were asked to comment on whether the current-level funds were adequate for meeting the ICPD and MDG goals for maternal health, and to suggest how to augment funding levels. While all representatives agreed that funds were inadequate to meet stated maternal health goals, they proposed a wide range of solutions, including the following:
• Central to increasing funds is doubling advocacy efforts around maternal health, and developing stronger linkages between maternal health and other public health priorities.

“Part of the problem is our inability to connect things. Internationally we discuss SM and HIV separately, but the issues in both areas are common and should be discussed on the same playing field.”

• Several donors called for broadening focus from an issue-specific approach (focusing on single areas such as maternal health or HIV/AIDS) to one on health systems; this would build technical capacity and infrastructure, and have a much wider impact on several public health priorities.

• Also cited was the need to increase political will and donor commitment to maternal health. A few representatives felt that the donor community had not fulfilled its own commitments, and that governments and donors both must increase the total amount of funds available.

“Part of the problem is us. We are too focused on the money but not on how it is being used. Money will always be inadequate, but we need to focus on how best to use what is available and countries need to start investing themselves.”

• Finally, some representatives felt that funds would always remain short of what is needed. It may be more important to focus on using funds efficiently, and not on how much money is available.
Political commitment and action in support of safe motherhood have been mixed at the country level: in some countries (e.g., Malaysia, Sri Lanka, Egypt, Honduras) concerted efforts on the policy, program, and budgetary fronts resulted in improved access and availability of maternal health services and a reduction in maternal mortality levels; in other countries, maternal mortality ratios have stagnated, and in some settings, appear to have increased.\(^{32}\)

What needs to be in place at the national level in order for pregnancy and childbirth to be safe for all women? Several published reports\(^ {33}\) have examined the strategies and interventions that have been conducive for improving maternal health. Building upon this body of work, this report seeks to analyze the development of national (government) policies, programs, and budgetary allocations for safe motherhood in select countries in Latin America, sub-Saharan Africa, and Asia, in particular focusing on the time period from 1987 to the present. In consultation with a range of partners, the following countries were identified: Bolivia, Indonesia, Lao People’s Democratic Republic, Malawi, Mali, and Tanzania.

The profiles provide a brief overview of the key policy, programmatic, and budgetary efforts related to safe motherhood in these countries, and as such are not a comprehensive analysis of what has occurred at the national level. They examine how and why maternal health was identified as a national priority, what main programmatic strategies were put forward, and what have been the associated budgetary allocations. For those countries operating under SWAps, it assesses to the extent possible how maternal health has fared within this resource-allocation mechanism. Through interviews and document research, in-country consultants traced the development of each government’s commitment to safe motherhood; identified the main programmatic priorities; and, to the extent possible, analyzed the budgetary allocations for safe motherhood. What follows are the main findings from each of the country reviews.

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In Bolivia, maternal mortality stands at 229 deaths for every 100,000 live births. In the last ten years, between 1991 and 2001, Bolivia was able to reduce maternal mortality by 40%, from 390 to its current level. In spite of this decline, maternal mortality remains a health problem, particularly for women in lower social strata and income levels. Wide disparities in the country’s socioeconomic indicators pose an obstacle for effectively guaranteeing all Bolivian women a safe pregnancy and childbirth.

Bolivia is located in the heart of South America. It is bordered by Brazil at the north and east, Argentina in the south, Peru in the west, Paraguay at the southeast, and Chile at the southwest. The country is divided into three significant geographical areas: the Andean zone which covers 28% of the territory, the sub Andean zone (13%), and the Plains, at 59%.

The 2001 census indicates a population of just over 8 million inhabitants. The population structure by age suggests Bolivia is a “young” country: 38% of the population is under the age of 14 years, and 56% between 15 to 64 years. Bolivia is among the three poorest countries in Latin America, as evidenced by the high levels of inequality: 49% of Bolivia’s municipalities have a very low Human Development Index, 35% are at the low level, and the remaining 16% are at the medium level. The average income of the richest 10% of the population is 15 times the average income of the poorest 10%.

Safe motherhood is a national priority, evidenced by the level of public discourse and in the creation of progressive national policies and programs. Since 1985 there have been more than five incumbent government administrations in Bolivia, the most recent elected by a clear majority in December 2005. While the health sector has undergone a series of structural changes, the commitment to guaranteeing Bolivian women the right to safe motherhood has been paramount in almost every government administration. The political commitment, however, has not always been translated into, or supported by, concrete actions.

**Policies for Safe Motherhood**

National policies for safe motherhood can be categorized according to the following time periods:

**1985–1989.** During this period, there was no explicit policy document on safe motherhood. While infant health was identified as a national priority, national health plans did not include concrete maternal health strategies, or set specific goals for reducing maternal mortality or increasing coverage of maternal health services.

**1989–1993.** During this period, maternal mortality was a key component of the National Child Survival Plan (which focused on service delivery), and of the ten-year Action Plan for Children and Women, which highlighted the government’s obligation to reduce maternal mortality by 50% by the year 2000. In 1993, the Andean Safe

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34 The National Statistics Institute projection for 2005 is 9,427,219 inhabitants.

35 The Human Development Index (HDI) is a composite index to measure a country’s progress in human development, as measured by life expectancy at birth, adult literacy and educational enrollment, and GDP per capita.
Motherhood Conference brought together key policymakers, program planners, and researchers from the Andean Region who worked together to analyze the problem of maternal death, develop priorities for action, and outline guidelines for inter-country and national action on safe motherhood.

1993–1997. Bolivia experienced profound structural changes that transformed the organization and operation of the national health care system. With the implementation of the Law of Popular Participation, the administrative and management functions of the public health system were decentralized from the national to the municipal levels. The National Treasury transferred funds to municipalities for health-related infrastructure improvement, while the normative functions of the Ministry of Health remained centralized.

During this period, the National Plan for Reducing Maternal and Neonatal Mortality (1994–1997) and the Life Plan for the Accelerated Reduction of Maternal and Neonatal Mortality and for Child Survival were implemented, as were several other strategic plans for improving safe motherhood at the national, departmental, and municipal levels. The National Insurance for Maternity and the Child was launched, which mandated that municipal governments provide a basic package of services at no fee to all women during pregnancy, delivery, and the postpartum period, and to children under the age of five.

In 1996, a National Safe Motherhood Committee was legally established as an intersectoral body responsible for coordinating and monitoring national action to reduce maternal mortality and morbidity. The national committee was created under the authority of the Office of the First Lady, which helped strengthen the committee’s potential to conduct outreach and advocacy at the national and international levels. Since 1996, the First Ladies of Bolivia have assumed a paramount role in promoting safe motherhood in national and international fora, including the 1997 World Health Day activities in Washington.

1997–2002. During this period, the new National Program for Sexual and Reproductive Health (1998–2002) was consolidated, and a new health insurance program (Seguro Básico de Salud) was implemented as part of the National Plan of Maternal and Neonatal Health. These programs and policies set the goal of reducing maternal mortality by 35%, and infant mortality by 15%, by 2002 (from 1991 base line figures).

With safe motherhood positioned as a key issue in the national dialogue on sexual and reproductive health, the problem of maternal death in Bolivia gained greater international visibility and attention. National action on safe motherhood led to improved coordination between and among a range of health programs. In the opinion of many health officials, this integrated approach was the factor that most contributed to reducing maternal mortality in Bolivia over the last ten years.

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36 Delegations from Bolivia, Chile, Colombia, Ecuador, Peru, and Venezuela participated as members of the Andean subregion, as well as Argentina, Mexico, Nicaragua, and Uruguay; other participants included agencies like FCI, the Population Council, IPPF, and Ipas. The meeting issued a declaration and a report.

37 Members of the council include FCI, UNFPA, PAHO/OPS, USAID, Save the Children, PROCOSI, and the Ministry of Health and Sports, and several non-health organizations. In 2002, the Committee was renamed the “Inter-Institutional Council.” Since 2004, the Council has not been in operation.
2002–2007. During this period, the Universal Maternal/Child Health Insurance Law (Seguro Materno Infantil or SUMI) was implemented, as well as a range of processes within the broader context of decentralization, including:

- strengthening the decision-making power of primary health care networks;
- building bridges between health care providers and social networks;
- improving the clinical and communication skills of providers at the health care level; and
- promoting community mobilization strategies and individual, family, and community empowerment schemes.

During this period, policies focused on the need to address obstetric emergencies and incorporate evidence-based clinical protocols—by improving the referral system, strengthening transport and communication networks, and developing strategies to promote community mobilization and advocacy in response to gaps in service. Also, the National Government adopted a set of goals including: reducing maternal mortality by 40% by 2008 and 75% by 2015 (based on 1990 levels); reducing infant mortality by 10% by 2008 in relation to the ENDSA 2003 (National Survey on Demographics and Health); and increasing the number of births assisted by skilled attendants by 24%.

Family planning has been an implicit and explicit component of national policies, especially in the 1998–2003 National Program for Sexual and Reproductive Health, and in the current 2004–2008 program, which adopts a strong rights-based approach. Ministry of Health efforts have focused on strengthening the availability of contraceptives; the introduction of Depo Provera has been a key factor in increasing contraceptive coverage. According to the 2003 ENDSA survey, in the last five years modern contraceptive method use among women in union has increased from 25.2 to 34.9%. For the first time, the increase in rural areas (from 11.3 to 25.0%) was higher than the increase in urban areas, due in large part to an increase in use of Depo Provera. The Ministry of Health considers that the higher contraceptive prevalence rates, resulting from the increase in availability of services and of modern methods, have helped result in a decrease in maternal deaths in Bolivia.

Programmatic Priorities

Technical shifts in programmatic approaches and priorities reflect the changes occurring at the international and regional levels: a shift from the risk approach to evidence-based practice; from training traditional birth attendants to promoting the use of skilled attendants and of the care they provide; from an emphasis on the mother and child to a more integrated approach that focuses on sexual and reproductive health more broadly. For example, since 1983, the risk approach was developed and implemented as a long-term strategy, staunchly supported by the Ministry of Health. From 1983 until 1994, other program strategies were put forward to complement the risk approach, including the promotion of prenatal and delivery care, and care during the postpartum period. Although the risk approach has not been completely abandoned, it became outdated with the enactment of Resolution 0496,
which introduced a set of 18 evidence-based practices to prevent the over-medicalization of delivery care, and promote the humanization of maternal and neonatal services. However, as this resolution has not been widely publicized, efforts are needed to continue to promote it.

Between 1993 and 1997, the national program for training traditional birth attendants in clean birthing techniques gradually declined and disappeared. Although there have been renewed interest and efforts to build bridges with traditional providers in the broader context of promoting inter-cultural dialogue and tolerance, this should not be interpreted as a return to former program strategies. Skilled care during childbirth and focused prenatal care were introduced after 2000, and are considered relatively new priority areas. The skilled care approach was introduced on a national scale during the Regional Technical Consultation on Skilled Care during Childbirth, convened in Santa Cruz, Bolivia in July 2003, by the Regional Task Force on Maternal Mortality Reduction in Latin America and the Caribbean. In 2003, an extensive survey was conducted to assess the conditions under which emergency obstetric services were provided at key health care facilities. Findings from the survey pointed to the urgency of improving emergency obstetric care services at the district and tertiary care levels (see Monitoring and Evaluation section).

<table>
<thead>
<tr>
<th>Type of Facility</th>
<th>1996</th>
<th>1999</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Health Center</td>
<td>891</td>
<td>1112</td>
<td>1332</td>
</tr>
<tr>
<td>Health Care Clinic</td>
<td>818</td>
<td>947</td>
<td>1129</td>
</tr>
<tr>
<td>Basic Hospital</td>
<td>111</td>
<td>127</td>
<td>155</td>
</tr>
<tr>
<td>General Hospital</td>
<td>23</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Specialized Institute</td>
<td>20</td>
<td>22</td>
<td>26</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1863</strong></td>
<td><strong>2234</strong></td>
<td><strong>2668</strong></td>
</tr>
</tbody>
</table>

Source: Ministry of Health, National Statistics Institute

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38 The resolution was adopted by the Ministry of Health in October 2001.
39 It is well known, for example, that some NGOs have been training and even recruiting lay/traditional midwives, since the decentralization process has allowed them to avoid the central and departmental health sector ministries and their policies.
40 The Regional Task Force is composed of the following members: UNFPA, IDB, the World Bank, FCI, the Population Council, unicef, and PAHO.
**National Insurance Fund**

In 1996, the National Maternal and Child Insurance was launched to help reduce the economic barriers that prevent women and children under age five from accessing public health services. The strategy focused on providing health centers with medicine and supplies for pregnant women before and after childbirth, and for children under age five. The health centers receive financial support from the municipal fund, which in turn receives support from the National Treasury. The strategy has made it possible to increase the number of services that can be provided for pregnant women, including clinical, surgery, and trauma services.

The data in the chart below highlight the progress made in improving coverage of maternal health services, following the implementation of the National Maternal and Child Insurance. While coverage has improved, coverage rates in rural areas remain low. In urban areas, three out of every four births (75.5%) take place at a health facility, whereas in rural areas, only one of every three births (32.7%) takes place in a facility. In certain regions of the country where indigenous populations are concentrated, the proportion of deliveries in health facilities has actually decreased.

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*Source: INE/National Survey on Demographics and Health*

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41 In 1998, its name was modified to Basic Health Insurance, and in 2005 to the Universal Maternal/Child Health Insurance (SUMI is the Spanish acronym).
Critics of the free voluntary health coverage strategy—created for all but aimed in favor of the poorest—claim that it has in fact benefited groups living under better economic circumstances. The figure below illustrates how institutional births are distributed by income quintile, from the poorest to the richest.

**Percentage of Births in Health Service Facilities in the Five Years Before the Survey, by Level of Income. Bolivia, 2003**

- Q1 = Poorest Quintile
- Q5 = Richest Quintile

Source: National Survey on Demographics and Health 2003
Monitoring and Evaluation

National Surveys on Demographics and Health (ENDSA) carried out in 1994 and 2003 and the Post-Census Survey on Maternal Mortality (EPMM)\(^{42}\) conducted in 2000 provide a snapshot of national maternal mortality levels in Bolivia (see below).

Another indicator is the percentage of pregnant women able to access health care facilities for obstetric complications. But this information is not registered consistently by the National System for Health Information (SNIS, for its Spanish Acronym) or the Universal Maternal/Child Insurance system (SUMI, for its Spanish acronym).

In 2003, the Ministry of Health conducted an evaluation of the availability, access, and use of emergency obstetric health care services for 85 key healthcare facilities in the health system, with financial support from UNFPA. The survey estimated the percentage of obstetric emergencies treated, and found that the average percentage of obstetric emergencies handled at health care facilities varies between 22–28\%.

Factors related to these trends include: the distance women experiencing complications have to travel to reach facilities; the availability of public transportation; the condition of transportation networks; and the level of trust the community has toward health care providers.

\(^{42}\) This was generated by a different procedure from the ENDSA, but is still consistent with the results of these surveys.
Expenditures for Maternal Health

Funds for government expenditures on health come from different sources: the nation’s General Treasury; fees for services not covered under the insurance program; municipal allotments through the tax co-participation scheme; international cooperation funds and extraordinary allotments, like those linked to the external debt relief program. One very specific source of funds, the National Lottery for Poverty Assistance and Health, has encountered problems due to corruption.

As a percentage of GDP, health expenditure has varied considerably. After reaching 4.52% in 1989, it dropped to 2.5% in 1992; it has since recovered without reaching an optimum level. In 1997 it rose to 3.98%, and again in 1998 to 4.9%; both years this increase came as a result of allotments made for the National Insurance for Maternal and Child Health.

Public investment in maternal health includes both external aid and funds from the Treasury. External aid is channeled through the government (bilateral and multilateral aid) and through nongovernmental organizations, in the form of cash donations or credit. The Treasury, which is usually the national counterpart when these funds are invested, is in charge of monitoring expenditures in capital investment projects. Between 1993 and 1997, public investment related to health grew 269%, from US$22.8 to US$61.3 million. This was due in large part to two large-scale projects, one financed by the World Bank (the Integrated Project of Healthcare Services, or PROISS), and the Institutional Development Project financed by the Inter-American Development Bank. These projects provided a total of US$16 million of support for basic infrastructure and equipment. In 1998, public investment was near US$98 million.

Currently, the Safe Motherhood Initiative in Bolivia faces a financial challenge. Although SUMI and international cooperation provide resources specifically to support safe motherhood, coverage is still lagging and funding is insufficient to meet the population’s needs. Not only is there a need for additional resources for safe motherhood, but funds allotted must also be expended in an effective, efficient, and transparent manner, and reach the populations most in need.

Over the last ten years, international cooperation agencies including USAID, UNFPA, and unicef have radically changed the modality of funding and fund disbursements. They have gone from direct disbursements to the national government to creating agency projects with separate structures and personnel. In addition, two of the three UN agencies (UNFPA and unicef) have cut back on funds allotted to national initiatives in Bolivia. USAID has reduced funds for health; from the US$20 million dollars disbursed in 2000, the amount has dropped to US$16 million for 2005. Sexual and reproductive health receives one third of these funds. It remains to be seen how the recent political transition in Bolivia will affect bilateral contributions from USAID.
Conclusion

Maternal mortality decreased by 40% between 1991 and 2000 in Bolivia. Safe motherhood policies and programs evolved from a simple and relatively isolated vision to integrated plans developed in the broad context of sexual and reproductive health. Safe motherhood was first identified as a priority in the early 1980s with a general understanding of the problem, but not based on the available evidence. In the 1990s, the landscape for safe motherhood changed as a consequence of the Andean Safe Motherhood Conference (1993); the results of the National Survey on Demographics and Health (1994); and the National Insurance for Maternal and Child Health (1996). Subsequently, safe motherhood policies have increasingly been based on epidemiological data and have promoted evidence-based protocols addressing the obstetric causes of maternal mortality.

While international cooperation has supported safe motherhood projects in Bolivia, funding has been adversely affected by broader global economic processes, which eventually resulted in a change in priorities and a refocusing of programs. National allotments for safe motherhood, on the other hand, increased on account of the national maternal and child insurance strategies and the involvement of municipal governments. In spite of a national insurance fund for safe motherhood focusing on the poor, marginalized women, especially those living in the rural highland regions, and those with limited income and educational levels, continue to lack adequate coverage.
With 215.3 million people in 2003, Indonesia is the fourth most populous country in the world. A vast tropical archipelago of 17,000 islands across the equator between Asia and Australia, it occupies a total area of 9.8 million sq km covering 7.9 million sq km of ocean and 1.9 million sq km of land. The country is home to more than 300 ethnic groups spread over 6,000 inhabited islands with five big land masses (Sumatra, Java, Kalimantan, Sulawesi, and Papua).

On a number of health and social indicators, Indonesia has experienced significant gains: life expectancy has increased (from 59.8 to 65.4 years), infant mortality has decreased (from 71 to 47 per 1,000), and maternal mortality was reduced from 450 to 373 deaths per 100,000 live births in the period 1986–1996. The population growth rate in 1999–2000 was 1.48%.

There have been several milestones in the government policies for safe motherhood in Indonesia. Since the 1970s, as part of government policy to expand primary care, MCH became an integral component of six basic services provided at the health center level (serving 30,000 people).

Beginning in 1989, as a result of the high maternal mortality of 450 per 100,000 live births found in the Indonesian Household Survey (IHHS, 1985), in 1989 the Minister of Health issued a new policy to accelerate the reduction of MMR; and to train and deploy a large number of community midwives to provide village-based MCH services. The objective was to improve women’s access to skilled attendants through the training and deployment of over 54,000 community midwives (nursing school graduates plus one-year midwifery education) between 1990 to 1996.


Source: MOH, 2004

In 1994, the government reaffirmed its commitment to accelerate the reduction of maternal mortality through management of the complications of pregnancy and delivery and improving the proportion of births attended by health personnel. The strategy aimed to increase the coordination of different health care providers and facilities to function as a comprehensive referral network: the community midwife as first-level provider for obstetric and neonatal emergency; the health center as the source for 24-hour basic emergency obstetric and neonatal care, and the district hospital providing 24-hour comprehensive emergency obstetric and neonatal care referral services.\textsuperscript{44}

The ICPD (1994) and the Beijing Fourth World Conference on Women (1995) brought about a more integrated approach vis-à-vis safe motherhood and reproductive health, and promoted linkages with women’s socioeconomic status and reduction of maternal mortality.

In 1996, the President launched the Mother Friendly Movement aimed at mobilizing communities and providers to address the three delays in obstetric and neonatal emergencies (delay in household decision making, delay in making referral, delay in case management at health facilities). The movement enhanced efforts to increase the demand for safe motherhood among families and communities, improve access of pregnant/delivering/postpartum women to quality maternal care, and support the referral of obstetric and neonatal emergencies with district resources.\textsuperscript{45}

Following the economic crisis that devastated Indonesia and the rest of Asia in late 1997, the government took steps to protect the increasing proportion of the poor (which rose from 11% in 1996 to 40% in 1998) with social safety net (SSN) programs, including one on health services. Initially supported with a loan from the Asian Development Bank in 1998, the government continued the program with funding derived from oil price compensation. Through this safety program, the poor receive free services ranging from basic outpatient care including MCH to hospital inpatient care.

In the year 2000, following the Millennium Development Goals, the President launched the Making Pregnancy Safer (MPS) Strategic Plan 2000–2010, with support from WHO, with the goal of reducing maternal mortality to 125 per 100,000 live births by 2010. The four strategies put forward in the MPS program were:

1. to improve access and quality of obstetric and neonatal services;
2. to develop effective partnership among sectors, programs, and different parties for optimum mobilization of resources;
3. to enhance the empowerment of women and families in healthy behavior and utilization of maternal and neonatal services; and
4. to facilitate community involvement in ensuring availability and utilization of maternal and neonatal services.

The MPS strategy was developed in conjunction with the Strategy to Achieve Healthy Indonesia by 2010, which identifies safe motherhood and reproductive health as one out of ten priority areas.

\textsuperscript{44} Ministry of Health, Republic of Indonesia. \textit{Strategies to Accelerate the Reduction of MMR}. Jakarta: MOH, 1997.

\textsuperscript{45} Cholil et al., 1997.
a decentralization policy shifted the responsibility for providing MCH services from central to province/district levels, with the aim of improving access and quality of services.

Despite the high-level commitment to improving maternal health in Indonesia, a number of factors have hindered adequate decline in maternal mortality levels. The process of decentralization, after a 32-year period of strong commanded central rule, has been problematic due to the lack of preparedness of different levels of government bureaucracy to changing roles related to technical capacity and funding management. Further, the 1997 monetary crisis brought prolonged social conflicts and unrest that impaired the development of the safe motherhood program.

**Programmatic Priorities for Safe Motherhood**

Since the early 1990s, the national program no longer promotes the training of TBAs due to its inconsequential role in improving maternal health. Evidence-based knowledge on screening for high-risk pregnant women resulted in its discontinuation, to be replaced with the philosophy that *every pregnancy faces risk* since the late-1990s. Greater emphasis has been placed on the education and mobilization of communities through multi-channel IEC activities and social mobilization principles. Antenatal care and counseling has improved with a standardized content that includes height and weight measurement, blood pressure examination, iron tablet, tetanus toxoid immunization, abdominal (height of top-uterine) examination and health/nutrition education. In Indonesia, the SM program has set at least four visits for antenatal care: one in the first trimester, one in the second trimester and two in the third trimester.

Beginning in 1990, the government, supported by a World Bank loan, began implementing an expansive program (*Bidan Di Desa* or BDD) to ensure improved coverage by a skilled birth attendant during delivery. The BDD program posted a community midwife (nursing graduate with one additional year of midwifery training) at the village level. By 1996, almost all 65,000 villages had been staffed with a community midwife. Subsequently, the training of the midwife was upgraded (12-year basic education plus three-year nursing and midwifery training) in a move toward the provision of improved skilled care.

The Making Pregnancy Safer and Healthy Indonesia 2010 policies have put forward three program interventions:
1. improving access to skilled health providers;
2. increasing access to referral services; and
3. prevention of unwanted pregnancy and care of postabortion complications. At the operational level, the implementation of this program during 2000–2004 has been hindered by lack of resources, administrative capacity, and funding support.

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While the national safe motherhood program gained strength and momentum during the 1980s and 1990s as a result of high-level policy commitment, less progress has been observed in the last 5–6 years. The end of the 32-year centrally dominated government in 1998, replaced by a more democratic and decentralized system, has resulted in diminished concern, enthusiasm, and response for top-down government initiatives.

**Monitoring and Evaluation**

The national monitoring and evaluation system includes a set of indicators that includes MMR and causes of maternal deaths; coverage of antenatal care; births attended by skilled providers; access to comprehensive emergency care at district hospitals and basic emergency care at health centers; proportion of obstetric complications managed by the district health system including its case fatality rate; and percentage of C-section deliveries.\(^\text{47}\)

The quality of service statistics is poor, particularly a result of the decentralization process which fostered a noncompliant attitude toward the national monitoring system. Health staff show a lack of appreciation for data recording and collection, and underreporting is also common.

Lacking accurate data from service units, monitoring and evaluation is based on the following mechanisms: local area monitoring (LAM)\(^\text{48}\) revitalized after 2000, the periodical survey reports from national demographic analyses such as the IHHS and Indonesian Demographic Health Survey; national censuses; periodic socioeconomic surveys; survey on the profile of women’s status; maternal and neonatal studies; and behavioral studies and studies on specific sentinel/pilot project areas supported by international donors. The long, periodic nature of data collection and analysis often fails to resonate with policymakers. Policy decisions are often made without proper use of evidence.

Survey data show that the BDD program of training and deploying community midwives at the village level has improved maternal care. Between 1991 and 2002, the percentage of women receiving four or more antenatal visits increased (from 56% to 81%), with higher numbers of pregnant women visiting a midwife (from 65% to 81%). Those completing four antenatal visits are more likely urban women (72%) than rural women (57%). The percentage of births attended by TBAs is declining (from 64% to 32%) while those attended by trained health providers is increasing (from 32% to 57% by doctor and midwife). The use of modern contraception has also gone up (from 47% to 57%) in the same period. However, despite the declining percentage of deliveries attended at home (from 79% to 59%), home deliveries remained at 60% in 2002 (Series of IDHS 1991, 1994, 1997, and 2002).

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\(^{48}\) Local Area Monitoring (LAM) is a management tool for monitoring MCH program coverage in a specific area. Through tracking coverage indicators (e.g., antenatal care visits, births attended by skilled professionals, postpartum care, neonatal care) on a monthly basis, LAM aims to facilitate prompt and quick action for achieving MCH program objectives.
The main sources of government health funding are central and regional government budgets. At the national level, the main source is the State Income and Expenditure Budget (APBN or Anggaran Pendapatan dan Belanja Negara) which includes International Loans and Grants. At the regional level, funding comes from provincial and district budgets.

Financial Expenditures for Safe Motherhood

Health development has been consistently underfunded. Government health expenditure has been around 0.7–0.8% of Gross Domestic Product (GDP), contributing roughly 30% of total expenditure. In 1984–1985 and 1994–1995, the per capita expenditure on health was $11.40 and $17.10 respectively. A marked increase in the health budget was noted in 1997 and 1998 following the economic crisis, as the government instituted SSNs for health (including increased funding for maternal health) from an ADB Loan. However, the increase is not real due to the devaluated rupiah (Rp.) currency as a result of the crisis.

Accurate data are not available regarding the level of health expenditures for safe motherhood, as the budgetary system is based on integrated funding by institution or services unit (hospital, health center, etc.) down to the operational level. Using the allocation for programs under the Directorate of Family Health, it is estimated that central-level safe motherhood activities have received a very small portion from the overall central health development budget, ranging from 0.14% to 1.13% annually in the period of 1999–2000 to 2004 as shown in the following table and figure.

### Safe Motherhood/Family Health Budget as Percentage of Total Health Development Expenditure, 2000–2004 (in Million Rupiah)

<table>
<thead>
<tr>
<th>Budget Items</th>
<th>1999/00</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Development Budget in APBN*</td>
<td>83,648,300</td>
<td>41,605,700</td>
<td>465,461,400</td>
<td>52,299,100</td>
<td>55,770,000</td>
<td>70,871,200</td>
</tr>
<tr>
<td>Total Development Budget for Health*</td>
<td>4,428,800</td>
<td>2,910,900</td>
<td>3,927,000</td>
<td>3,505,500</td>
<td>3,790,100</td>
<td>5,442,000</td>
</tr>
<tr>
<td>% Development Budget for Health*</td>
<td>5.08</td>
<td>7.0</td>
<td>8.6</td>
<td>6.7</td>
<td>6.85</td>
<td>7.7</td>
</tr>
<tr>
<td>Central Development Budget for Health**</td>
<td>3,139,517</td>
<td>1,532,618</td>
<td>3,011,994</td>
<td>3,370,322</td>
<td>5,138,546</td>
<td>4,784,191</td>
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<tr>
<td>% of Foreign Assistance</td>
<td>44.1</td>
<td>52.5</td>
<td>45.8</td>
<td>32.2</td>
<td>20.9</td>
<td>21.1</td>
</tr>
<tr>
<td>Central Development Budget for Family Health***</td>
<td>35,426</td>
<td>16,034</td>
<td>17,032</td>
<td>10,065</td>
<td>12,169</td>
<td>6,472</td>
</tr>
<tr>
<td>% Central Health Dev Budget for SM/RH***</td>
<td>1.13</td>
<td>1.05</td>
<td>0.57</td>
<td>0.30</td>
<td>0.24</td>
<td>0.14</td>
</tr>
</tbody>
</table>

* National Development Planning Board 2005 (1 USD=Rp. 9000)
** Bureau of Planning and Budgeting, MOH, 2005
*** Directorate of Family Health, MOH, 2005

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For 2005–2010, the government is expected to elevate safe motherhood to priority status, with a corresponding increased budget allocation. The greater funding allocation for safe motherhood fits within an overall increase in health (development and routine) budget of Rp. 11 trillion in 2006, a 22% increase from the 2005 level of Rp. 9 trillion.

It will be a challenge to safeguard the 2006 increased allocation for safe motherhood, especially with the decentralized budget that places priority on physical infrastructure/equipment rather than health and social development programs. SWAps and other finance mechanisms such as PRSPs have not yet affected funding for maternal health. Indonesia has finalized its PRSP document in 2005, and has only recognized SWAps as a potential mechanism without follow-up for implementation.

International Financing

The figure below illustrates that health sector grants have been increasing from US$52 million in 2000 to US$95 million in 2003, with a slight decrease to US$83 million in 2004. In the future, grants are expected to increase with The Global Fund to Fight AIDS, Tuberculosis and Malaria as one of the major contributors.


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Conclusion

Indonesia has been addressing its high maternal mortality level with increasing policy action since the 1987 Nairobi Conference. The commitment shown by the President and other high level officials to accelerate the reduction of maternal mortality has fostered the development of a range of technical guidance and manuals for lower-level implementation. At the operational level, the national program of posting community midwives at the village level has increased the coverage of antenatal care and births attended by skilled providers.

The slow decline in maternal mortality in the last 15–20 years is an indication of poor quality of care and problems at the supply and demand levels. Policies formulated at the national level have not always been supported by proper and effective implementation. With greater emphasis on decentralization and regional autonomy, district governments have gained responsibility for a wider spectrum of tasks that include health, education, public works, industry, trade, and communication, often without adequate management skills needed for implementation. Finally, a review of national budgets indicates that safe motherhood has not been prioritized adequately, although politically it has attained a certain level of commitment.
Lao People’s Democratic Republic

The Lao People’s Democratic Republic is a landlocked nation in southeast Asia whose western border is defined by the Mekong River. It is approximately 1,700 km long from north to south and 400 km wide. It shares lengthy borders with Vietnam to the east, Thailand to the west, Cambodia to the south, and China and Myanmar to the northwest. The Mekong River serves as a source of transport and food. Two thirds of the terrain is mountainous, with consequent challenges regarding communication and provision of social services. Over 65% of the population lives along the Mekong and the lowlands.

The Lao PDR is one of the world’s least developed countries\(^52\) and one of the poorest in Asia with an average annual per capita income of US$350. More than three-quarters of the people live on less than US$2 a day, and the country’s social indicators are among the worst in the region.\(^53\) While the economic situation has improved since the introduction of the New Economic Mechanism in 1986, which shifted the economy from a centrally planned system to a largely free market model, it is estimated that 46% of the country’s total population of 5.5 million\(^54\) live below the poverty line. The population is young, with 43.6% below 15 years old, and has a total fertility rate of 4.9.

Despite considerable improvement in the quality of life over the past two decades the general health status of the Lao PDR population remains low. The health situation is characterized by a low life expectancy of 59 years, an infant mortality of 82 per 1,000 live births, under-five mortality of 106 per 1,000 live births, and a maternal mortality ratio of 530 per 100,000 live births. Only one half of the entire population has access to safe drinking water and less than half to safe sanitation facilities.

Approximately one third of the population is considered ethnic minorities who live in geographically isolated mountain areas. Health and socioeconomic indicators lag for these minorities as compared to the whole nation. The ethnic minority areas in the highlands have higher rates of poverty, worse health indicators and fewer services for many reasons among which are remoteness, lower levels of educational achievement, and increasing land pressure that limits their ability to achieve food self-sufficiency. Many of the ethnic minorities do not speak Lao.

Public health services in the Lao People’s Democratic Republic are provided through a network of about 700 facilities at the central, provincial, district, and sub-district levels. About 67% of the population has access to at least some basic health services. Although 79% of villages were within four hours of a district hospital in the dry season as of 1999, utilization of the public health care system was very low. About 33% of the villagers seek care from the informal private sector when ill; these include drug sellers, birth attendants, traditional healers, and herbalists.

There has been a trend toward falling maternal, infant, and child mortality as measured by national health surveys from 1995 through 2000; however, these rates are still among the highest in the region. During this period, MMR fell from 656 to 530 per 100,000. There is no vital registration system and the health information system is not able to provide estimates for other indicators.

The Reproductive Health Survey 2000 showed that only 23% of women received antenatal care from a midwife, nurse, or doctor while 76% did not receive any antenatal care at all. Traditional birth attendants (TBAs) provided antenatal care to less than 1% of pregnant women. Relatives or friends assisted in 55% of deliveries while skilled health workers assisted in 17%, TBAs in 13%, and 8% of deliveries were unattended. Severe urban–rural disparities exist in receiving care by health professionals (63% for urban and 12% for rural areas).

In view of the limited availability of information regarding maternal health services in Lao PDR especially prior to 1995, an assessment of maternal health needs was conducted by a team of experts in three provinces in 1998 (unicef/Lao MOH/FCI). Among the key findings were the following:

- Centralized, vertical structure of health and family planning
- Limited resource allocations for health
- The lack of an action plan. Safe motherhood was a vague concept for most policymakers who lacked information on what constituted the basic elements of a safe motherhood program.
- Insufficient NGO capacity for service delivery and research

- Safe motherhood interventions remained largely uncoordinated and donor-driven.
- As was true for other health sector programs, much of the conceptualizing and designing of programs were done by outside agencies, limiting opportunities to build local capacity and leadership.
- Health personnel generally lacked clinical and management skills and most had not received in-service training in recent years
- The consistency and quality of routine MCH services varied considerably.
- Monitoring was difficult as recordkeeping was poor due to:
  - Lack of uniform guidelines for proper recording of information
  - Short supply of blank records to document relevant patient information
  - Lack of staff training
  - Insufficient supervision and feedback

These findings were validated by the Strategic Assessment of Reproductive Health conducted in 1999 (MOH/WHO). In addition, the assessment noted that community members did not recognize the complications of pregnancy and childbirth requiring immediate referral; a large number of the district hospitals had very limited resources and were providing substandard care; and there was lack of strong professional leadership in obstetric and gynecological care. The assessment recommended the strengthening of the safe motherhood program and the development of a comprehensive reproductive health policy in order to integrate reproductive health services with safe motherhood.

In 1995, the National Birth Spacing Policy was formulated to ensure that the number of children born to a woman would not impair her health and well-being. Family planning services were to be made available as a means of child spacing for health reasons and for the overall reduction of maternal and infant morbidity and mortality. The major goals were:

- Reduce maternal mortality and infant mortality by 25% in the year 2000.
- Increase access and availability of birth spacing methods and services as well as accurate information needed by women and couples who wish to plan and space the births of their children.

The birth spacing program was to be implemented in a phased manner and integrated with safe motherhood activities. It covered a variety of issues like program management, contraceptive methods, service delivery, IEC, clinic management, fertility, and the import of contraceptives.

In 1997, the Safe Motherhood Policy was promulgated as an addition to the existing Birth Spacing Policy. This policy document was prepared after the first safe motherhood conference was held in Vientiane in March 1996. Ninety-seven delegates from the central and provincial health departments, institutes, and hospitals worked together to come up with a draft document that was approved in 1998. Only in 2000 was the action plan developed. The 1997 policy defined the roles of each health facility level; emphasized the need to upgrade these facilities and the competencies of health staff; and called for improved quality of care through the development of clinical protocols and the promotion of good maternal health practices such as antenatal and postnatal care, and skilled attendance at delivery. The aim of the policy was to reduce the MMR by 25% by the year 2000 (from a MMR of 653 in 1993). It mandated the provision of antenatal care (at least once), and called for the prompt recognition and treatment of the five most common obstetric emergencies. At the community level, TBAs, health volunteers, and family members were to be provided training on the recognition of high-risk conditions during pregnancy, childbirth, and after delivery to be able to assist in early referrals to hospitals. For health promotion purposes, they are also required to be trained on early breastfeeding, maternal and child nutrition, and immunization.

In 2002, the safe motherhood policy was amended with the following revisions:

- Acknowledgment of the rights of women regardless of age and class to reproductive health information and services and as well as the newborn’s rights to health care.
- Need for a continuum of care from childhood to menopause.
- Reiteration of the four pillars of maternal health care services (antenatal care, delivery, postnatal care, and family planning) and the relevant activities to be conducted at the central, provincial, and district hospitals as well as the health center and in the community. The role of the community in these four areas of safe motherhood was emphasized.

Furthermore, the document called attention to the need to upgrade the midwifery skills of health care providers at the different levels of
care, and develop a new training curriculum to include emergency obstetric care, counseling, management of complications of abortion, management and treatment of STIs, and prevention of HIV/AIDS. It also reiterated the need for training TBAs, especially in remote areas and where ethnic groups have expressed a preference for them.

In 1999, the Birth Spacing Policy was amended by the National Population and Development Policy (NPDP) of Lao PDR. One of the goals of the amended policy was to motivate and assist the population in improving the quality of their lives by ensuring safe motherhood, reducing maternal and child morbidity and mortality, and enabling couples to responsibly decide the number and spacing of their children.

Specific targets are included in the table below.

### Targets of the National Population and Development Policy

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline data</th>
<th>2000</th>
<th>2010</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality ratio (per 100,000 live births)</td>
<td>656 in 1993</td>
<td>490</td>
<td>250</td>
<td>130</td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>5.6 children in 1995</td>
<td>4.5</td>
<td>3.5</td>
<td>3</td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>3% in 1994</td>
<td>25–30%</td>
<td>50–55%</td>
<td>60–65%</td>
</tr>
<tr>
<td>Infant mortality rate (per 1,000 live births)</td>
<td>104 in 1995</td>
<td>85</td>
<td>40</td>
<td>20</td>
</tr>
<tr>
<td>Under 5 mortality (per 1,000 live births)</td>
<td>170 in 1995</td>
<td>127</td>
<td>60</td>
<td>30</td>
</tr>
<tr>
<td>Literacy rate of women</td>
<td>48% in 1995</td>
<td>60%</td>
<td>75%</td>
<td>85%</td>
</tr>
<tr>
<td>Girls’ enrollment rate in primary school</td>
<td>68% in 1995</td>
<td>75%</td>
<td>89%</td>
<td>95%</td>
</tr>
<tr>
<td>Girls’ enrollment rate in secondary schools</td>
<td>28% in 1995</td>
<td>35%</td>
<td>55%</td>
<td>74%</td>
</tr>
</tbody>
</table>

In response to recommendations to broaden the scope of family planning into an integrated approach to reproductive health, a National Reproductive Health Policy was developed in January 2005. The policy mandates that a core package of integrated reproductive health services consisting of safe motherhood and nutrition, family planning, and prevention and control of RTIs (including STIs and HIV/AIDS) will be made available in all primary health care facilities. A two-way referral system will ensure vertical and horizontal continuity of care from different health and information providers and service delivery points.
The policy’s specific objectives to reduce maternal, infant, and perinatal mortality and morbidity include:

• achieve a significant and sustainable reduction in maternal, perinatal, and infant mortality and morbidity
• ensure adequate child growth, nutrition, and development among children
• protect the mothers and children from preventable infectious diseases
• integrate safe motherhood and child growth and monitoring with reproductive health program activities

The policy calls for the upgrading of facilities and skills of health care providers at the district/sub-district levels for improved detection and early referral of emergency obstetrical conditions as well as provision of transport and systematic referral. It also mandates the dissemination of clinical practice guidelines in all health centers and hospitals. The government has formulated other policy papers, poverty reduction strategies, and master plans up to the year 2020 which included maternal and child health as one of the priority concerns, especially among poor and marginalized minority groups. It has also targeted the improvement of the health sector and education of girls to correct gender imbalances.

Programmatic Priorities

Most activities have been carried out on a project basis and are funded by different international agencies. As outlined in the 1995 maternal needs assessment, projects have generally been implemented as vertical programs in specific areas of the country, and not on a national scale.

Beginning in 1995, a government-led community health project to integrate maternal and child health services was instituted at the community and district levels, with the aim of building the capacity of the health system to improve the coverage and quality of maternal health care. Maternal and child health services serve as an entry point to link other primary health care interventions and facilitate the delivery of services to the community. The project has expanded to six provinces and is still ongoing.

Donor-financed projects include the Survival, Growth and Development program implemented by unicef which targets women and children through an integrated project of maternal and child health management and promotion, child survival interventions, growth development, and safe motherhood. The latter component included the development of an integrated package of safe motherhood outreach services in remote villages of six provinces; the development of training curricula/guidelines on emergency obstetric care; and training physicians and nurses in collaboration with WHO and UNFPA. A UNFPA project supports mobile clinics and provides equipment and supplies to health facilities in three southeastern provinces. The mobile clinics provide a range of reproductive health services and information—including family planning, prenatal care, treatment of sexually transmitted infections, and education on HIV/AIDS prevention.

Monitoring and Evaluation

The system for monitoring and evaluating progress toward safe motherhood goals and assessing health system performance remains inadequate. With no uniform health information system, recordkeeping remains poor and nonstandardized. As a result, data needed to assess national progress toward improving maternal health are not systematically collected. The necessary forms and records exist but are often not available.

Surveys and studies have identified general trends in a number of indicators: the MMR, IMR, under-5 mortality rate (see graph below), and total fertility rate have declined; whereas the contraceptive prevalence rate, the proportion of deliveries attended by skilled personnel, and the proportion of pregnant women receiving antenatal care have increased.

In 2005, a high-level committee was established to monitor progress in implementation. The committee is headed by the Minister of Health with two deputy ministers, department directors, and the division chief of safe motherhood. The country has been divided into three areas—north, central, and south—to facilitate monitoring, with the intention to fast track the activities on safe motherhood to reach the Millennium Development Goals.

National Expenditures on Safe Motherhood

Health expenditure constitutes as little as 2% of Laos PDR’s Gross Domestic Product. In the mid-1990s the government allocated 5% of its budget to the health sector but it currently stands at 2%. Health spending is about $12 per capita with 11.5% from government sources. Households contribute approximately 55% of health expenditure and foreign assistance accounts for 35%.

Sources: National Population and Development Policy (NPDP); Lao PDR Reproductive Health Survey 2000; Country Health Information Profiles, 2004 Revision, WHO WPRO (CHIPS).

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57 Country Health Information Profiles, 2004 Revision, WHO WPRO (CHIPS).
According to the MOH during a round table meeting in 2000, government funding for health has been increasing in nominal terms, though inflation in recent years has decreased the value of this funding. Government recurrent and investment spending by central MOH contributes 3.2% of total expenditures, 1.1% by other ministries, and provincial health offices contribute more than twice this level at 7.2%. In the national Department of Hygiene and Prevention, safe motherhood constitutes about 2% of the budget. This does not include the costs of conducting deliveries, managing complications, and the funds channeled through other units in funding safe motherhood-related areas such as reproductive health, primary health care, health sector reform, and others. As a result, it is difficult to quantify the expenditure and financial contributions related to safe motherhood.

Donor spending represents an important proportion of health expenditure. Usually it falls into one of four categories: technical assistance, general construction and vehicles, medical equipment and pharmaceuticals, and study fellowships and tours. Overall donor assistance represents 24.3% of total health expenditure.58

The main donors to the safe motherhood program are unicef, WHO, and UNFPA. It is difficult to determine the level of funding for safe motherhood because of its integration with other programs. According to the main donors, their funding contributions have been consistent as far as their regular budgets are concerned.


External resources as percentage of total expenditure on health

Year

0 10 20 30 40 50 60 70 80 90 100

1998 1999 2000 2001 2002

20.4 19.5 19.7 21.1 9.6

Conclusion

In Lao PDR, the maternal mortality ratio is among the highest in Asia at 656 per 100,000 live births in 1995. The high MMR is attributed to a range of factors, including very low utilization of health facilities, poor coverage of skilled attendance during childbirth, very low antenatal care, almost no postpartum care, inadequate essential obstetrics care, lack of functioning referral system, absence of birth and death registration systems, and a poor functioning health system. Compounding these are a high total fertility rate at 5.6, and a low contraceptive prevalence of 3%.

While maternal mortality has declined, progress has been slow. A long history of neglect of the health system, punctuated by inadequate human resources and poor infrastructure, has featured as a main obstacle to continued improvements in safe motherhood.

Most safe motherhood interventions have been funded by international donors, with the government contributing recurrent expenditures including staff salaries, facilities’ maintenance, etc. While financial support in general has been inadequate, the lack of coordination among donors, the vertical programming structure, and the lack of efficient monitoring and data systems have further contributed to funding inefficiencies.

The government is making efforts to coordinate the multiple agencies to fast-track implementation, avoid duplication of programs, promote better working relationships, and identify unmet program needs. Substantial efforts are still needed to improve monitoring and evaluation systems, establish registration and referral systems, develop more effective partnerships with NGOs, and provide an assessment of program implementation. A reassessment of maternal health needs is needed to determine the quality of maternal and neonatal care available, the level of service utilization, and the sustainability of interventions in an effort to build on the gains that have been achieved thus far.
Malawi is a landlocked country in Central Africa, with a total surface area of just over 118,000 sq km, of which 80% is land. The total population is currently estimated at 12 million people, with a population density of 105 persons per square kilometer. This is not evenly distributed: the more fertile plains in the Southern Region of the country are more densely populated than the drier, rocky, and hilly areas.

The annual population growth rate is 2.0%, and life expectancy is 40 years for males and 44 years for females. Life expectancy has deteriorated over the past 10 years mainly due to the HIV/AIDS epidemic, which is considered the number one cause of death among adults. The total fertility rate has dropped from 7.6 in 1977 to 6.3 in 2000, with urban areas having a lower level than rural areas, (4.5 vs. 6.7 respectively). These are higher than the desired fertility, 5.2 nationally and 3.5 for urban and 5.5 for rural residents, possibly indicating the degree of unmet need for family planning and extent of unplanned pregnancy.

In the early 1990s the estimated national MMR in Malawi was 620 per 100,000 live births. Between 1992 and 2000, the MMR increased from 620 to 1,125 per 100,000 live births based on local surveys; WHO/unicef/UNFPA (2000), however, estimates that the MMR stands at 1,800 per 100,000 live births, making Malawi the country with the second highest MMR in Africa, and the third highest globally. Preliminary results of the 2005 Malawi DHS indicate that the MMR may have risen even higher.

The national increase in MMR has been mirrored by an increase in institutional MMR; for example, at the Central Teaching Hospital in Blantyre, the MMR increased from 476 in 1994–1996 to 1,125 per 100,000 live births in 1999–2000. A 2005 national assessment of emergency obstetric care showed a case fatality rate of 3.4%, which is higher than the recommended level of 1% by UN process indicators. The impression of many health care providers in the country is that the current MMR may actually be much higher than what is seen in health facilities.

Several factors have been cited as contributing to the high MMR in Malawi. There has been a significant decline in the quality of health care delivery nationally. This has been documented in studies, surveys, and assessments conducted nationally or within health institutions. Over the past ten years, the country has witnessed an unprecedented depletion of the workforce within the health sector, through death from the HIV/AIDS epidemic or resignations due to the low pay. Hundreds of nurses have left the country for overseas posts or public service for local NGOs. Physicians training overseas have not returned home for economic reasons. Many health facilities have no qualified staff and therefore essential services such as deliveries are conducted by unqualified auxiliary staff.

There is a shortage of essential drugs, supplies, and equipment for life-saving procedures and treatment. Although the country has established a national blood transfusion service (MBTS) supported wholly by the European Union, there is a critical shortage of viable blood donors, due to the HIV/AIDS epidemic. Many health facilities do not have functional blood banks, yet obstetric hemorrhage is the second largest cause of maternal deaths in the country. In the 2005 national assessment on emergency obstetric care, not one of the health centers could be classified as a basic emergency obstetric care (EmOC) facility as they did not provide the requisite six signal functions.\(^{62}\)

Good quality of care is also influenced by the availability and accessibility of essential services, which is another problematic gap in Malawi’s health care delivery system. A number of health centers, which function as the entry points for the health system, are not open and functional 24 hours a day, seven days a week due to staff shortages and security concerns. In some areas, staff have no official houses near health facilities. They must walk long distances, even at night after their shift ends. Women who go into labor at night or on weekends/public holidays may resort to a TBA, travel to distant health facilities, or wait till the next day. Referral systems and mechanisms are also not always functional for a number of reasons, such as staff attitudes, lack of recognition of emergencies, and unavailable or poorly maintained vehicles and radio communication facilities.

There is significant delay in deciding to seek maternal health care for social, cultural, or economic reasons, especially for the poor rural majority. Decisions to seek care are often made by family members rather than the woman herself. Studies have indicated delays in receiving care after reaching a facility due to lack of skilled personnel, equipment and supplies, or poor staff attitudes. It is not unusual for a woman to wait for 24 hours or more from the time a decision is made to perform an emergency caesarean section to the time it is actually carried out. Studies have also shown that the national public health facility caesarean section rate is 2.8%, which is about half of the minimum recommended level of 5.0% by UN process indicators.

Unsafe abortion, resulting from an unplanned or unwanted pregnancy is a major contributor to the high maternal mortality rate in Malawi, accounting for about 25% of the maternal deaths, with the majority taking place among adolescents and youths (< 25 years). Adolescents contribute between 20–25% of maternal deaths in Malawi.

**Policies for Safe Motherhood**

Since independence in 1964, the government of Malawi has endeavored to provide free health care services including maternity care. As with other developing countries, national health policies and programs have to a large extent been dictated or influenced by international declarations or events. Notable among such international declarations or events are the International Safe Motherhood Conference in Nairobi 1987; the International Conference on Population and Development (ICPD) in Cairo 1994; The

\(^{62}\) Signal functions refer to a set of important emergency obstetric activities that must be available at an EmOC facility. The six signal functions that are performed at the health center level include: administer parenteral antibiotics; administer parenteral anticonvulsants; administer parenteral oxytocic drugs; perform manual removal of placenta; perform removal of retained products; and perform assisted vaginal delivery.
Fourth World Conference on Women (FWCW) in Beijing 1995; and the United Nations Millennium Summit in New York 2000. Regional events have also had an influence, such as the Abuja Declaration on malaria (April 2000), etc. These have contributed to the development of national policies and/or programs to address maternal health issues in Malawi.

National Safe Motherhood Policy

Following the Global Safe Motherhood Conference (1987), which brought to the world’s attention the high maternal mortality in the developing world, the government of Malawi responded favorably. Malawi was represented at the conference by a government delegation, which upon returning home briefed the government. In acknowledgement of the high MMR and the need to reduce it, the government of Malawi undertook a series of steps which included the establishment of a national SM Task Force (1993) to guide program development and its implementation; a National Needs Assessment (1994); and a National Strategic Plan in 1995.

In 1996, a national safe motherhood program was launched with the goal of reducing MMR by 50% over a period of four years (1996 to 2000). It also included a goal to reduce neonatal mortality by 50% within the same period.

The program had four key strategies:
• to increase public awareness on maternal mortality issues;
• to generate political, government, and donor commitment for resource allocation;
• to reduce delays by expectant mothers to reach emergency obstetric care; and
• to improve the quality of reproductive health care and to reduce the total number of high-risk pregnancies.

Between 1996 and 1998 the national safe motherhood program supported by WHO undertook a range of programmatic activities (see next section). However, with the launch of a DFID-supported project in the Southern Region, the pace of activities increased. In 2004–2005, when the DFID project ended, there was diminished activity at the national level, mainly due to a dependence on external funds for its operation and implementation.

While a national safe motherhood program was established in 1996, it has not had the desired impact on improving maternal health. Although studies and surveys have shown increasing maternal deaths and deteriorating quality of health care services, there has been little, if any, government or political response and commitment to address them. The objectives and goal of the national program have not changed since 1996, although the target year for reducing maternal mortality (2000) has passed. According to Ministry of Health officials, safe motherhood is regarded as a low-to-medium priority health issue nationally. It is reportedly not on the top of the national development agenda.

National Reproductive Health Policy

In 2002, a comprehensive reproductive health policy was promulgated; the policy outlined reproductive health as a major component of the poverty reduction plan (PRSP). Six priority areas were identified:
Safe motherhood
Adolescent reproductive health
Family planning
Prevention, early detection, and management of cervical, prostate, and breast cancers
Prevention and management of STIs and HIV/AIDS
Elimination of harmful practices and reduction of domestic violence and infertility.

With regard to safe motherhood, the policy states that:
- Provision of safe motherhood services will be offered by skilled health workers at all health facilities.
- Safe motherhood services will be made male-friendly.
- At the community level, safe motherhood services shall be provided by trained and supervised TBAs.
- Comprehensive essential obstetric care services shall be provided to all pregnant women.
- Health facilities providing safe motherhood services shall put in place appropriate and functional transport and communication systems.
- Public, NGO, and private health facilities shall offer voluntary counseling and testing (VCT) to all pregnant women according to National AIDS Commission’s (NAC) policy.
- HIV-positive mothers shall be counseled on breastfeeding.
- Postabortion care services shall be provided at all approved health facilities.
- All pregnant women shall be screened for syphilis and treated with involvement of their partners.\(^63\)

### National Road Map

In 2004, the MOH developed a national Road Map for Maternal Mortality Reduction. This policy document outlines nine strategies for safe motherhood, including policy review and development, program implementation, and monitoring and evaluation. The Road Map will serve to guide policymakers; government, international, and donor representatives; training institutions; civil society; and the community on safe motherhood and maternal health care issues. The Road Map has clear targets and indicators for monitoring and evaluation, which are based on the MDGs.

### Program Priorities

The following activities have been carried out through the national safe motherhood program:
- Advocacy for political, government, and donor commitment for resource allocation
- IEC campaigns for the public through dramas (on national mother’s days, world health days, etc); jingles; radio messages; and posters
- Training of health care providers
  - Pre-service—postgraduate nursing for BSc and MSc
  - In-service for nurses working in maternity areas in health centers and hospitals including NGO and private facilities on life-saving skills
- Improvement of physical infrastructure
  - Building new health facilities such as health centers or maternity wings in existing hospitals and health centers
- Refurbishment of existing maternity units in existing health facilities
- Improvement of the referral system

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National Programs, Policies, and Budgetary Commitments for Safe Motherhood

- Procurement of motorized ambulances
- Procurement and installation of radio communication equipment in health facilities and ambulances
- Telephone networks, including mobile phones for central hospitals, and land line phones for district hospitals and some health centers
- Development of emergency obstetric case management protocols, for health centers and for district hospitals, and orientation of health care providers on its use
- National Conference on Safe Motherhood (2001)
- Introduction of PMTCT in 31 health facilities by 2004
- Research on various aspects of maternal health, including use of bicycle ambulances; barriers to utilization of maternity services; perceptions, utilization, and quality of care in maternity waiting huts; feasibility and acceptability of revolving health funds for emergency medical and obstetric referral
- Assessments on various issues related to maternal health

Monitoring and Evaluation

While the national safe motherhood program has not lowered overall maternal mortality levels in Malawi, it has achieved some measurable improvements in the following key programmatic areas:

- Upgrading the training of health care providers, particularly at the health center level. Medical assistants have been trained in maternity care and clinical officers as anesthetists through an upgraded diploma course, which includes emergency obstetric anesthesia and resuscitation of the newborn.
- Influencing policies of professional regulating bodies such as the Medical Council and Nurses and Midwives’ Council. Nurse Midwives were not previously allowed to perform manual removal of placenta, or give intravenous oxytocics or intravenous anticonvulsants. State Registered Nurse Midwives are now trained and allowed to perform manual vacuum aspiration (MVA) for incomplete abortion and provide postabortion care.
- Increased public awareness on maternal health issues, through posters, jingles, dramas, public speeches, etc.
- Increased availability, and to some extent accessibility and quality, of services provided in some health facilities, through building of new health facilities; refurbishment and renovation of some dilapidated structures.
- Development of other national policies, guidelines, etc. to facilitate implementation of the SM policy and program, e.g., PMTCT, Human Resource Development and Management Policy.

With regard to the quality of obstetric care services, all assessments and research reports have shown that it remains very poor. Many facilities lack basic equipment for quality obstetric care services such as blood transfusion, and there is a critical shortage of health care providers, especially nurse midwives. The national EmOC assessment (2005) showed that none of the health centers could be regarded as a basic EmOC facility as they did not provide the six signal functions.


Numerous studies have shown that lack of appropriate knowledge and skills and poor staff attitudes are some of the contributing factors to poor quality of care.\textsuperscript{66}

\textbf{Financial Expenditures for Safe Motherhood}

Following external pressure, the government of Malawi adopted the SWAp approach in October 2004. While not all relevant systems and mechanisms necessary for its operation are complete, it is expected to be functional by the end of 2005. Donors will pool their resources in the SWAp basket; some donors may continue to manage their funds directly. Both donor and government representatives assert that it is too early to tell what impact SWAp will have on health care delivery and safe motherhood specifically. It is interesting to note that safe motherhood does not feature specifically in either the MOH budget or SWAp. It is therefore impossible to identify how much will be used for safe motherhood activities in Malawi.

According to the finance department of the Ministry of Health, the budget for the health sector under the SWAp is US$89.9 million over a period of six years (2004–2010). The government will contribute 37.0\% of the earmarked budget, while the remainder will be donor funds. The British Government appears to be the main contributor to the SWAp, with contributions of £100 million over this period.

The principal external donors include: UNFPA, unicef, WHO, DFID, the EU, the World Bank, and USAID. According to the MOH there has not been an increase in donor presence since 1996 when the safe motherhood program was launched.\textsuperscript{67}

The general consensus is that current levels of funding for safe motherhood are inadequate, though it is unclear how much more is needed.

\textbf{Conclusion}

The national safe motherhood program, launched in 1996, was a response to a call by the international community at the 1987 global SMI conference held in Nairobi, Kenya, to reduce maternal mortality by half by the year 2000. A range of strategies was proposed and interventions carried out, with financial support by international agencies and donors. In spite of this investment, maternal mortality has continued to increase and the quality of maternal health care services has deteriorated considerably. These are partly due to inadequate government support and commitment, with safe motherhood largely influenced and financed by international agencies and donors.

Safe motherhood is not a high-priority health concern in Malawi, and is not visible in the MOH budget or national development agenda. Unless there are adequate and appropriate domestic influence, determination, and development of locally appropriate programs, supported by adequate financial resource allocation, safe motherhood will continue to elude most women in Malawi.


Mali is a landlocked Sahelian country located in the heart of West Africa, with a surface area of 1,241,238 sq km, a population of 11.6 million (2005), and an average population density of 9 inhabitants per square kilometer. In terms of basic and economic indicators, Mali ranks near the very bottom among countries worldwide. Mali is the fourth poorest county in the world (after Niger, Burkina Faso, and Ethiopia), with 64% of the population living in poverty. Food absorbs close to 60% of household budgets.\(^{68}\)

Nevertheless, in the past decade the economy has improved and notable progress has been achieved, a result of controls on public spending, sound management of the devaluation of the CFA franc, and the implementation of an ambitious policy for economic and social development. Major programs have been introduced, particularly in the areas of health, education, rural development, and agriculture. These sectoral programs are linked together under the Strategic Framework for Poverty Reduction (SFPR), adopted in 2002.

Maternal mortality levels in Mali have remained stagnant over the last 15 years: the number of maternal deaths per 100,000 live births was 700 in 1987, 577 in 1996, and 582 in 2001.\(^{69}\) Factors contributing to this slow progress include:

- A critical shortage of human resources, particularly of medical practitioners capable of performing cesarean deliveries. Specialized training is not available at the local level and fellowships for training abroad have become increasingly difficult to obtain. Huge overcrowding of educational establishments (e.g., 15,000 students enrolled at a school built initially to accommodate 200), coupled with the shortage of teachers (instructor/student ratio of 1:80) and the lack of a continuing education system, make it impossible to ensure quality training for students. Medical students today, unlike their predecessors, no longer learn to perform cesareans, which underscores the urgent need to ensure proper training.
- Poor distribution of human resources, especially midwives, of whom more than 60% are concentrated in urban areas. While they are plentiful in the nation’s capital, they are critically lacking in underserved areas, such as the northern regions.
- Poor quality of services, a result of inadequately trained personnel; high turnover rates; uncaring provider attitudes; services that are unaffordable for most Malians; stock shortages of drugs; irregularity of supervision; unsatisfactory health facilities at all levels of the health system; and deficiencies in health recordkeeping.

\(^{68}\) DNSI, 1993.
\(^{69}\) Demographic and Health Survey for Mali I, III, and III.
Mali has demonstrated growing political commitment to reducing maternal mortality, as evidenced by its accession to various international declarations and conventions, including:

- the Bamako Declaration by the First Ladies of West and Central Africa (Vision 2010), issued in 2001, which calls for a 50% reduction in maternal and neonatal mortality by the year 2010. In recognition of the fact that any woman can face risk during pregnancy and childbirth, the Vision 2010 Forum mobilized First Ladies, ministers of health, reproductive health experts, women’s associations and groups, NGOs, development partners, and the media to:
  - ensure political commitment and political support for the implementation of regional operational strategies for the reduction of maternal and neonatal mortality.
  - advocate for pro-women’s health policies, particularly the allocation of resources for maternal and newborn health care.
  - raise awareness of the magnitude of maternal and neonatal mortality in West and Central Africa.
  - share experiences concerning the reduction of maternal and neonatal mortality in the region.
- the Millennium Development Goals, which aim to reduce current maternal and child mortality rates by 75% by 2015.
- The Alma-Ata conference in 1978 which highlighted the importance of maternal and child health.

The highest level government authorities have demonstrated a commitment to safe motherhood—in particular the First Lady, who is a trained midwife—through a number of advocacy initiatives. These include the designation of a national Safe Motherhood Day (June 8); the celebration of National Midwives’ Day; and the awarding of the Tara Boré prize for outstanding efforts to reduce maternal and neonatal mortality. In addition, a number of national entities such as the Ministry of Health; the Ministry for the Promotion of Women, Children and the Family; the Ministry of Social Development, Solidarity and Aging; and civil society groups such as the Malian Association for the Protection and Promotion of the Family (AMPPF) and Groupe Pivot/Santé Population, have also demonstrated strong commitment to maternal health.

Mali’s national health policy is grounded in the principles of primary health care, the Bamako Declaration, and the African Strategy for Health Development. The Safe Motherhood Conference held in Nairobi in 1987, which set the goal of reducing maternal mortality, and which was subsequently reaffirmed at other international meetings.

The overarching goal of the national health policy is the achievement of health for all. To attain this overall objective, the following intermediate goals have been identified:

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70 The African Strategy for Development (1998 – 2007) aims to help member-states develop comprehensive reproductive health programs, especially at the district level, in an effort to foster a more coherent approach to program conception and development.
National Programs, Policies, and Budgetary Commitments for Safe Motherhood

• Improve the health status of the Malian people to enable them to participate more actively in the social and economic development of the country.
• Extend health care coverage and make health services accessible to the population.
• Improve the effectiveness and performance of the health system.
• Improve general management and strengthen institutions.
• Prevent and control diseases and promote reproductive health.
• Strengthen and maintain infrastructure and equipment.
• Strengthen training and research.

Malian health policy can be characterized by three distinct time periods:

1960–1979: The health policy during this period was guided by the political ideology of the socialist era, the aim of which was to equip the country with a core set of health institutions. It advocated access to modern health care services for all, free of charge. The government’s policy in maternal and child health focused on expanding coverage of health services through the development of rural childbirth centers and the training of TBAs.

1980–1990: In the second ten-year health development plan for the period 1981–1990, the primary health care strategy focused on the development of rural health care services and deploying village health workers, particularly public health/first-aid workers and trained traditional birth attendants.

1990–2002: During this period, a five-year plan (1998–2002) on reproductive health was promulgated. The plan included four components, including one on safe motherhood, and aimed to improve health care coverage. With regards to safe motherhood, the plan sought to expand the referral and evacuation system, with the perinatal period as the port of entry, and improve the health system’s capacity for managing obstetric emergencies.

For 2005–2009, the Program for Health and Social Development identifies the following aims for safe motherhood, with greater emphasis on addressing poverty:
• The reduction of maternal, neonatal, and infant/child mortality through attention to the problems of acute respiratory infections, diarrheal diseases, malaria, malnutrition, and communicable diseases such as HIV infection and tuberculosis.
• The reduction of maternal morbidity and mortality through better maternal, antenatal, and obstetric care, and attention to nutritional deficiencies and communicable diseases.

Programmatic Priorities for Safe Motherhood

The government’s current priorities for maternal mortality include:
• Organization of a referral/evacuation system, and establishment of a solidarity fund financed by contributions from individual and village members in all district health facilities and hospitals
• Development and implementation of an emergency obstetric care (EmOC) program that includes postabortion care
Mali

• Follow-through on the recommendations and conclusions of the Regional Forum on Reduction of Maternal and Neonatal Mortality (Vision 2010)
• Implementation of a policy providing free services for women requiring cesarean delivery in all district and referral health facilities and all public hospitals
• Repositioning of family planning and coverage of unmet family planning needs as a means of reducing maternal, infant, and child mortality
• Development of alternative health care financing mechanisms (health mutual funds and health insurance schemes)
• Development of the human resource system

The deficiency in the number and quality of health and social services personnel has been identified as a serious concern for the government. This situation has prompted the country to formulate a policy aimed at improving the availability, quality, and motivation of health personnel through the planning and management of human resources, formulation of new professional training programs, revision of the training curricula, and strengthening the capacity of schools to train sufficient health care personnel. Accordingly, schools for the training of health personnel have been opened in almost every region in Mali, and an Institute for Training in the Health Sciences has also been created. A national continuing education policy, with norms and standards, has been disseminated nationwide.

As outlined above, current government priorities emphasize extending coverage and enhancing quality of services, developing alternative health care financing systems, and training human resources able to help improve the effectiveness and performance of the system. Over the past 20 years, there have been significant shifts in the government’s programmatic emphasis. Specific thematic shifts included:

- The training of TBAs: While in the years following 1987 the emphasis was chiefly on providing training to TBAs, the current emphasis is on the professionalization of skilled birth attendants. TBAs serve as a link to the formal health system and their role is oriented toward clean delivery, recognition of danger signs, and referral of pregnant women with complications to health facilities.
- A shift from risk screening to refocused antenatal care as an approach for managing obstetric complications and birth planning. The latter approach recognizes that frequent visits do not necessarily improve pregnancy outcomes, and that many women identified as “high-risk” do not develop any complications, whereas those considered “low-risk” can potentially experience them.

Monitoring and Evaluation

The mechanisms for monitoring and evaluating the national safe motherhood program include:

- Integrated supervision
- Quarterly reports from the health information system on maternal and neonatal morbidity and mortality data
- Annual report of the Health and Social Development Program, which contains specific reproductive health indicators
- Report of the monitoring committee for Vision 2010
- The health information system monitoring software (DESAM)
- Evaluation of EmOC facilities and the referral and evacuation system
• Audits of maternal deaths and serious cases of maternal and neonatal illness and safe motherhood assessments
• Twice-yearly monitoring meetings at community health centers to:
  - measure progress
  - identify operational problems and their causes
  - recommend corrective action that can be carried out with available local resources

In 1992, the physician/population ratio was 1:23,154, which is far below the recommended standard of one physician per 10,000 population. For the same period, the ratio of registered or graduate nurses to population was 1:12,120, which was also less than the recommended standard of 1 per 5,000. In 2001, the ratios had improved somewhat, particularly in the physician category, approaching the level recommended by WHO.

<table>
<thead>
<tr>
<th>Type of Health Care Practitioner</th>
<th>Ratio 1992</th>
<th>Ratio 2001</th>
<th>WHO Recommended Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>23,154</td>
<td>13,478</td>
<td>10,000</td>
</tr>
<tr>
<td>Graduate/registered nurse</td>
<td>12,120</td>
<td>10,022</td>
<td>5,000</td>
</tr>
<tr>
<td>Registered midwife</td>
<td>24,524</td>
<td>21,329</td>
<td>5,000</td>
</tr>
<tr>
<td>Practical/technical nurse</td>
<td>9,020</td>
<td>9,276</td>
<td>1,000</td>
</tr>
</tbody>
</table>

Between 1998–2004, the antenatal care rate rose from 48% to 69%, while the rate of skilled attendance during childbirth increased modestly, from 37% to 40%. A study conducted in Mali in 1998 indicated an unmet obstetric need of 52% (75% in rural areas versus 3% in urban areas). A subsequent analysis carried out in June 2005 demonstrated that the overall unmet obstetric need remains high (44%), with levels varying from one region to another.

Funding for Safe Motherhood

The health budget for the 2005 financial year is CFAF 55.7 billion, which is 6.7% of the total national budget. While the amount of the national budget allocated to health is known, it is difficult to determine how much of the health budget is allocated for safe motherhood, given the catch-all nature of the account.
About 80% of the health budget is devoted to the most vulnerable population groups—women, children, and young people. For 2005, the budget for safe motherhood at the central level is estimated at around CFAF 98.5 million; the budget figures for the regional and local levels, which account for a larger share, remain to be compiled.

As the table below outlines, financing for the health sector has been erratic between the ten-year period 1995–2005. While there was an increase in the health budget as a proportion of the total budget from 1999–2003 (from 5.3% to 6.8%), the percentage of funds allocated to health has declined.

With regard to the government budget for health, two persistent difficulties exist:
- The government budget remains insufficient to cover the operating expenses of national institutions; as a result, they are unable to function without outside funding.
- The proportion allocated to health within the overall budget in 2005 is only 6.68%, well below the target percentage established under the Abuja Declaration, in which the member states of the African Union agreed to devote 15% of their total budgets to health.

<table>
<thead>
<tr>
<th>Year</th>
<th>Health Budget (in Thousands of CFA Francs)</th>
<th>Total Budget (in Thousands of CFA Francs)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>25,683,090</td>
<td>353,960,000</td>
<td>7.26</td>
</tr>
<tr>
<td>1996</td>
<td>31,352,837</td>
<td>380,325,000</td>
<td>8.24</td>
</tr>
<tr>
<td>1997</td>
<td>28,777,080</td>
<td>400,323,000</td>
<td>7.19</td>
</tr>
<tr>
<td>1998</td>
<td>27,065,754</td>
<td>433,712,000</td>
<td>6.24</td>
</tr>
<tr>
<td>1999</td>
<td>23,967,365</td>
<td>476,113,000</td>
<td>5.03</td>
</tr>
<tr>
<td>2000</td>
<td>34,580,607</td>
<td>522,537,000</td>
<td>6.62</td>
</tr>
<tr>
<td>2001</td>
<td>36,943,517</td>
<td>556,881,000</td>
<td>6.63</td>
</tr>
<tr>
<td>2002</td>
<td>39,577,529</td>
<td>607,952,155</td>
<td>6.51</td>
</tr>
<tr>
<td>2003</td>
<td>51,322,941</td>
<td>754,385,000</td>
<td>6.80</td>
</tr>
<tr>
<td>2004</td>
<td>51,834,459</td>
<td>767,110,164</td>
<td>6.76</td>
</tr>
<tr>
<td>2005</td>
<td>55,749,686</td>
<td>834,576,138</td>
<td>6.68</td>
</tr>
</tbody>
</table>
The guidance issued with regard to the 2006 budget calls for greater emphasis on reproductive health and, especially, safe motherhood. Accordingly, CFAF 1.64 billion have been mobilized for safe motherhood activities, of which CFAF 840 million are to cover the cost of providing cesarean deliveries free of charge and CFAF 800 million are for the purchase of medicines, notably contraceptives.

Notable shifts have occurred in donor policies over the last several years; for example, there is greater emphasis on a program approach involving all donors, rather than on individual projects, and increased country ownership and greater emphasis on national five-year plans. Some donors, such as the Netherlands Development Organization, have opted for sector-wide budgetary support in 2006. Other partners plan on adopting SWAp in 2007.

**Conclusion**

The current policy of the Malian government on reproductive health and safe motherhood is fully in line with the Millennium Development Goals and the Vision 2010 targets, both of which identify maternal and child health as a priority. To translate this priority into action, a number of initiatives have been undertaken, including the designation of 8 June as National Maternal and Neonatal Mortality Reduction Day, the introduction of a policy providing for cesarean delivery free of charge in public health care facilities, and the awarding of the Tara Boré prize for outstanding efforts to reduce maternal and neonatal mortality.

In spite of this policy commitment, Mali faces a number of challenges in reducing maternal mortality levels; these include the scarcity of trained specialists; lack of incentives and career plans for health workers; shortages and poor distribution of health personnel, particularly midwives; high rates of unmet obstetric needs and low rates of skilled attendance during childbirth; and the threat of HIV/AIDS. In addition to human resource issues, other factors that have limited progress on safe motherhood include poor quality of services, inadequate budget levels, and the low level of education of the population, which contributes to poor use of services.

The current level of financing for health in Mali (in 2005) is well below the Abuja target of 15%. Despite strong political commitment, the level of financing is plagued with poor management and limited decentralization of funds.

To achieve its objectives with regard to safe motherhood, Mali needs to focus on:
- Extending health care coverage, with the creation or strengthening of community health centers offering the basic package of services.
- Increasing the financial resources allocated to the sector.
- Combating the persistence of certain customs and traditions that are harmful to health.
- Raising the level of literacy, education, and information among the population.
- Involving communities at the grassroots in health activities.
- Improving health human resources in both number and quality.
Situated on the east coast of Africa, the United Republic of Tanzania is bordered by Kenya and Uganda on the north; Rwanda, Burundi, and the Democratic Republic of the Congo on the west; and Zambia, Malawi, and Mozambique in the south. To the east lies the Indian Ocean. Population distribution in Tanzania is extremely uneven. Density varies from 1 person per sq km (3/mi²) in arid regions to 51 per sq km (133/mi²) in the mainland’s well-watered highlands. More than 80% of the population is rural, with much of the livelihood dependent on agriculture. The population is ethnically diverse, consisting of over 120 ethnic groups.

Tanzania’s population is estimated at 36.1 million (2004) of whom 51% are female and 47% are under 15 years of age. With the economy growing in real terms by 6.7% in 2004, Tanzania has one of the highest per capita income growth rates in Africa.

Ministry of Health (MOH) statistics and national surveys offer some indication of the magnitude of women’s health problems in Tanzania. According to DHS (2004) data, 25% of all women in Tanzania are currently using a contraceptive method and 17% are using modern methods. The National AIDS Control Program estimates the 2003 national HIV prevalence at 8.8%. Antenatal care attendance is high at 94% and has remained at roughly this level since 1992. In 2005, only 46% of deliveries were attended by a health professional at a health facility; this is a decline from 53% in 1992. Less than 2% of deliveries were conducted by cesarean section in 2004–2005 as compared to 3% and 2% in 1999 and 1996 respectively.

In terms of data on maternal mortality and morbidity, the Tanzanian government estimates that for the period 1995–2004 the maternal mortality ratio was 578; in the preceding ten years, the MMR was recorded at 529 deaths per 100,000 births. Because of the statistically insignificant difference between these figures, it is difficult to conclude whether national maternal mortality levels have improved or deteriorated in the last 20 years. While there is little data on maternal morbidity in Tanzania, it is estimated that between 150,000 to 450,000 women and girls suffer from pregnancy-related morbidities annually.

Despite the high rates of maternal mortality, it is believed that there is significant underreporting, with many deaths occurring outside of health facilities. Many of these unreported deaths are due to unsafe abortion, which are not disclosed for fear of stigma and/or prosecution. Reflecting a recent rise in mortality from anemia, malaria, and HIV/AIDS in Tanzania, an increased proportion of maternal deaths (approximately 40–50%) are due to indirect causes.

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Factors contributing to the persistently high levels of maternal mortality and morbidity include:

- poor quality and availability of basic and essential obstetric care, at primary and first referral level;
- insufficient numbers and outdated skills of health personnel, due to inadequate basic education, and lack of continuing education and supervision, with particular neglect of midwifery cadres;
- poor-quality antenatal care;
- cost of health care, as a result of official and unofficial charges, and fees for transport and delivery-related supplies; and
- weak referral systems.

Indirect factors include the HIV/AIDS epidemic and the increasing incidence of malaria; distance to health facilities; the low status of women and lack of decision making power; and the widespread poverty and inequity in access to health care.

**Government Policy for Safe Motherhood**

Beginning in the 1960s, the government pursued people-centered egalitarian policies which aimed to ensure and expand health services to the majority of the population. With regard to safe motherhood, there was no explicit policy prior to 1990; the government’s health and development objectives were laid out in the country’s five-year plans, as outlined below.

### The First and Second Five-Year Plans

The First Five-Year Plan (1964–1969) focused on the achievement of two major objectives:

- self-sufficiency in health personnel requirements and
- raising life expectancy from 35–40 to 50 years.

In 1967, the Arusha Declaration for Socialism and Self Reliance put forward an egalitarian, people-centered development philosophy that aimed to rapidly extend primary health care to all rural areas. Following the promulgation of the Arusha Declaration, the Second Five-Year Plan (1969–1974) sought to expand services with particular emphasis on controlling the spread of contagious diseases. Emphasis was placed on the provision of preventive services and on the construction of rural health units.

### The Third Five-Year Plan

Largely informed by the egalitarian philosophy of socialism and rural development, the Third Five-Year Plan (1976–1981), identified the following priority areas for health: environmental sanitation; good nutrition; expansion and consolidation of preventive services; enrollment of all school-age children in primary school; and construction of rural health centers and dispensaries. This period marked the beginning of a multi-sectoral approach in

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the delivery of primary health care, which brings together other areas and actors, including water, education, community development, political parties, and civil society organizations, in an effort to make use of all available resources.

In 1974, the first national maternal health program was launched. A coordinating team consisting of MOH, UMATI (National Family Planning Association), and UWT (National Women’s Organization) was appointed to formulate a maternal and child health policy and a unit was established in the Ministry of Health to plan, organize, coordinate, and administer its implementation nationwide. The overall goal of the program was to reduce the morbidity and mortality of mothers and infant children.

The overarching policy objective was to provide integrated health care services to at least 90% of the population by 1980 through a chain of rural dispensaries and health centers. Services at the lowest level were to be provided by trained MCH Aides—a new cadre of medical personnel—under the direct supervision of medical assistants and rural medical aides. The MCH Aides would replace traditional village midwives.

The program aimed to train 2,500 MCH Aides at the rate of 600 per year. By 1980, MCH Aide training schools had been built in each of the country’s 17 regions. Approximately 600 aides had graduated from them—far short of the 2,500 target. About 100 trainers had been recruited and retrained to take up teaching positions at the MCH Aide training schools. Over 3,000 basic MCH kits were in use in all the clinics in the country. By 1980, on average 93% of the population were living within 10 km of a health facility.

The 1990 National Health Policy

In 1988, the Ministry of Health appointed an internal team of experts to prepare proposals for a comprehensive national health policy. The team prepared and circulated initial suggestions and recommendations to other ministries and key players in the health sector for comment. The final proposals were submitted to the Minister in 1989 and formed the basis of the first Health Policy published in 1990.

The overall objective of Tanzania’s first health policy was “to improve the health and well-being of all Tanzanians, with a focus on those most at risk, and to encourage the health system to be more responsive to the needs of the people.”

The government states as its first specific policy objective: “to reduce maternal and infant morbidity and mortality and increase life expectancy through the provision of adequate and equitable maternal and child health services, promotion of adequate nutrition, control of communicable diseases, and treatment of common conditions.”

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79 MCH Aide training lasted 18 months, and included six months of practice at a recognized health center under the close supervision of the district MCH coordinator. Beginning in 2000, basic training for the MCH Aide cadre was discontinued, and the government embarked on upgrading all MCH Aides to Public Health Nurses-B and Clinical Officers through a two-year in-service training program.


81 Ibid.
Referring specifically to maternal and child health, the government directed that such services “must be provided in all health facilities throughout the country...as an integrated curative and preventive service which:

• Reduces deaths, diseases, and disabilities among women and children and women of child-bearing age;
• Provides comprehensive health education to mothers;
• Promotes proper health care to families through home visits and health education; and
• Sensitizes mothers, communities, and leaders at all levels about the importance of childhood immunization and solicits their active support.”


Tanzania was one of the first countries in sub-Saharan Africa to endorse and adopt a safe motherhood strategy. A multisectoral Safe Motherhood Task Force, consisting of representatives from government ministries, NGOs, and UN agencies, was established in 1989 to undertake a situation analysis and plan for the launch of the national safe motherhood program. Following its establishment, a national workshop was held in 1990, followed by a meeting of parliamentarians and other lawmakers in 1991, in an effort to raise awareness of and mobilize support for safe motherhood. These activities helped to raise the profile of safe motherhood at the national level and resulted in increased discussion and public attention to these issues.82

While finalized in 1991, the strategy was not published until a year later. Its implementation, however, was inconsistent and uneven, and little or no action was taken in key areas. Programs were implemented in a vertical fashion, and there was little coordination among relevant stakeholders. For example, no steps were taken to establish a multi-sectoral safe motherhood coordinating committee, as was called for in the strategy document. As a result, a WHO/UNDP/NORAD mission recommended undertaking a rapid assessment of maternity care in select districts. The evaluation, which was conducted using the Rapid Evaluation Method developed by WHO, assessed the quality and availability of maternal health services. The assessment revealed that quality of care was poor, and identified gaps in human resources, providers’ knowledge and skills, and equipment and supplies. In addition, the findings indicated that there was little community involvement in maternal health care.83

Based on these findings, the strategy was significantly revised in 1993 to adopt a more integrated approach to maternal health, and was reflected in the National Safe Motherhood Project Document of 1995–1999, which called for improving maternal health services and emergency obstetric care, and expanding family planning services. The Safe Motherhood Strategy was consequently superseded by a comprehensive strategy on reproductive health (see next section).


Following the International Conference on Population and Development in Cairo in 1994, the government developed a comprehensive strategy for reproductive and child health. This broader strategy, titled “The Strategy for Reproductive Health and Child Survival 1997–2001,” aimed to improve the health of women, children, and adolescents. With regard to maternal health care, the Strategy aimed to reduce maternal mortality by 50% by the year 2001 through the following strategies:

- improving the nutritional and socioeconomic status of women;
- strengthening postabortion and antenatal care;
- reviving postnatal care;
- increasing human resource capacity for managing maternal care;
- strengthening management of obstetric problems in health facilities; and
- enhancing efficiency of the referral system.

The Strategy was developed in the context of health sector reform (see next section), and provided a framework for district level planning. While no formal evaluation of the Strategy has been undertaken, anecdotal evidence indicates that little progress has been made toward stated indicators.


A follow-up strategy document, Reproductive and Child Health Strategy 2005–2010, was developed based on the experiences and lessons learned from the implementation of the previous versions. The vision of the Strategy is to foster “a healthy and well-informed Tanzanian population with access to quality reproductive and child health services that are accessible, affordable, sustainable, and which are provided through an efficient and effective support system.” Maternal health is identified as a key priority, and includes the following areas of action: focused antenatal care, skilled care during childbirth, care for obstetric emergencies, postpartum care, postabortion care, family planning, and prevention of harmful practices (e.g., female genital mutilation).  

The Strategy also puts forward a framework for research and monitoring and evaluation in an effort to better assess service utilization patterns and monitor progress on implementation of interventions.

Health Sector Reform and Decentralization

In 1996, the government instituted a process of health sector reform which included the decentralization of health care, cost-sharing, and other modifications in the delivery of health services. The planning, monitoring, and management of health services is devolved to district health management teams, as part of a strategy to provide greater autonomy in identifying and prioritizing the health needs of the districts. The government continues to guide policy formulation and regulation, while the private sector plays a more prominent role in the provision of health services. As part of this effort, cost-sharing of health services are decentralized to health centers and dispensaries, and communities assume responsibility for their own health care.

responsibility for the financing of health services through a range of mechanisms, such as community health funds.

As part of the health sector reform process, in June 1998 the government of Tanzania and the donor community agreed to pursue a SWAp to improve and increase government ownership of the health care delivery system, and to improve aid coordination. Donors have shifted from project-based development assistance to basket or pooled funding of a specific sector. Eight donors (the Danish International Development Agency (DANIDA), DFID, GTZ/KfW, Irish Aid, Netherlands, Norwegian Agency for Development Cooperation (NORAD), Swedish International Development Cooperation, and the World Bank) established a Health Sector Basket Fund (HSBF) through which they would deposit funds into a US$ holding account at the Bank of Tanzania. In 2005, while many donors continue sector-based support, some have shifted to general-budget support.85

The decentralization of health care delivery has altered the delivery system for safe motherhood and maternal and child health care.86 Each of the 113 district councils is required to prepare an annual health plan for recurrent and development expenditure. Since 2004, this process is part of an overall Council Development Plan and council-specific Medium-Term Expenditure Framework. A Basket Fund Committee, chaired by the Ministry of Health, President’s Office, Regional Administration and Local Government, and the Ministry of Finance, approves funding for each council on the basis of a consolidated Council Health Plan and recommendations made by MOH, and releases funds quarterly, in line with existing government procedures and based on performance reports and recommendations from both the Ministries of Health and Finance. The District Council therefore is the accounting office for all local and donor resources going into primary health care, including safe motherhood.

Both government and donor representatives interviewed for this report concurred that basket funding has succeeded in minimizing off-budget financing and improved coordination of the flow of donor resources into safe motherhood and other primary health care services.87 A recent increase in earmarked funding for specific health areas (e.g., HIV/AIDS, malaria, and TB) has, however, weakened joint planning processes, as these tend to operate in parallel project mode.

### Funding for Health

The Tanzanian budgetary allocation system consists of five broad sector categories: Administration, Defense, Social Sectors, Productive Sectors, and Economic Infrastructure. Health falls under the Social

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85 General-budget support is an approach in which allocation of donor finances to different sectors is left to the government to determine according to nationally defined priorities. Sector-budget support, on the other hand, is an arrangement under which a donor prefers to support a specific sector, regardless of sector priorities as defined in the national development plan.


87 Off-budget financing of development projects is discouraged because it is influenced by donor preferences and introduces distortions in the national development investment plan and in reporting on external development financing. The preferred option is general-budget support under which all donor resources are channeled through the Treasury, which then allocates them centrally to different projects according to nationally defined priorities.
Sectors category, along with education and water. Approximately 10% of the recurrent budget is allocated to health (see table below). Approximately 10% of the recurrent budget is allocated to health (see table below).

The four sources of funds for government expenditure on health include:
- domestic revenue;
- foreign loans and grants;
- private cost sharing through the Health Service Fund and Community Health Service Fund; and
- The National Health Insurance Fund (NHIF).

Beginning in 1999–2000, more than 50% of the health budget is financed by donor funds, largely through the HSBF, described above. Central government tax revenues finance between 43–46%, with the remainder of the budget supported by a health insurance scheme and two cost-sharing funds established between 2002–2003.


<table>
<thead>
<tr>
<th></th>
<th>Ceiling 2003/04</th>
<th>Projection 2004/05</th>
<th>Projection 2005/06</th>
<th>Projection 2006/07</th>
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<tr>
<td>Administration</td>
<td>27.3</td>
<td>34.9</td>
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<tr>
<td>Defense</td>
<td>18.1</td>
<td>15.9</td>
<td>15.8</td>
<td>15.8</td>
</tr>
<tr>
<td>Social Sectors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Education</td>
<td>22.3</td>
<td>20.5</td>
<td>20.6</td>
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<tr>
<td>• Health</td>
<td>10.8</td>
<td>9.7</td>
<td>9.6</td>
<td>9.6</td>
</tr>
<tr>
<td>• Water</td>
<td>1.5</td>
<td>1.5</td>
<td>1.5</td>
<td>1.5</td>
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<tr>
<td>• Other Social</td>
<td>0.6</td>
<td>0.6</td>
<td>0.6</td>
<td>0.6</td>
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<tr>
<td><strong>Subtotal Social Sectors</strong></td>
<td><strong>35.2</strong></td>
<td><strong>32.3</strong></td>
<td><strong>32.3</strong></td>
<td><strong>32.3</strong></td>
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<tr>
<td>Economic Infrastructure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Roads</td>
<td>7.7</td>
<td>6.7</td>
<td>6.7</td>
<td>6.8</td>
</tr>
<tr>
<td>• Others</td>
<td>3.7</td>
<td>3.1</td>
<td>3.1</td>
<td>3.1</td>
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<tr>
<td><strong>Subtotal Economic Infra</strong></td>
<td><strong>11.4</strong></td>
<td><strong>9.8</strong></td>
<td><strong>9.8</strong></td>
<td><strong>9.9</strong></td>
</tr>
<tr>
<td>Productive</td>
<td>7.5</td>
<td>6.8</td>
<td>6.6</td>
<td>6.6</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>100</td>
<td>100</td>
<td>100</td>
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</tr>
</tbody>
</table>


As stated previously, the HSBF was established in 1998 as part of the Health Sector Reform process, and is managed by a National Basket Financing Committee hosted by the Ministry of Health, the Ministry of Finance, and the President’s Office, Regional Administration and Local Government. While basket funds initially supported the recurrent budget, they have begun in 2001–2002 to support the development budget as well.88 Basket funding has increased steadily from 1.0% of total health funds in 1999–2000 to just over 15% in 2004–2005 as shown on the next page.

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88 The recurrent budget finances salaries and operational costs (such as drugs, fuel, etc.); the development budget funds capital works and purchases of a capital nature, such as new construction and repairs and the purchase of motor vehicles, machines, and equipment.
The government budget allocation for safe motherhood is not easily isolated as government records categorize it together with the other components of reproductive and child health. Further complicating matters is that funding for safe motherhood cannot be isolated from broad budget categories, such as human resources, equipment, drugs, transport, and communication. In addition, with primary health care devolved to local authorities, funding is also decentralized and consequently more difficult to isolate. A review of Public Expenditure Review reports produced every year provided important general budgetary information relating to the health sector but no specific data on the safe motherhood component.

Under the circumstances, budgetary allocation for reproductive and child health serves as the best proxy for government expenditure to safe motherhood. As the table below outlines, while there was an increase by 40% in the MOH budget between 2001–2002 and 2002–2003, there was a drop in the percentage of funds allocated to RCH/SM (from 5.9% to 3.7%). The subsequent year saw an absolute reduction in funds for RCH/SM, from Shs. 3.2 billion to Shs. 2.2 billion, although the total MOH budget remained steady. In 2004–2005, there was a large increase in the MOH budget for health, with a proportionate rise in the amount of funds allocated to RCH/SM.

### Sources of Health Expenditure by Percentage

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<tr>
<td>Government Funds</td>
<td>50.9</td>
<td>45.7</td>
<td>44.4</td>
<td>43.0</td>
<td>46.5</td>
<td>48.4</td>
<td>41.1</td>
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<tr>
<td>NHIF</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>2.5</td>
<td>2.7</td>
<td>3.4</td>
<td>2.2</td>
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<tr>
<td>Cost Sharing</td>
<td>0.9</td>
<td>1.1</td>
<td>1.0</td>
<td>0.6</td>
<td>0.7</td>
<td>2.4</td>
<td>1.7</td>
</tr>
<tr>
<td>Total Local Funds</td>
<td>51.8</td>
<td>46.9</td>
<td>45.5</td>
<td>46.0</td>
<td>50.0</td>
<td>54.2</td>
<td>45.0</td>
</tr>
<tr>
<td>Donor Basket Funds</td>
<td>0.0</td>
<td>1.0</td>
<td>5.9</td>
<td>11.8</td>
<td>15.1</td>
<td>8.0</td>
<td>15.2</td>
</tr>
<tr>
<td>Donor non-Basket*</td>
<td>13.7</td>
<td>7.0</td>
<td>7.0</td>
<td>6.4</td>
<td>10.1</td>
<td>11.1</td>
<td>10.3</td>
</tr>
<tr>
<td>Donor Others**</td>
<td>34.5</td>
<td>45.2</td>
<td>41.6</td>
<td>35.8</td>
<td>24.8</td>
<td>26.7</td>
<td>29.5</td>
</tr>
<tr>
<td>Total Foreign Funds</td>
<td>48.2</td>
<td>53.1</td>
<td>54.5</td>
<td>54.0</td>
<td>50.0</td>
<td>45.8</td>
<td>55.0</td>
</tr>
<tr>
<td>Total Health Funds</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>


**“Donor non-Basket” are members of the Health Sector Basket Fund who finance activities/projects without passing through the basket.

***“Donor Others” are donors who are not members of the Health Sector Basket Fund.**
Since the 1960s, Tanzania has demonstrated strong and consistent policy commitment to ensuring health services for its citizens, particularly in rural and other underserved areas. As part of this commitment, Tanzania was the first African country in the 1990s to issue a safe motherhood strategy as part of its national health policy. Following the ICPD in 1994, Tanzania developed a comprehensive reproductive health strategy that included safe motherhood as a key priority area. While there has been strong policy support for safe motherhood, program implementation has been weak and inconsistent. Policies have not been adequately funded to produce measurable impact or reach all districts. This has hampered a sustained decline in maternal mortality levels.

Tanzania’s funding base depends in large part on external donor support and in the last five years, dependency on donor funds to finance health has increased. Most bilateral and some multilateral donors have shifted their assistance from project-specific funding to a central basket that is used by the MOH for central and district-level health activities. While government budget allocations to health increased by 9% over the period 1999–2002, they remain below the target of 15%. The shift to basket funding has resulted in an overall improved coordination of funds; however, more needs to be done to ensure that funding for NGOs is maintained and that the government can respond to emergency needs in the health sector. It remains to be determined whether basket funding ultimately increases available resources for safe motherhood.

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>MOH Budget</td>
<td>39,200</td>
<td>49,390</td>
<td>61,600</td>
<td>86,380</td>
<td>86,380</td>
<td>104,081</td>
</tr>
<tr>
<td>RCHS/SM</td>
<td>—</td>
<td>—</td>
<td>3,655.8</td>
<td>3,199.8</td>
<td>2,170.0</td>
<td>8,081.3</td>
</tr>
<tr>
<td>Percentage of MOH Budget Allocated to RCHS/SM</td>
<td>0</td>
<td>0</td>
<td>5.9%</td>
<td>3.7%</td>
<td>2.5%</td>
<td>7.7%</td>
</tr>
</tbody>
</table>

Source: Planning and Privatizations and Ministry of Finance. Guidelines for the Preparation of Medium Term Plan and Budget Framework for 2004/05–2006/07
Since the launch of the global Safe Motherhood Initiative in 1987, the landscape for safe motherhood has changed dramatically. The last two decades have witnessed improvements in maternal health indicators, e.g., the proportion of births attended by a skilled birth attendant, and several middle-income developing countries (e.g., Honduras, Bolivia, Egypt) have dramatically reduced their maternal mortality levels. As one of the essential components of a comprehensive reproductive health framework, safe motherhood is central in the fight to reduce poverty and advance human development.

Since 1987, safe motherhood has achieved widespread attention and prominence in international agreements. The call for a reduction in maternal mortality has reverberated in all the major international conferences in the 1990s; most recently in the Millennium Development Goals, it was defined as essential for poverty reduction and development. Yet it is also recognized that maternal health has not achieved its due place in the global health agenda.

Over the past 18 years, the knowledge base for safe motherhood is more clearly articulated and understood. The technical interventions for preventing and/or treating the vast majority of obstetric complications are known, and have been identified as simple and cost-effective. There is broad agreement that good-quality maternal health services need to include skilled care for both routine and complicated cases, including emergency obstetric services for life-threatening complications, and a functioning referral system to ensure timely access to appropriate care. The challenge remains to develop and evaluate effective strategies through which this approach can be implemented in low-resource settings.

At the national level, as illustrated by the case studies presented in this report, there has been increasing political commitment for safe motherhood through the promulgation of national policies; these however, have not always been supported by adequate programs and financing. The case study on Lao PDR, for example, highlights how a range of specific policies and objectives to promote safe motherhood were developed at the national level, but did not receive adequate support for full-scale, nationwide implementation. In many of the case studies, the level of funding allocated to safe motherhood is impossible to discern, thus making it difficult to assess whether funding is sufficient to meet stated policy goals. Not only is safe motherhood absorbed within broader categories such as reproductive health and population, making it difficult to isolate, but recent trends in selected countries toward decentralization and basket funding have further complicated the challenge of identifying the amount of funding dedicated for maternal health. Finally, many general budget categories, such as commodities and personnel, include expenditures relevant to maternal health.

Over the last few years, a notable shift has reframed maternal health from a “disease-specific” approach focusing on “quick fix” interventions to improving the broader health system through which maternity
care is provided. The 2005 report of the UN Millennium Project Task Force on Child Health and Maternal Health calls for strengthening the health system, particularly at the district level, in an effort to achieve dramatic and sustainable progress in maternal health. A well-functioning health system can ensure the equitable and efficient delivery of safe motherhood information and services to the entire population, reaching them at home, in the community, and within health facilities at both primary and referral levels. Programmatically, this implies implementing multiple, mutually supportive strategies that affect systems (e.g., human resources, education and training, supplies and logistics, transportation, and communication, etc.) with the aim of improving the use and availability of high-quality maternal health services. Both the supply side (e.g., availability of drugs, supplies, and equipment; adequately trained personnel) and the demand side (community behaviors and practices regarding care-seeking during pregnancy and childbirth) of the equation need to be addressed.

As the findings highlighted in this report illustrate, financial trends have improved overall for safe motherhood since the launch of the global Initiative. But it appears that they are not adequate to meet international goals for improving maternal health. The goal of improving maternal health by 2015 will not be met unless dramatic action is taken. In discussions with a range of national decision makers and colleague agencies, the following recommendations were put forward:

• The most critical requirement for realizing MDG and ICPD goals in maternal health is for donors and governments to increase their financial commitment to maternal health specifically, and to the health sector more generally. Several representatives also reiterated the importance of ensuring that these funds are used efficiently:

> "We need to make sure funds are being used in the best manner, and we are using opportunities as they arise. How come we do not see PEPFAR\(^{89}\) as an opportunity for women’s health? We need to change our attitude to funding, and the environment of doing business."

Responding to the Challenge

Despite the strides made in maternal health, women in the developing world are still at extremely high risk of dying or being injured from pregnancy-related causes, with the lifetime risk of maternal mortality being as high as one in eight in some places. With the increasing focus on the MDGs, there is an extraordinary opportunity for accelerating progress and expanding efforts to improve maternal health worldwide. Governments are being called on to clarify their policies, develop practical and achievable plans, and identify the resources needed to achieve these goals. Civil society organizations can make a critical contribution to this process, in part by monitoring and evaluating the implementation of government programs (recommendations 2 and 3 of the UN Millennium Project, UNDP 2005).

89 PEPFAR is President George W. Bush’s Emergency Plan for AIDS Relief, a U.S. five-year $15 billion global initiative enacted in 2003 to combat the HIV/AIDS epidemic.
• Increased funds need to be invested in strengthening the existing health system. Donors need to broaden their funding scope, and move from a disease-based approach to one focused on making systemic improvements in the delivery of services. For maternal health in particular, the continuum of care at the health system needs to be addressed, from the community level to referral care available at the facility.

• Greater advocacy is needed for safe motherhood at the global and national levels. What has been missing from previous advocacy campaigns is a single, unified message supported by the safe motherhood community globally. Safe motherhood advocates have tended to lobby for individual or separate components (e.g., emergency obstetric care, skilled care during childbirth), rather than for maternal health as a whole.

• There needs to be better understanding of the various financing mechanisms in development. National funding strategies either have already adopted or are in the process of adopting a basket approach, in the form of SWAps, PRSPs, or other financing mechanisms. Only through engagement with finance and economics experts will safe motherhood be ensured a piece of the funding pie.

• Finally, health and gender equity need to be addressed within overall development strategies and those specifically for maternal health. Long-neglected issues within safe motherhood, such as unsafe abortion and the needs of pregnant adolescents (married as well as unmarried), should be dealt with in a scientific and nonbiased manner.

In maternal health we cannot get away with a health facility that is not functioning optimally, as may be the case for other diseases. For maternal health everything has to be connected and well tied together, or else it will result in higher mortality and higher morbidity.
### List of Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>BDD</td>
<td>Bidan di Desa (Program in Indonesia)</td>
</tr>
<tr>
<td>CHIPs</td>
<td>Country Health Information Profiles</td>
</tr>
<tr>
<td>EmOC</td>
<td>Emergency Obstetric Care</td>
</tr>
<tr>
<td>ENDESA</td>
<td>National Survey on Demographics and Health</td>
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<tr>
<td>EPMM</td>
<td>Post-Census Survey on Maternal Mortality (Bolivia)</td>
</tr>
<tr>
<td>FWCW</td>
<td>Fourth World Conference on Women</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>HDI</td>
<td>Human Development Index</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HSBF</td>
<td>Health Sector Basket Fund</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<tr>
<td>IEC</td>
<td>Information/Education/Communication</td>
</tr>
<tr>
<td>IHHS</td>
<td>Indonesian Household Survey</td>
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<tr>
<td>IMR</td>
<td>Infant Mortality Rate</td>
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<td>LAM</td>
<td>Local Area Monitoring</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MVA</td>
<td>Manual Vacuum Aspiration</td>
</tr>
<tr>
<td>NGO</td>
<td>Nongovernmental Organization</td>
</tr>
<tr>
<td>NPDP</td>
<td>National Population and Development Policy</td>
</tr>
<tr>
<td>ODA</td>
<td>Official Development Assistance</td>
</tr>
<tr>
<td>PER</td>
<td>Public Expenditure Review</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother-To-Child Transmission</td>
</tr>
<tr>
<td>PRSP</td>
<td>Poverty Reduction Strategy Paper</td>
</tr>
<tr>
<td>PSA</td>
<td>Public Service Announcement</td>
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<tr>
<td>RTI</td>
<td>Reproductive Tract Infection</td>
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<td>SFPR</td>
<td>Strategic Framework for Poverty Reduction</td>
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<td>SSN</td>
<td>Social Safety Net</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>SWAp</td>
<td>Sector-Wide Approach</td>
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<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
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<td>Agencies and Organizations</td>
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<tr>
<td>-----------------------------</td>
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<tr>
<td><strong>ACCESS</strong></td>
<td>Access to clinical and community maternal, neonatal, and women’s health services (USAID’s global program to improve maternal and newborn health)</td>
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<tr>
<td><strong>ACNM</strong></td>
<td>American College of Nurse-Midwives</td>
</tr>
<tr>
<td><strong>AMDD</strong></td>
<td>Averting Maternal Death and Disability</td>
</tr>
<tr>
<td><strong>AMPPF</strong></td>
<td>Malian Association for the Protection and Promotion of the Family</td>
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<tr>
<td><strong>DANIDA</strong></td>
<td>Danish International Development Agency</td>
</tr>
<tr>
<td><strong>DFID</strong></td>
<td>Department for International Development</td>
</tr>
<tr>
<td><strong>FCI</strong></td>
<td>Family Care International</td>
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<tr>
<td><strong>FHI</strong></td>
<td>Family Health International</td>
</tr>
<tr>
<td><strong>FIGO</strong></td>
<td>International Federation of Obstetrics and Gynecology</td>
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<td><strong>IAG</strong></td>
<td>Safe Motherhood Inter-Agency Group</td>
</tr>
<tr>
<td><strong>IDB</strong></td>
<td>Inter-American Development Bank</td>
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<tr>
<td><strong>IMMPACT</strong></td>
<td>Initiative for Maternal Mortality Programme Assessment</td>
</tr>
<tr>
<td><strong>IPPF</strong></td>
<td>International Planned Parenthood Federation</td>
</tr>
<tr>
<td><strong>MPS</strong></td>
<td>Making Pregnancy Safer</td>
</tr>
<tr>
<td><strong>NAC</strong></td>
<td>National AIDS Commission</td>
</tr>
<tr>
<td><strong>NHIF</strong></td>
<td>National Health Insurance Fund</td>
</tr>
<tr>
<td><strong>NIDI</strong></td>
<td>Netherlands Interdisciplinary Demographic Institute</td>
</tr>
<tr>
<td><strong>NORAD</strong></td>
<td>Norwegian Agency for Development Cooperation</td>
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<tr>
<td><strong>PAHO</strong></td>
<td>Pan American Health Organizatoin</td>
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<tr>
<td><strong>PCI</strong></td>
<td>Population Communications International</td>
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<tr>
<td><strong>PMM</strong></td>
<td>Prevention of Maternal Mortality Network</td>
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<tr>
<td><strong>PMNCH</strong></td>
<td>Partnership for Maternal, Newborn, and Child Health</td>
</tr>
<tr>
<td><strong>PROCOSI</strong></td>
<td>Collaborative Program for Integrated Health</td>
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<tr>
<td><strong>PROISS</strong></td>
<td>Integrated Project of Healthcare Services funded by IDB</td>
</tr>
<tr>
<td><strong>SIDA</strong></td>
<td>Swedish International Development Cooperation Agency</td>
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<td><strong>SMI</strong></td>
<td>Safe Motherhood Initiative</td>
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<tr>
<td><strong>UMATI</strong></td>
<td>National Family Planning Association, Tanzania</td>
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<tr>
<td><strong>USAID</strong></td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td><strong>UNAIDS</strong></td>
<td>Joint UN Programme on HIV/AIDS</td>
</tr>
<tr>
<td><strong>UNDP</strong></td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td><strong>UNGASS</strong></td>
<td>UN General Assembly Special Session on Children</td>
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<tr>
<td><strong>unicef</strong></td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td><strong>WHO</strong></td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Annex I: Development and donor agencies participating in in-depth interviews

Academy for Educational Development
Alan Guttmacher Institute
American College of Nurse Midwives
The Bill & Melinda Gates Foundation
Care International (USA)
Department for International Development (DFID), UK
Department for Development Aid Cooperation, Finland
EngenderHealth
Family Health International
Global Health Council
International Planned Parenthood Federation
Ipas
International Rescue Committee
IntraHealth International
MacArthur Foundation
Pathfinder International
Population Reference Bureau
Program for Appropriate Technologies in Health
Save the Children Federation
Swedish International Development Cooperation Agency (Sida)
United Nations Population Fund (UNFPA)
United States Agency for International Development (USAID)
Women's Commission for Refugee Women and Children
World Bank
World Health Organization

### Major Activities/Publications

- **International SM Conference (Nairobi, 1987); conference report**

- **Regional Workshops (1989–1994):**
  - *Andean region, 1993* (Bolivia, Colombia, Ecuador, Peru; held in Bolivia)
  - *Central America, 1992* (Belize, Costa Rica, Cuba, Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua, Panama; held in Guatemala)
  - *Francophone Africa, 1989* (22 sub-Saharan francophone countries; held in Niger)
  - *Arab states, 1988* (13 Arab states; held in Jordan)
  - *South Asia, 1990* (Bangladesh, Bhutan, India, Maldives, Myanmar, Nepal, Pakistan, Sri Lanka; held in Pakistan)
  - *Southern Africa, 1990* (Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, Swaziland, Tanzania, Zambia, Zimbabwe; held in Zimbabwe)

- **National Workshops (1989–1993):** Brazil, Cameroon, Ethiopia, Egypt, Indonesia, Mexico, Morocco, Namibia, Niger, Nigeria, Philippines, Sudan, Tanzania, Uganda

- **NGO Bellagio Conference (1989)**

### Area of Emphasis/Action

- **Gathered 130 participants to draw attention to maternal mortality and to mobilize action at the international and national levels**

- **To mobilize and inform government and NGO leaders around the issue of maternal death and disability**

- **To mobilize and inform government and NGO leaders around the issue of maternal death and disability**

- **Brought together world’s largest international NGOs involved in health/family planning to mobilize commitment to SM**
### Major Activities/Publications

- **Information Tools & Resources:**
  - *Challenge for the Nineties: Safe Motherhood in South Asia* (1990, full and summary versions)
  - SM brochure (1992, 1994) in English, Spanish, French, Arabic
  - Global Fact Sheet (1992)
  - Regional Fact Sheets (1990, 1994—South Asia, West Africa, Southern and Lusophone Africa, Mexico and Andean region)
  - Mexico & Andean SM conference declaration and report (1994)
  - Safe Motherhood Action Kit (1994) in English, Arabic
  - Safe Motherhood in Latin America and Caribbean (1994) monograph
  - Videos of the SM Regional Workshops: SADCC (1991) and South Asia (1990)

- **Meeting of Partners for SM** (Washington DC, 1992); background document; conference report (full and summary versions)

- **Program Guidelines Workshop** (Washington DC, 1992); conference report

- **Issues in Essential Obstetric Care Technical Meeting** (New York, 1995); conference report

### Area of Emphasis/Action

- To provide information resources on safe motherhood

- Review progress of the SMI at the local, national, and international levels; discuss priorities; and generate support for field-level programs. Shift from advocacy to design and implementation of community-level programs

- Gathered international experts to work toward development of SM program guidelines for World Bank staff and others

- Held to clarify the definition of EmOC, bridge the gap between research and program planning, and stimulate field-level activity
## II. The Tenth Anniversary (1997–1998)

### Major Activities/Publications

<table>
<thead>
<tr>
<th>Activity</th>
<th>Area of Emphasis/Action</th>
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<tbody>
<tr>
<td>SM Technical Consultation (Colombo, 1997)</td>
<td>Brought together over 200 specialists, program planners, and decision makers to share experiences, review needs and priorities, and identify cost-effective strategies for SM; development of ten SM Action Messages</td>
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<td>World Health Day (Washington DC and countries all over the world, 1998)</td>
<td>Issued a Call to Action to urge developing country policymakers to make SM a policy and programmatic priority and to ensure that SM receives continued, sustained financial support</td>
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<tr>
<td>Corporate Council</td>
<td>Aimed to raise awareness about the SMI among global corporations, and to encourage their support of SM</td>
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<tr>
<td>Information Tools and Resources</td>
<td>A set of materials designed to be useful, enduring, and targeted to different audiences</td>
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<tr>
<td>- SM brochure</td>
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<td>- Fact sheets</td>
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<td>- Pocket card</td>
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<td>- The SM Action Agenda: Priorities for the Next Decade</td>
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<td>- National press kits</td>
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<td>- SM Presentation Package</td>
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<td>- Public Service Announcements</td>
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<td>- Technical Consultation video</td>
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<td>- SM Experiences video</td>
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<td>- SM Web site</td>
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<td>- International Commitments to Safe Motherhood</td>
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<td>Media campaign:</td>
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<td>- media training for potential SM spokespeople; SM speakers’ bureau</td>
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<td>- creation of journalist circle</td>
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<td>- journalist press kit</td>
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**Major Activities/Publications**

  - Annotated bibliography of SM publications and other resources, structured along the ten Action Messages

- Dissemination of SM information and materials
  - Respond to individual requests for information and materials; distribute materials at relevant conferences and meetings

- SM Partners listserve (launched 2000)
  - Improve communication and collaboration among a range of organizations

**IV. Skilled Care During Childbirth (1999–2000)**

**Major Activities/Publications**

- Preparation of a “review of the evidence” paper
  - A review of the evidence on the impact of skilled care during childbirth in reducing maternal mortality

- Technical Consultation (Geneva, April 2000)
  - Gathered leading experts to assess the evidence on skilled care, and to develop key strategies for implementing the intervention in a range of developing country settings

- International Conference (Tunisia, November 2000)
  - Facilitated the development of national-level action plans on skilled care in selected countries in sub-Saharan Africa and South Asia

- A set of materials on skilled care:
  - policy booklet
  - briefing cards
  - country case studies
  - Tunisia conference report
  - Resources for program planners and managers interested in developing or modifying programs/projects on skilled care
V. Address Unsafe Abortion (2003–2005)

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<tr>
<th>Major Activities/Publications</th>
<th>Area of Emphasis/Action</th>
</tr>
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<tbody>
<tr>
<td>• Regional conference (Kuala Lumpur, Malaysia, September–October 2003)</td>
<td>Brought together delegations from 11 countries and internationally recognized experts to highlight unsafe abortion as a major contributor of maternal deaths and to situate it within the safe motherhood framework</td>
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<tr>
<td>• Conference report</td>
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Annex III: Ten Action Messages for SM

During the tenth anniversary of the Safe Motherhood Initiative, a series of “action messages” were articulated that summarized key programmatic priorities from the Initiative’s first decade. The messages highlight the most critical interventions for reducing maternal mortality and morbidity, and the range of barriers (economic, legal, social, and cultural) that women face in accessing high-quality maternal health care. These messages have been widely adopted by national and international partners, and are echoed in a range of publications produced by the Inter-Agency Group members and other partner agencies.

Each of the action messages is solidly grounded in research and country-level experiences—the first three messages are directed at changing the political environment to support women’s health and empowerment; the remaining seven action messages relate to health services and education.

The action messages are described in detail in the following two pages:

1. Advance Safe Motherhood Through Human Rights
2. Empower Women, Ensure Choices
3. Safe Motherhood Is a Vital Economic and Social Investment
4. Delay Marriage and First Birth
5. Every Pregnancy Faces Risks
6. Ensure Skilled Attendance at Delivery
7. Improve Access to Quality Reproductive Health Services
8. Prevent Unwanted Pregnancy and Address Unsafe Abortion
9. Measure Progress
10. The Power of Partnership
1. **Advance Safe Motherhood Through Human Rights**
Preventing maternal death and illness is an issue of social justice and women’s human rights. Making motherhood safer requires women’s human rights to be guaranteed and respected. These include their rights to good-quality services and information during and after pregnancy and childbirth; their right to make their own decisions about their health freely, without coercion or violence, and with full information; and the removal of barriers — legal, political, and health—that contribute to maternal mortality.

2. **Empower Women, Ensure Choices**
Maternal deaths are rooted in women’s powerlessness and their unequal access to employment, finances, education, basic health care, and other resources. These realities set the stage for poor maternal health even before a woman becomes pregnant, and can worsen her health when pregnancy and childbearing begin. Legal reform and community mobilization are essential for empowering women to understand and articulate their health needs, and seek services with confidence and without delay.

3. **Safe Motherhood Is a Vital Economic and Social Investment**
All national development plans and policies should include safe motherhood programs, in recognition of the enormous cost of a woman’s death and disability to health systems, the labor force, communities and families. Additional resources should be allocated for safe motherhood, and should be invested in the most cost-effective interventions (in developing countries, basic maternal and newborn care can cost as little as US$3 per person, per year).

4. **Delay Marriage and First Birth**
Pregnancy and childbearing during adolescence can carry considerable risks. To delay first births, reproductive health information and services for married and unmarried adolescents need to be legally available, widely accessible, and based on a true understanding of young people’s lives. Community education must encourage families and individuals to delay marriage and first births until women are physically, emotionally, and economically prepared to become mothers.

5. **Every Pregnancy Faces Risks**
During pregnancy, any woman can develop serious, life-threatening complications that require medical care. Because there is no reliable way to predict which women will develop these complications, it is essential that all pregnant women have access to high-quality obstetric care throughout their pregnancies, but especially during and immediately after childbirth when most emergency complications arise. Antenatal care programs should not spend scarce resources on screening mechanisms that attempt to predict a woman’s risk of developing complications.

6. **Ensure Skilled Attendance at Delivery**
The single most critical intervention for safe motherhood is to ensure that a health worker with midwifery skills is present at every birth, and transportation to a health facility is available in case of an emergency. A sufficient number of health workers must be trained and provided with essential supplies and equipment, especially in poor and rural communities.
7. Improve Access to Quality Reproductive Health Services
A large number of women in developing countries do not have access to maternal health services. Many of them cannot get to, or afford, high-quality care. Cultural customs and beliefs can also prevent women from understanding the importance of health services, and from seeking them. In addition to legal reform and efforts to build support within communities, health systems must work to address a range of clinical, interpersonal, and logistical problems that affect the quality, sensitivity, and accessibility of the services they provide.

8. Prevent Unwanted Pregnancy and Address Unsafe Abortion
Each year, an estimated 75 million unwanted pregnancies occur around the world. Many women without access to safe services for termination of pregnancy resort to unsafe abortion—which often results in death or disability. Unsafe abortion is the most neglected—and most easily preventable — cause of maternal death. These deaths can be significantly reduced by ensuring that safe motherhood programs include client-centered family planning services to prevent unwanted pregnancy, contraceptive counseling for women who have had an induced abortion, the use of appropriate technologies for women who experience abortion complications, and, where not against the law, safe services for pregnancy termination.

9. Measure Progress
Governments around the world have pledged to reduce maternal mortality by 50%. However, maternal mortality is difficult to measure, due to problems with identification, classification, and reporting. Therefore, safe motherhood partners have developed alternative means for measuring the impact and effectiveness of programs; for example, by recording the proportion of births attended by a skilled health provider. These indicators can identify weaknesses and suggest programmatic priorities so that maternal deaths can be better prevented in the future.

10. The Power of Partnership
Reducing maternal mortality requires sustained, long-term commitment and the inputs of a range of partners. Governments, nongovernmental organizations (including women’s groups and family planning agencies), international assistance agencies, donors, and others should share their diverse strengths and work together to promote safe motherhood within countries and communities and across national borders. Programs should be developed, evaluated, and improved with the involvement of clients, health providers, and community leaders. National plans and policies should put maternal health into its broad social and economic context, and incorporate all groups and sectors that can support safe motherhood.