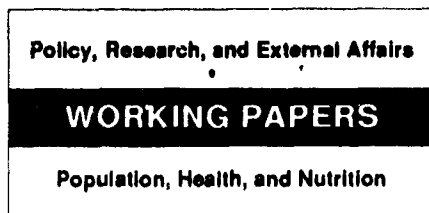


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Population and Human Resources
Department
The World Bank
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WPS 413

Supporting Safe Motherhood

A Review of Financial Trends

Full Report

L. M. Howard

FILE COPY

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

WORKING PAPERS

Population, Health, and Nutrition

This paper — a product of the Population, Health, and Nutrition Division, Population and Human Resources Department — is part of a larger effort in PRE to promote policy and resource commitment to the Safe Motherhood Initiative. Copies are available free from the World Bank, 1818 H Street NW, Washington DC 20433. Please contact Sonia Ainsworth, room S6-065, extension 31091 (50 pages with figures and tables).

Financial trends for safe motherhood initiatives.

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

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

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

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

- Strengthening recipient countries' ability to articulate project demand — providing specific training, technical advisory assistance, and operational guidelines for mobilizing financial resources.
- Improving the data on safe motherhood financial trends — establishing a consensus on definitions; seeking a consensus on financially measurable program or project categories of safe motherhood; defining methods for the systematic collection of donor and recipient country data on financial trends.

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

SUPPORTING SAFE MOTHERHOOD
A REVIEW OF FINANCIAL TRENDS

L.M. Howard

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

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

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

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I. INTRODUCTION

At the February 1987 Conference on Safe Motherhood in Nairobi¹, Herz and Measham (1987) presented a paper on "The Safe Motherhood Initiative," in which they proposed a new approach to reduce maternal mortality and morbidity in developing countries. Herz and Measham noted that in spite of progress toward child survival and improvements in life expectancy, an estimated 500,000 women, 99 percent of them from the developing world, die each year from pregnancy-related causes².

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

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

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

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

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

II. TERMS OF REFERENCE

A. *Purpose*

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

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

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

statistical methodology that may constrain the analysis, and establish a baseline for 1988 against which to measure future financial trends.

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

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

1. The wide variations in statistical methods for recording maternal health data make it difficult to compare data sets.
2. New projects started immediately after the conference are unlikely to have recorded expenditures in time to be included in this review.
3. The absence of international uniformity on the criteria for the initiative and the wide range of activities with direct and indirect maternal health effects means that much of the data were based on interpretations.
4. The relatively brief duration of the study.

B. Assumptions

1. The study looks at financial flows rather than cost-effectiveness, and does not assume that magnitude of investment is directly correlated to improvements in maternal health.
2. Because there is no comprehensive global system to monitor health expenditures by developing countries or external sources, the data would have to be obtained from each financial source.
3. Because of variations in statistical recording systems and in definitions of health, full comparability would be difficult to assure.
4. It would be premature to expect identifiable new financing specifically addressing the initiative. Official statistical systems have not been adjusted to identify SM components. As a result, the data reflect unofficial estimates derived from multiple sources. The author, not the sources, is responsible for the composite estimate.
5. To accomplish the study in the four-month period prior to the June 1989 Meeting of Interested Parties, direct interviews with the major bilateral and multilateral financial sources were considered preferable to risking a low response rate to a mailed questionnaire. For developing countries, however, the sources of information were resident WHO and UNDP representatives.

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

C. Methodology

1. The study drew on data sets for 1985 to 1989 in order to permit a comparison of trends before and after the Nairobi conference.
2. The data were examined for characteristics that would identify SM components.
3. Where there were no specific components within a health loan or primary health care program, the respondent was asked to estimate the amount of financing for SM. Information from interviews was supplemented by the official annual reports of bilateral and multilateral agencies.
4. For purposes of comparison, each financial source was asked to use common definitions and to include all major categories of ODA for the health sector as follows:
 - Bilateral financing (regional or country projects or programs)
 - Official contributions to multilateral sources (omitting assessed contributions, for instance, to WHO)
 - Official contributions to nongovernmental and private organizations.
5. Interviews were held with the following countries and other international organizations⁴ from January to March 1989:

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

⁴ For governmental organizations, the responsible international development aid authority was interviewed. The bracketed number indicates the number of official aid-related agencies. Development agencies in Australia, Canada, Japan, Norway and New Zealand were canvassed by mail or telephone. As of April 22 only two organizations had responded.

UNFPA
UNICEF
WHO Headquarters
World Bank

The following financial sources were not canvased:

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

D. *Definitions and Criteria for Safe Motherhood Activities*

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

- Reducing the number of pregnancies through family planning education, promotion, and services.
- Reducing the risks to pregnancy and childbirth from medical factors (for instance, hemorrhage) and environmental factors which impair maternal health (anemia resulting from hookworm); limited motivation and financial resources to make use of health facilities; poor identification of high risk mothers; constraints to transportation and communication during a period of emergency need. This effort includes three major components:
 - community-based family planning services, prenatal care, supervised deliveries at home or local health centers, screening and referral for high-risk mothers.
 - facilities and services for referred high-risk mothers at designated centers equipped to manage the complications of pregnancy.
 - communication and transport for high-risk and complicated deliveries.

1. Selecting Financially Measurable Program or Project Categories

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

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

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

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

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

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

3. Calculating the Safe Motherhood Content

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

a. Core Maternal Health Projects - Direct

- The actual percentage was used in the case of projects with a specific core SM content.

- **Family planning/population programs (excluding census activities): 100 percent.**
- **Specific maternal health projects: 100 percent.**
- **Contributions to and by UNFPA: 50 percent on expenditures for health, community-based delivery systems, fertility regulation and program management.**
- **Contributions to and by WHO: 100 percent for maternal health and the Program for Research on Human Reproduction. This figure/underestimates WHO contributions to member governments for general health programming and health systems that have a favorable indirect impact on maternal health.**

b. Inclusive Projects - Direct and Indirect

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

- **Health sector loans and primary health projects that include components to improve geographic access to pregnant women and that reduce maternal morbidity and mortality - 30 to 50 percent.**
- **AIDS projects. Improving the safety of blood banks prevents infection during transfusions - 10 percent.⁵**
- **Malaria and other major endemic disease control projects that reduce anemia - 25 percent.**
- **Water supply and sanitation projects are not included, though donors note the relevance of reducing the distance pregnant women are obliged to walk to get water. Up to 25 percent of rural water supply is included, if it is an integral part of a primary health or general health loan.**
- **Contributions to and by UNICEF. Since only 80 percent of UNICEF contributions are applied to health (primarily child health), the maternal care component is probably about 10 percent of total UNICEF program expenditures. (Unofficial UNICEF estimates attribute a larger percentage).**
- **Assessed contributions by member governments to UN organizations are excluded. Voluntary contributions for SM components by UN organizations are included.**
- **Governmental contributions to NGOs are included at a level of 25 percent. Global NGO contributions for health have been estimated at \$700 million. Information on funding for maternal health programs is extremely limited.**
- **Women in Development and other projects: as appropriate.**

⁵ Herz and Measham refer to estimates by Rochat (1985) indicating that hemorrhage accounts for a third of all maternal deaths in the Anantapur area of India and a half of all deaths in Indonesia and Egypt.

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

E. *Official Multilateral and Bilateral Development Data*

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

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

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

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

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

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

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

F. *Developing Country Data*

Efforts to track global health trends face enormous problems of methodology, staffing, and training. A basic statistical method in government budgeting is to categorize budget functions by such traditional components as personnel, transport, allowances, and equipment. While special studies permit

disaggregation into specific functions, such as primary health care, maternal health care, and nutrition, the absence of functional accounting does not permit disaggregation as a general practice. WHO has recently encouraged health ministries to establish accounting formats that identify the principal sources of income and specify the principal distribution of that income, by function and over time (Mach and Abel-Smith, 1983). Without functional accounting, health ministries find it difficult to attribute the total costs (manpower, equipment, facilities) to, say, primary health care or other subsectoral components.

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

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

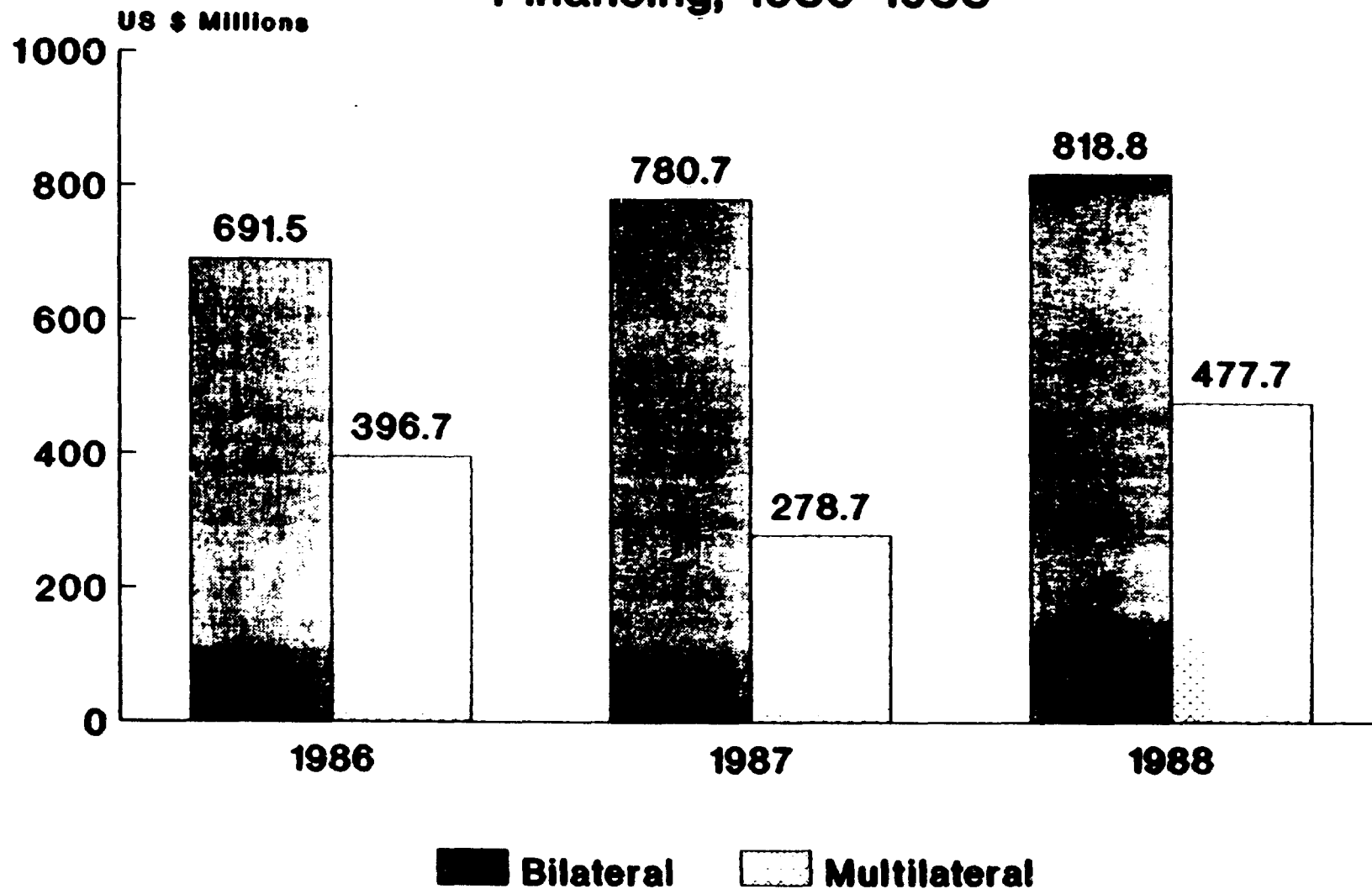


Figure 1

III. INTERVIEW NOTES

A. *Safe Motherhood Financing by External Financial Sources*

AUSTRIA

The Safe Motherhood Initiative is acceptable within the development policy of Austria. Estimates of SM content should be possible and would include bilateral programs, contributions to UNFPA, and a proportion of voluntary contributions to UNICEF. In 1988 there were several bilateral programs -- five in Africa, one in Asia, and one in Latin America. In addition, Austria participated in a \$10 million World Bank loan to Uganda.

ODA spending amounted to \$198 million in 1986 and \$196 million in 1987.

Technical staff does not record annual health sector statistics. The standard procedure is to record development programs by country. An annual approximation of spending on bilateral health programs is provided to DAC/OECD. Statistical information on program content is too sparse to permit conclusions on maternal health expenditures, except for UNFPA contributions.

Estimated Financial Flows to Developing Countries
\$ millions

	1985	1986	1987	1988
Total Health Sector (bilateral, multilateral, nongovernmental)	4.5	4.2	8.3	12.6
Safe Motherhood	.56	.47	2.8	5.3

Dept. of Development Aid
Federal Ministry of Foreign Affairs
Minoritenplaz 9
1040 Vienna

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

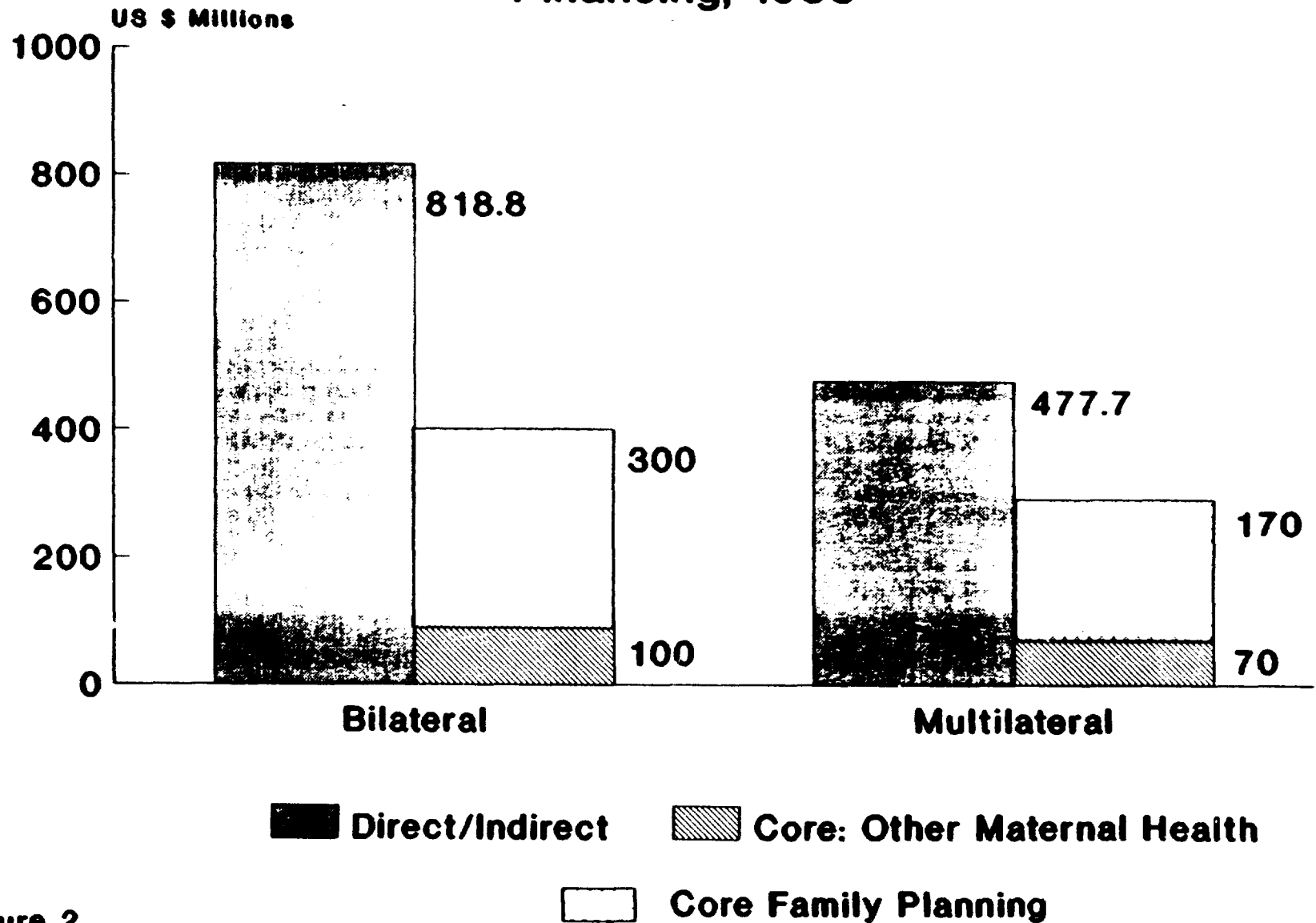


Figure 2

BELGIUM

Belgium's ODA levels rose from \$440 million in 1985 to \$689 million in 1987. Sixty percent of this aid is administered by the Belgian Development Agency (BADC), and the remainder through five other agencies, including the Ministry of Finance, which distributes about 35 percent of ODA. These proportions are not expected to change in the next few years.

Health sector expenditures increased from 8.9 percent of bilateral ODA to 10 percent in 1988 (\$39 million at current exchange rates). Officials expected the emphasis on health to decline slightly after 1990, a contraction that will affect three countries -- Zaire, Burundi, and Rwanda -- the recipients of 80 percent of Belgium's bilateral aid to the health sector. Altogether, health aid has been extended to about 18 of the 35 countries to which Belgium has extended cooperation. Geographic assistance is routed predominantly to Africa.

The share of maternal health in ODA is hard to identify. Statistical reporting methods do identify primary health, rural health, and rural and urban hospital projects, within which maternal care may play a large role. Using a narrow definition of direct support for maternal care, BADC estimates that at least 25 percent of bilateral projects in 1988 were committed to maternal care (approximately \$10 million), including maternity services and facilities at hospitals and rural health centers. Funding for multilateral activities in 1988 included an additional BF56 million (\$1.5 billion) for direct maternal health activities, for instance, through UNFPA, UNICEF, and for AIDS victims (partial) and indirect support for maternal care activities at the ICDDR (International Centre for Diarrheal Disease Research)/Bangladesh.

Cofinancing for NGO projects in public health were \$3 million in 1988, of which some \$1.5 million is attributable to maternal health support.

Estimated Financial Flows to Developing Countries
\$ millions

	1985	1986	1987	1988
Total Health Sector (bilateral, multilateral, NGO)	25	31	38	39
Safe Motherhood	8	10	12	13

Administration Générale de la Coopération au Développement (BADC)
Ministère des Affaires étrangères et du Commerce extérieur
Place du Champs de Mars 5
1050 Bruxelles

Estimated net flows for maternal care in 1988 were \$13 million.

The financial outlook beyond 1989 is favorable for support to UNFPA, UNICEF, and NGOs. Marginal declines will affect hospital-related maternal care funds in Zaire, although total health investments are expected to remain at a level of about 9 percent of sectoral assistance.

Health and Maternal Care Policy

Maternal care has long been a major component of Belgian assistance, with particular concentration on Africa (Zaire, Burundi, and Rwanda). BADC supports WHO's primary health care programs by working to expand the network of rural health centers and enlarge the infrastructure for referral to secondary or tertiary hospitals. BADC is sensitive to the specific problems of maternal mortality in Africa and attempts to address the complications of childbearing through hospital and laboratory services.

In supporting services at the village, urban and research institute levels with WHO and Belgian NGOs, health sector policy singles out high-risk populations. Mothers are specifically included in this group⁶. BADC considers it counterproductive, however, to initiate separate vertical programs for maternal health or Safe Motherhood. These views mirror those of a number of other European donors that are committed to Safe Motherhood practices within the context of primary health care. For example, the Belgian Government has assisted Senegal's Ministry of Health, with a study of the Project Pikine on maternal health (Senegal, Ministry of Health 1989). In the Belgian view it is not only important for the donor to recognize the risks of childbearing but to help recipient countries identify high-risk populations. The implication is how to strengthen recipient country demand.

⁶ The principles of health sector assistance, including support for maternal health, are stated in the February 1988 (second edition) of *La Belgique et la Coopération au Développement*.

CANADA

Canadian ODA increased from \$1.631 billion in 1985 to \$1.885 billion in 1987. Continued growth is anticipated with the government's decision to maintain appropriations at the 0.5 percent of GNP through 1991.

Detailed computerized project information was provided for 1985 to 1988, with the caveat that such data do not identify Safe Motherhood components. The distribution given below was estimated using the Herz-Measham criteria.

For comparability with other data sets in this review, funds for water supply systems have been excluded unless water and sanitation are integral parts of assistance to other general health systems. The Canadian data offers the potential for attributing at least a third of such services to SM, since access to water is directly relevant to the daily work of women of reproductive age and contributes to the reduction of anemia-producing parasitic diseases.

Policy

Canada intends to focus on maternal health and family planning, with the broader goal of improving the health of women. This intent suggests a willingness to identify more specific statistical markers for maternal health.

An important component of Canadian assistance is the value given to country demand; financing depends less on preplanning by CIDA than on responding to requests from cooperating countries.

Estimated Financial Flows to Developing Countries \$ millions

	1985	1986	1987	1988
Total Health Sector (bilateral, multilateral nongovernmental)	77.6	101.58	131.56	148.1
Health plus Water/Sanitation	149.0	172.0	223.9	327.8
Safe Motherhood (SM)	15.7	36.6	43.0	44.1
SM with Water/Sanitation	51.3	72.2	89.6	133.9

Canadian International Development Agency
200, Promenade du Portage
Hull (Quebec)
Canada K1A 0G4

DENMARK

Comprehensive health project data are not routinely collected, so annual sector amounts are rough estimates. For comparability with other donors, water data is excluded from this review.

The estimated SM attribution of Denmark's contribution to WHO includes 30 percent for TDR (for instance, malaria research), 10 percent for immunization (tetanus), 50 percent for the essential drugs program, and 100 percent for research on human reproduction. The share of UNFPA and IPPF allocations for SM are 50 and 100 percent, respectively. Twenty-four percent of contributions to UNICEF are attributed to SM.

It is assumed that half of the NGOs supported by DANIDA work in the health sector and that half of these activities are of direct benefit to mothers.

There appears to be a net increase in DANIDA contributions to the health sector over the three-year period from 1986 to 1988, including bilateral, multilateral and NGO contributions (but excluding funds for water). There has been no measurable increase in bilateral health financing, but multilateral financing levels have increased.

Between 1988 and 1992 ODA is expected to increase from \$890.8 million to \$1.162 billion. Multilateral cooperation accounts for about 40 percent of ODA.

Although estimated levels of support for Safe Motherhood show no marked increase since 1986, the direction of support is positive. Maternal health benefits from DANIDA's policies of support for primary health care, family planning, water supply, essential drugs, and other priority programs. DANIDA questions whether a new program emphasis is needed or whether Safe Motherhood issues should be addressed through better health sector program analysis at the country level. A staff member observed that reducing the causes of maternal mortality would require, in addition to family planning, strong support for facilities and transport to cope with the complications of pregnancy, particularly hemorrhage, infection and toxemia. The discussion highlighted the weakness in the recipient countries' ability to identify appropriate areas for external cooperation.

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A further question is whether socioeconomic development, in the long-term, might be sufficient to lower maternal mortality rates. The discussion concerned the impact of long-term development on health. The author noted that the actual reduction of maternal mortality in developed countries has been associated with the specific practice of hospital versus home childbirth deliveries -- a practice that permitted access to specialized care for the complications of childbirth. While socioeconomic development has favorably influenced this process, the change has been brought about through specific obstetrical expertise and facilities. Based on the decline of maternal mortality rates in Europe and North America, such Safe Motherhood components as family planning, nutrition, education, and improved economic levels are thought to be necessary but insufficient factors if developing countries are to lower maternal mortality to the levels prevalent in developed countries.

Estimated Financial Flows to Developing Countries
\$ millions

	1986	1987	1988	1989 (estimates)
ODA	829.8	926.9	890.8	953.5
<u>Health</u>				
Bilateral	27.0 (15)	28.2 (7.9)	28.0 (7.9)	--
Multilateral	21.7	30.4	34.0	38.8
WHO	6.9 (3.2)	10.0 (3.4)	11.0 (3.6)	--
UNFPA	7.2 (3.6)	10.0 (5.0)	11.2 (5.6)	12.4 (6.2)
UNICEF	7.6 (1.7)	10.4 (2.5)	11.8 (2.8)	15.4 (3.4)
Non-UN				
IPPF	2.6 (2.6)	3.1 (3.1)	3.5 (3.5)	4.16 (4.16)
NGOs (All sectors)	5.6 (1.8)	16.0 (4.0)	16.0 (4.0)	--
Total	56.0 (26.2)	77.7 (25.9)	81.5 (27.4)	--
(at an exchange rate of DK6.85 = \$1.00)				

Danish Department of International Development Cooperation
(DANIDA)
Ministry of Foreign Affairs
Asiatisk Plads 2
DK-1448 Copenhagen

Note: **Brackets** indicate estimated Safe Motherhood component.
DANIDA staff note that identifying Safe Motherhood components from current statistical records is difficult and these estimates are tentative.

Source: Denmark's Development Assistance 1987/88, Ministry of Foreign Affairs 1988; Memo on Danish Health Aid for 1987; a series of memoranda providing projections for UN organizations.

EUROPEAN COMMUNITY

Total EC development financing has increased almost 140 percent, rising from \$800 million in 1978 to \$1.9 billion in 1986. Financing under the EC's current five-year cycle (1986 to 1990) by the Sixth European Development Fund is approximately \$9.25 billion. Health sector financing is estimated at about \$37.5 million a year, excluding rural and urban water supply.

While precise annual expenditures for health or maternal health are difficult to identify, expenditures in the health sector generally support SM activities through:

- Rehabilitation of urban hospitals (including consideration of recurrent costs).
- Development of integrated health systems.
- Strengthening of district health systems.

In addition to EDF expenditures, health-related programs are incorporated into refugee programs and NGO projects.

The EC considers maternal health a component of primary health care projects rather than a separate program. Maternal health components (including operational research) are eligible for support as part of the health system investment.

The EC responds to requests from recipient countries, although demand for the health sector is still articulated with difficulty by developing countries. The Community is prepared to respond to appropriately channelled requests for assistance.

A health sector paper is now under preparation. The Community's policy is to provide support for global health priorities, such as primary health care (including maternal health), provided that recipient countries identify and include projects within the EC's indicative program for each country. This applies particularly to the African/Caribbean/Pacific States (the Lomé Convention).

Because the EC has only one professional staff member at headquarters level responsible for the health sector, promotion and monitoring of Safe Motherhood initiatives is difficult.

Directorate-General for Development (DG VIII)
Commission of the European Communities
Rue de la Loi 200
1049 Brussels, Belgium

FINLAND

Finnish International Development Agency (FINNIDA) policy provides support for maternal health and family planning within primary health care programs. There are no projects specifically labelled Safe Motherhood and the agency's statistical system does not provide information on SM components. Officials agreed to estimate SM components of bilateral, multilateral and NGO disbursements over the past several years.

Planning and negotiating bilateral projects of any size often requires more than two years. It would be premature to expect significant change in investments in SM in the two years since Nairobi.

Reflecting the agency's experience in Sri Lanka, FINNIDA notes that external support must often take into account the availability of counterpart financing. Such financing is often part of a country's multi-year plan. The time required for such planning and legislative approval is often a constraint on efforts made by external agencies to accelerate project financing.

As for financing by developing countries, it is FINNIDA's impression that social sector financing in their cooperating countries (for example, in Tanzania) is declining.

In 1985 Finland agreed to try to meet the DAC target of setting aside 0.7 percent of GNP as foreign aid by the end of the decade. In US dollars disbursements have increased from \$134.7 million in 1981 to \$432 million in 1987. For 1988 the budget was \$622.5 million (disbursement statistics for 1988 are not yet available). With this increase in total ODA, the health sector's share increased from 5.1 percent in 1983 to about 9 percent in 1987. Finland also contributes to UNFPA, UNICEF, and WHO. In absolute terms total bilateral and multilateral health contributions increased from approximately \$23 million in 1985 to approximately \$54 million in 1987, pointing to a gradual increase in the future. Subject to the pending report from Helsinki, the estimate for SM in 1987 would be \$6 million in bilateral aid, \$9 million to UNFPA, \$6 million to UNICEF and up to \$500,000 for WHO -- an estimated 1987 total of \$21.5 million. This support for SM components should increase along with support for primary health care bilateral projects, UNICEF, UNFPA, and WHO. For 1988 total budgeted ODA is \$622.5 million, a 30 percent increase over 1987. Subject to confirmation, the maternal health component would approximate \$28 million in 1988, if it increased at the same rate.

**Finnish International Development Agency (FINNIDA)
Ministry of Foreign Affairs
Mannerheimintie 15 C
SF-00260 Helsinki**

FEDERAL REPUBLIC OF GERMANY (1)

Between 1985 and 1987, Bonn's net annual commitment to health activities increased from DM304 million to DM352.5 million (\$195 million at 1987 exchange rates). Sector totals increased from 4.2 percent to 5 percent of total development financing. In fiscal 1989 the major emphasis in the health sector will be on maternal health, community health, and health education and planning. Past and current priorities in support of family planning and AIDS have received strong interest from Parliament. The emphasis of the Federal Ministry for Cooperation (BMZ) on maternal health is based on the importance of the mother as a key figure in implementing efforts in community health, population, and child health.

Support for family planning and maternal health programs in two regional training centers in Africa are direct manifestations of support for the Safe Motherhood Initiative (see following entry on GTZ).

BMZ notes some constraints on the development of SM programs, such as staff shortages in Health ministries already preoccupied with the administration of large family planning programs. BMZ notes that the World Bank and WHO could take a more dominant role in supporting the need for SM--and for its financing -- in view of the many competing development priorities. Specifically, officials suggest the World Bank might have greater influence if new health sector policy guidelines were prepared.

Section 221
Health, Population, Sport, AIDS, and Drug Addiction
Bundesministerium für wirtschaftliche Zusammenarbeit (BMZ)
Federal Ministry for Economic Cooperation
Karl-Marx Strasse 4-6
Postfach 12032
5300 Bonn

FEDERAL REPUBLIC OF GERMANY (2)

The Germany Agency for Technical Cooperation (GTZ) is a government-owned corporation that provides technical services and implements bilateral health assistance projects. Since 1985 such bilateral projects have represented 40 to 47 percent of total annual health sector commitments by the Federal Republic of Germany.

Project statistics for the current portfolio show annual expenditures as well as the year of origin and life-of-project funding. This mode does not facilitate estimates of annual expenditures.

Thirty-five selected current multiyear projects that contain Safe Motherhood components have a total project-duration value of DM138.56 million. A rough estimate of the SM content for these projects puts it at DM97.4 million (\$54 million at current exchange rates), about 70 percent of the total disbursement value of current projects.

Annual expenditures on health, nutrition, and population projects increased from DM38.36 million in 1983 to DM63 million in 1988. An estimate 50 percent of these projects have an SM component. For 1988 the bilateral SM component was approximately \$17.5 million. The outlook for an increase in SM components is favorable in view of the progressive increase in annual GTZ financing.

Both the policymaking headquarters at Bonn and the implementing agency have endorsed the importance of maternal health. Training for traditional birth attendants was supported as early as the 1960s. Current SM components include prenatal care, identification of high-risk pregnancy, family planning, maternity hospital construction, primary health care, outreach services, and training. The historical emphasis on hospital construction has shifted in favor of primary health care programs. The agency has put special emphasis on improving the status of women.

As a direct result of the 1987 conference there is now an effort to support regional training centers for maternal and family health in Ouagadougou for Francophone Africa, and in Harare (IEC component) for Anglophone Africa.

The outlook for continued support for SM is favorable not only because of rising health expenditures but also because of the increase in total financing for development. The annual levels of GTZ support for health or for SM components are not predetermined. West German assistance is based upon country request. In the absence of resident health representatives (in contrast to project-assigned health specialists), it has been difficult for GTZ to generate demand for health sector assistance. For the past 10 years, health expenditures have been approximately 4 percent of total BMZ annual commitments (5 percent in 1987). There is an agreement with WHO to cooperate in specific projects for German assistance. Beyond this, there has been no special effort to strengthen national capability in developing countries to mobilize external assistance. In effect, the potential for greater BMZ assistance is possible if the demand can be identified by the developing countries.

Tangential to the main directions of SM support, GTZ is providing \$3 to \$4 million to improve hospital laboratories as one measure to control AIDS. The impact on improved blood transfusion services has obvious implications for obstetrical emergencies.

Health, Nutrition and Population Development Division
Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH
(German Agency for Technical Cooperation, Ltd.)
Dag Hammarskjöld-Weg 1
6236 Eschborn 1 (Postfach 5180)

FRANCE

France is the largest general development donor in Sub-Saharan Africa and the second largest on the continent. France's ODA rose from FF24.8 billion in 1985 to FF27 billion in 1987 and is expected to increase further in 1988 and 1989.

Aid to the health sector has climbed from approximately \$232 million in 1985 to \$295 million in 1988.⁷ Maternal health funding in the form of maternal and child health programs, health facilities development, disease control, nutrition and UN contributions is estimated at \$70 million (1985), \$60 million (1986), and \$90 million each in 1987 and 1988.⁸

Ministry officials endorse the importance of protecting the health of mothers. Projects for this purpose are largely integrated with programs for health and preventive medicine, making estimates of SM content extremely difficult.

France supports a broad approach to health, which includes both preventive and hospital-based maternity care. Approximately 90 percent of these programs are concentrated in 36 African and Caribbean countries. Programs emphasize prevention and disease control in populations that have limited access to medical facilities. An attempt is made to integrate health in general development programs, including nutrition, the role of women, and regional programs to control major endemic diseases.

To accomplish this program France employed 850 technical field staff in 1988. The Cooperation and Development program emphasizes the importance of education and training for health. Medical research receives continued support through Africa-based French institutions such as ORSTOM, the French overseas scientific and research organization.

While the financial prospects for maternal health are favorable, there is no immediate prospect of a special emphasis on SM in view of the inclusion of principal components in the general health program.

Ministère de la Coopération et du Développement
20, rue Monsieur
75700 Paris

⁷ Based on official reports to DAC/OECD, with supplementary data on contributions to WHO, UNFPA and UNICEF.

⁸ These totals exclude bilateral assistance through other channels, for instance the Ministry of Foreign Affairs, the Central Bank for Economic Cooperation, and the Ministry of Finance.

ITALY (1)

Italian officials prepare annual reports on bilateral sector financing for DAC/OECD, but there is no annual report listing all bilateral and multilateral sector projects. The annual health assistance report for 1988 was expected to be available in April, 1989.

The total volume of aid has increased markedly during the 1980s. According to DAC figures, health aid climbed from \$13 million in 1981 to \$206 million in 1986. The 1987 commitment was estimated at \$380 million and assistance is expected to exceed \$400 million in 1988, excluding support for private sector financing, some of which may pay for medical infrastructure.

Disbursements are estimated at \$94 million (1985), \$118 million (1986), and \$298 million (1987). The lag between commitments and disbursements for 1986 and later years suggests the rapidity with which sectoral aid is growing.

Health as a percentage of total development financing ranges between 6 and 8 percent, with an informal target of 10 percent. This growth suggests that Italy and Japan are the two major potential new bilateral sources for health financing.

In the absence of precise statistical data on maternal health components, officials estimate a 1988 level of \$40 million, approximately 10 percent of total bilateral and multilateral health sector commitments. Health sector expenditures have increased, although the estimated share for maternal health has not changed over the past several years.

Italian aid supports a number of investment categories for which no precise estimate of maternal health financing has been made, such as hospital infrastructure, essential drugs, and emergency services. Thus investment in hospital-based obstetrical care, as a part of general hospital facilities, is omitted from the maternal health total. For example, funds for the University Hospital in Mozambique reaches \$10 million over a three-year period (1987-90). An estimated 50 percent of all hospital beds and services are provided for obstetrical services and the complications of pregnancy.

By parliamentary resolution 40 percent of Italian aid is allocated for Africa; 80 percent is concentrated in five countries -- Ethiopia, Somalia, Mozambique, Angola, and Guinea-Bissau. A new three-year program to spend \$1.4 million has been announced in support of Safe Motherhood in these five countries. The government also supports the UNICEF-sponsored Bamako Initiative to support maternal and child health projects in countries south of the Sahara, including safe motherhood, child-spacing, and training of traditional birth attendants.

In nutrition, a five-year \$185 million contribution has been made to 17 African countries. The percentage attribution to maternal health is not stated.

Italian aid supports the Safe Motherhood Initiative, and financing in this area is likely to emphasize Latin American countries, particularly the Andean and Caribbean areas. Technical areas of emphasis will include maternal health care, both at the district level and within bilateral support of hospital facilities. Nutrition support will continue as at present. Sectoral financing will continue through the approximate 60:40 bilateral to multilateral division of contributions.

Within the broad definition of SM, it is difficult to identify specific development programs that fall under this rubric, since hospital services, professional training, transport, and nutrition benefit the whole population. Yet aside from specific prenatal care, treatment for the major causes of maternal mortality requires access to hospital facilities. Italian aid officials are concerned that maternal care may

not be adequately addressed in the district-level orientation of WHO and UNICEF, although they are aware of international opinion regarding over-investment in hospital infrastructure. There is also evidence that the recent emphasis on child survival, immunization, and other vertical programs produces substantial distortions in host-country budgeting and programming. Vertical programs are often justified on the grounds that they are cost-efficient, without considering that developing countries need to address other serious health problems that may also demand hospital services. For these reasons, policymakers say governments need help in planning health services to meet national needs. Italian development aid also offers technical staff to assist countries with sector studies.

Ministry of Foreign Affairs
Direzione Generale per la Cooperazione all Sviluppo
via Contarini No. 25
Rome

ITALY (2)

According to Dr. Ranieri Guerra, who has the responsibility for preparing official Italian health sector aid statistics, there is a current portfolio of 333 multiyear projects, of which approximately 100 projects with a total value of \$529.3 million have identifiable maternal health components. These components include maternity hospitals, general hospitals, health systems, maternal and child health programs, essential drug distribution, nutritional support, and emergency services. Assuming a 10 percent share goes to maternal health, the contribution to SM may be about \$52 million.

The outlook for continued support in maternal health is favorable. Italian aid planners feel that funds are not a limitation; the problem is identifying and preparing field projects.

Instituto Superiore di Sanita (National Institute of Health)
Aula Missiroli
via del Castro Laurenziano, 25 (also V. le Regina Elena 299)
00161 Rome

JAPAN

Japan is accelerating its development aid program and plans to disburse over \$50 billion during the period 1988-1992. Development aid is channelled through the Ministry of Foreign Affairs, the Japan International Cooperation Agency, and the Japan Overseas Economic Fund. Health sector aid ranges between 3 and 4 percent of ODA, or about \$360 million for 1987. These statistics often exclude large grants to UN organizations, including 1987's \$36 million to UNFPA and \$18 million to UNICEF.

While Japan supports international global priorities on primary health care, its policy is to respond to official development requests. In this sense, Japan provides one of the best examples of the importance for developing countries to articulate their own health priorities. Since Tokyo does not pre-allocate funds, trends are not readily identifiable. Currently Japan is cooperating in the support of eight hospitals, including professional and laboratory training. Through its UNFPA contribution (\$36 million in 1987), and through separate maternal and child health programs, there is substantial ongoing support for SM components. There is favorable potential for cooperation to provide support for critical areas of hospital-based care for high-risk births.

With 60 percent of all Japanese assistance going to Asia, geographic preferences should be kept in mind for global planning.

Estimated Financial Flows to Developing Countries
\$ millions

	1985	1986	1987	1988
Total Health Sector (multilateral, bilateral, non-governmental)	412	288	360	400
Safe Motherhood activities	40	30	40	45

Ministry of Foreign Affairs
2,3 - chome Kasumigasekei
Chiyoda-ku
Tokyo

Ministry of Health and Welfare
1-2-2 Kasumigaseki
Chiyoda-ku
Tokyo

Japan International Cooperation Agency
Shinjuku Mitsui Building
2-1-1, Nishi-Shinjuku
Shinjuku-ku
Tokyo

THE NETHERLANDS

Since 1895 the Netherlands development policy has emphasized well-integrated multisectoral development. The primary categories of assistance are rural and industrial development. Components such as health care, family planning or support for women in development are accepted as contributing elements but not as sectoral objectives. Health projects are identifiable for statistical purposes, but health is not programed as a separate sector. The budget categories include:

Category I: Sector Programs

- Rural Development -- food production, nutrition, food aid, infrastructure (including water, health care, family planning), energy and ecology, technical training, education, research (including health).
- Industrial Development

Category II: Country and Regional Programs

- Health, population, women in development (WID).

Category III: Multilateral Programs

- Health, population, WID.

Category IV: Joint Financing and Volunteer Program

- Health population financing through major NGO groups.

Category V: Netherlands Antilles and Aruba.

Category VI: Other Expenditures.

- Refugee assistance.

Budget categories follow development policy. Financial statistics in health are not routinely identified or collected except for bilateral medical and health care data reported under the special criteria of the DAC/OECD Creditor Reporting System. It is central to Dutch development policy that improvement of health in the context of development is a multisectoral consequence and cannot be defined in narrow terms. Dutch policy emphasizes the importance of responding to articulated demand for development assistance. While primary health care, for example, is strongly supported, so are programs which influence health status such as literacy, education, employment, water supply and rural development. Under this policy it is unlikely that the Dutch would support SM as a separate vertical program.

In view of longstanding Government support for primary health care and family planning, it is consistent that the Dutch have supported the Nairobi Safe Motherhood Conference and the SM workshops implemented by Family Care International. These are considered important activities for

increasing awareness among developing countries, rather than as entirely new concepts. Dutch officials argue that such a large proportion of the populations of developing countries does not have basic health coverage that national access to primary health care is an important goal. They suggest that the building of secondary or tertiary referral facilities for obstetrical complications should be a very long-term goal.

Estimated Financial Flows to Developing Countries
\$ millions

	1985	1986	1987	1988
Total Health Sector (multilateral, bilateral, non-governmental)	146	185	190	190
Safe Motherhood activities	62	78	80	85

Directorate-General for International Cooperation
Ministry of Foreign Affairs (Ministrie van Buitenlandse Zaken)
Bezuidenhoutseweg 67
2494 AC The Hague

OECD

The Development Cooperation Directorate, which serves as the Secretariat for the Development Assistance Committee of OECD, routinely maintains bilateral donor statistics according to the format for its Creditor Reporting System. A special health format requested of all DAC countries contains 11 general categories and 28 subcategories of health data. Although mother and child care is one of the subcategories, the classification system does not readily identify specific maternal health components. The data would have to be analyzed by each donor according to the share of maternal care in each subcategory. The Creditor Reporting System has other limitations:

- There is substantial variation in the response by each donor. Data is not always prepared by the health representatives of each donor organization.
- The system does not specifically identify health sector commitments by agencies, institutions, and funds in the United Nations family, for example, UNICEF, UNFPA, and WHO.
- Financial data represent project investments and may exclude the cost of technical cooperation by donors (technical advisory personnel) that constitute a major component of health assistance by a number of donors.
- Data in the DAC chairman's annual report are limited to a total annual figure for bilateral health investments, although more detailed data are provided to DAC.
- DAC collects gross data on donor contributions to NGOs, but not data on the sectoral distribution of NGO contributions. This omission means that a major financial resource for health is not identifiable.
- Since DAC does not collect health sector data from major multilateral sources, annual data do not permit estimates of global sectoral flows. Gross development flows, however, do include major bilateral and multilateral sources.

For special DAC meetings such as the September 1988 meeting on Primary Health Care, DAC does attempt to gather information by questionnaire. However, it has proved difficult to obtain a response from all major DAC major countries.

DAC Secretariat attention to health sector financing is dependent primarily on requests from member countries, an approach in which there is currently only limited official interest.

Secretariat staff note that the number of technical and professional health personnel in donor agencies is limited. In recipient countries, resident technical staff members are primarily associated with approved projects, although some resident health representatives also are responsible for assisting governments in the preparation of proposals. In this sense the limited number of professional health sector personnel both at headquarters and at the field level may not be competitive with larger staff resources available to other development sectors such as agriculture and industry.

Organization for Economic Cooperation and Development (OECD)
2 rue André Pascal
75775 Paris Cedex 16, France

OPEC FUND

OPEC's cumulative loan and grant commitments through 1987 amounted to \$2.1 billion, of which grants accounted for about 4.6 percent. In 1987 OPEC Fund commitments totalled \$101.5 million. Disbursements have declined from \$400 million in 1981 to \$101.5 million in 1987.

Nonetheless, health sector financing from 1985 to 1987 rose from \$430,000 to \$1.463 million. Health grants in 1988 are anticipated to be around \$1 million. An estimated 40 percent of the 1987 grant allocation indirectly benefited women of childbearing age through UNFPA, UNICEF, and hospital and health services rehabilitation.

A cumulative summary of financing operations through 1987 indicates that 9.9 percent of sectoral distribution has been directed to "other" activities, such as national development institutions, health, education, training, tourism, and balance of payments support.

The current statistical system does not permit more detailed analysis of SM components in the health sector. This is something that might be a feasible task for, say, a short-term consultant working with the World Bank PHN Division. The size of OPEC's collective resources merits a better understanding of expenditure trends and policies. There is evidence of support for health, education, and sanitation. It is not improbable that the potential supply of OPEC resources for health sector activities exceeds the articulated demand. Organizations such as the OPEC Fund and the AGFUND cooperate closely with WHO and UNICEF, but the organizations themselves are not formally organized to explore health opportunities.

Although OPEC expenditures for development have declined, net annual resources are substantial. Taking into account OPEC's past emphasis on capital development, there is no clear evidence of a policy bias against health sector activities, provided requesting countries and institutions make the case for project assistance. As noted above, at least 11 OPEC institutions have contributed to health activities that may include many elements of SM.

Although analysis by the Arab Fund for Economic and Social Development indicates a 52 percent distribution of financing operations in Arab countries, an additional 18.1 percent are in Africa, 27.3 percent in Asia, and 1.5 percent in Latin America.

The World Bank may suggest that one or more of the OPEC Fund Members sponsor a study of OPEC institutions to assess the current and potential financing for SM. For such a study it may be useful to meet with the Coordination Secretariat of the Arab Fund for Economic and Social Development. Assuming such a study is carried out, the number of potential SM projects may not be adequate to attract financing unless there is more demand from developing countries and organizations.

OPEC Aid Institutions

Among the 13 OPEC member countries, the principal development financing institutions are:

Multilateral Institutions

- Arab Authority for Agricultural Investment and Development
- Arab Bank for Economic Development in Africa
- Arab Fund for Economic and Social Development (Arab Fund)
- Arab Fund for Technical Assistance to African and Arab Countries (AFTAAC)
- Arab Gulf Program for United Nations Development Organizations (AGFUND)

- **Islamic Development Bank**
- **Islamic Solidarity Fund**
- **OPEC Fund for International Development**

Bilateral Institutions

- **Abu Dhabi Fund for Arab Economic Development**
- **Iraqi Fund for External Development**
- **Kuwait Fund for Arab Economic Development**
- **Libyan Arab Foreign Investment Company**
- **Organization for Investment, Economic, and Technical Assistance of Iran**
- **Saudi Fund for Development**
- **Venezuelan Investment Fund**

OPEC Trust Funds

- **Algerian Trust Fund**
- **Nigeria Trust Fund**
- **Venezuelan Trust Funds**

Health Sectoral Project Loans

- **AFTAAAC (education 100 percent)**
- **AGFUND (health 41.9 percent)**
- **Arab Fund (health 1 percent)**
- **BADEA (water and sewerage 2.4 percent)**
- **Iraqi Fund (water and sewerage 0.7 percent, health 1.8 percent)**
- **Islamic Development Bank (education and health 10.5 percent)**
- **ISF (education 100 percent)**
- **Kuwait Fund (water supply and sewerage 5 percent)**
- **OPEC Fund (water and sewerage 4.8 percent, education 53 percent, health 0.8 percent)**
- **Saudi Fund (water/sewerage 6.7 percent, education 6.5 percent, health 2.7 percent)**
- **Venezuelan Investment Fund (water and sewerage 0.3 percent)**

OPEC Fund for International Development
Park Ring #8
1010 Vienna, Austria

SWEDEN

Sweden's development assistance has been increasing about 10 percent a year over the past several years. In an attempt to meet its ODA target of 1 percent of GNP, the government is proposing a 12 percent increase in total ODA for the fiscal year beginning July 1989. Of the nine budget categories of ODA, 95.7 percent of total expenditures is directed to three categories:

1. Grants to international organizations (28.5 percent)
2. Bilateral aid through the Swedish International Development Authority (54 percent)
3. Other development programs (13.2 percent)

SIDA has long supported such SM components as family planning, primary health care, mother and child care, nutrition, water, sanitation, transport, and women in development. SIDA considers education and employment for women to be important factors in maternal health. While there are projects that emphasize maternal care, so far there are no specifically-labelled SM projects. Bilateral programming is primarily the responsibility of country missions. Some 50 countries receive Swedish bilateral assistance, although only 17 are defined as "program countries" -- recipients of long-term development efforts⁹.

SIDA is proposing a 12 percent increase for fiscal 1989-90. It may be assumed that health and maternal health will share in a proposed increase, although the budget does not specify sectoral priorities. SIDA continues to rely on recipient countries to state their sectoral preferences and identify priority projects. This requirement hinders programming since most developing countries do not adequately identify their external sectoral financing needs. At the present time there is no emphasis at the field level to assist recipient countries in developing health sector demand for external financing.

The table on estimated financial flows contains a number of assumptions:

1. Assessed contributions to UN organizations, such as WHO, are excluded. Voluntary contributions (UNICEF, UNFPA, WHO) are included.
2. Eighty percent of UNICEF contributions are attributed to maternal and child health activities, of which a third is attributed to programs that benefit mothers. (In view of UNICEF's emphasis on the child, the attribution for mothers may be less than a third).
3. Fifty percent of UNFPA contributions are attributed to maternal health/safe motherhood.
4. A very rough estimate of \$20 million (a third of bilateral programs) is attributed to SM activities, including maternal health programs, primary health care, tetanus immunization, health education, transport, facility maintenance, and nutrition. The estimated total figure for bilateral health in 1988 (\$59 million) is consistent with DAC figures. The total, however, excludes Swedish contributions to UNFPA, UNICEF, and general NGO activities.

⁹ Cape Verde, Guinea Bissau, Angola, Zambia, Botswana, Zimbabwe, Lesotho, Mozambique, Tanzania, Kenya, Ethiopia, India, Sri Lanka, Bangladesh, Vietnam, Laos and Nicaragua.

5. Grants to NGOs are 28 percent of bilateral aid. It is estimated that approximately a third of NGO projects involve health (\$70 million). It is assumed that about a third of the health activities are of direct benefit to mothers.
6. In the absence of clear statistical categories, these assumptions cannot be considered official estimates. If water, sanitation, and transport expenditures are added, the total estimate would be enhanced.

Since detailed comprehensive statistics are not available, SM expenditures can only be estimated on the basis of discussions with SIDA staff and a review of the documents noted.

Estimated Financial Flows to Developing Countries
\$ millions /a

	1985	1986	1987	1988
Total Health Sector (multilateral, bilateral, non-governmental)	123	136	135	182
Safe Motherhood activities	40	45	46	47

/a This table uses an exchange rate of SEK6=\$1.00

Based on information provided by SIDA 1989. Bilateral Development Assistance 1988-89, Stockholm. SIDA, Swedish Development Assistance, Appropriations 1988/89. Government of Sweden, Budgetaret 1989/90, Utrikes-departementet, Lettera C. Internationellt utvecklingssamarbete, Riksmotet 1988/89. SIDA health sector totals 1958-1986

Swedish International Development Authority (SIDA)
Birger Jarlgatan 61
S 105 25 Stockholm

SWITZERLAND

Although Switzerland's development policies are relevant to safe motherhood, including maternal and child care, nutrition, water, and sanitation programs, expenditures for maternal health are small. Swiss aid officials are concerned that maternal and child health activities that are sponsored by UN agencies, particularly UNICEF, may have limited maternal health content.

Switzerland is prepared to provide more funds for SM in the countries it emphasizes if the developing country has a commitment to maternal health; if there is sufficient technical knowledge to implement a maternal health plan; and if the government has prepared a credible proposal. This task is complicated by the lack of organized global system to help developing countries identify demand for maternal health components.

About 50 percent of Switzerland's health financing is directed to Africa, with emphasis on Mali, Benin, Chad and Madagascar. In Asia the program operates through NGOs, with the exception of Nepal. There is relatively little project activity in the Americas.

Direction de la Coopération au Développement et de l'Aide
humanitaire (DDA)
Département fédéral des Affaires étrangères
73 Eigerstrasse
Bern 3003

Estimated Financial Flows to Developing Countries \$ millions

	1985	1986	1987
Total Health Sector (multilateral, bilateral, non-governmental)	32	34	34
Safe Motherhood activities	5	5	6

UNITED KINGDOM

Britain's Overseas Development Administration (ODA) maintains data primarily in distribution categories such as geographical areas, multilateral and project aid, training, and technical cooperation. There is no comprehensive health/nutrition/population sectoral summary. Water supply and sanitation (which some donors include in "Health") are included in the category of "Environmental Amenities".

Although ODA is considering a health sector review, there is no current document that can provide official comprehensive trends. Health totals are thought to be between \$68 and \$85 million annually (Patten 1988).

Using the current portfolio of bilateral health and population programs, and official data in "British Aid Statistics 1983-87" and the 1987 ODA Annual Review, health and maternal health expenditures have been estimated. The estimates are based on a number of assumptions that permit comparability with other donors:

- Bilateral project aid is included for health, nutrition, and population programs. Each multiyear project expenditure is divided by the number of years for project duration to obtain an average annual expenditure. This method yields somewhat higher annual bilateral totals for the sector than reported in "British Aid Statistics 1983-87." Water and sanitation projects have been excluded, although rural water and sanitation may be elements of other bilateral and NGO projects.
- Multilateral support is included for UN agencies with a significant health component, for instance WHO, UNFPA, and UNICEF. For UNICEF and UNFPA, modest annual increases beyond 1987 have been assumed. Approximately a third of UNICEF contributions are included in SM calculations, erring on the side of a broad SM definition.
- Contributions by NGOs are included where the organization has a specific health or family planning content, such as IPPF.
- Special contributions for medical and population research are included. Maternal health components are estimated as follows:
 - Direct maternal health projects, including facilities (100 percent).
 - Family planning (100 percent).
 - General health systems and primary health care programs for women of childbearing age (30 to 50 percent).
 - Disease control, particularly projects that prevent serious anemia such as malaria (50 percent).
 - Rural sanitation and water projects that help reduce anemia from hookworm (50 percent).
 - Medical and population research as applied to maternal health (100 percent).
 - Health education (30 percent).

The UK has not yet developed a specific SM program. At the same time, ODA maintains strong support for family planning and primary health care activities within which maternal health is an accepted component. In July 1988, Patten states: "We shall continue to direct our efforts towards support for primary health care and preventive programs with special emphasis on mother and child health care and family planning programs". The role of women in improving health was also emphasized.

Illustrative of specific maternal health projects is a joint project with UNFPA to reduce maternal mortality in Pakistan, and another in the Gambia to improve records on maternal mortality. The outlook is favorable for strong family planning support through WHO, UNFPA, and IPPF.

ODA officials note that many factors influence maternal mortality. The agency attempts to meet this objective through current population and health programs, but does not envision the need for a separate SM program. ODA sector priorities already respond to a large number of international programs, such as Primary Health Care, AIDS, Child Survival, TDR, water, and sanitation. With its relatively small sectoral staff, ODA would find the rapid development of entirely new initiatives difficult.

Moreover, officials suggest that maternal health may currently have a limited political priority in many developing countries, in view of their existing programming responsibilities. Thus it is important to help countries identify their own specific maternal health priorities. Together with other major donors, ODA feels that external assistance for important issues such as maternal mortality depends on the degree to which a requesting country identifies its own priority requirements.

Estimated Financial Flows to Developing Countries

\$ millions /a

	1985	1986	1987	1988
Total Health Sector (multilateral, bilateral, non-governmental)	50,191	59,023	67,421	73,603
Safe Motherhood activities	28,293	32,514	32,178	34,000

Overseas Development Administration (ODA)
Eland House, Stag Place
London SW1E 5DH

UNITED STATES

The availability of a formal information tracking system for the health sector considerably simplifies the identification of annual U.S. aid expenditures by the Agency for International Development (A.I.D.). For purposes of comparison with other major bilateral donors, it is useful to point out the congressional requirement for advance approval of financing in sectors such as health, agriculture, education, and population. While financing levels are discussed at the cooperating country level, sectoral totals are held within certain limits -- a procedure that is in sharp contrast to budget planning in many donor countries. A.I.D. health and population sector officials have a direct program and project administrative responsibility, in contrast to many other donors whose professional staff may act only in a technical advisory capacity to geographic regional offices that have the program responsibility.

A.I.D. is required to prepare an annual report for Congress on the Child Survival Program. The system of calculating the percentage spent on the program is less than precise and often requires field staff to make arbitrary judgments. Similarly, the statistical system does not distinguish the components of maternal health.

Although the new Maternal and Perinatal Health project is the first of its kind in A.I.D. to specifically address the causes of maternal mortality, maternal health has long been a component of primary health care systems and a stated argument for the importance of family planning. Support in the form of training and services is eligible. But the programmatic and financial emphasis has been small in view of the congressionally mandated programs for Child Survival and Population, which together absorb approximately two-thirds of the combined health and population accounts. Within the health accounts, expenditures for Child Survival activities are around 50 percent.

The A.I.D. pattern is a financial supply-driven program system in which the direction of sector activity is controlled through congressional program approval. This has the advantage of supporting specific initiatives such as family planning, child survival and AIDS. The disadvantage of the system is its inflexibility in meeting developing country priorities as expressed by developing countries themselves. The new Africa Development Fund of A.I.D. is one effort to provide greater program flexibility and may provide greater balance in sectoral efforts to address the issue of maternal mortality.

In spite of a well-developed health tracking system, special adjustments are required to make the data comparable with other donors. The population account, for example, is tracked by the Office of Population and not by the Office of Health. There are comparable problems in tracking nutrition contributions to health. Major contributions to UN organizations such as UNICEF are not included in the health account, although special bilateral contributions to the UN are included.

Contributions from the health account to private and voluntary NGOs are recorded, but not contributions from non-health accounts (such as agriculture) that may have a partial health function.

The following estimates are based on the official A.I.D. health information system. Estimates of SM content are based on information from A.I.D. central and regional personnel and require a percentage attribution which, for this study, is based on the Herz-Measham criteria.

Estimated Financial Flows to Developing Countries
\$ millions

Budget Account	1985	1986	1987	1988	1989
Health	252.3	213.2	168.1	116.8	123.4
Child Survival Fund	23.0	36.0	75.0	64.6	64.4
Africa Development Fund	-	-	-	52.7	51.0
Economic Support Fund	42.2	56.8	42.8	14.6	25.0
Nutrition (Ag/Rur.Dev/Nut)	19.3	8.3	9.5	10.9	7.4
AIDS	-	-	-	28.7	30.5
UNICEF	53.5	52.5	51.0	54.0	32.0
Population	288.2	237.5	231.6	229.7	197.4
Total Health/Population (bilateral, multilateral excluding assessed contributions, and non-governmental)	689.3	614.1	587.3	572.0	531.1
Safe Motherhood Activities	280	231.7	227	222	190
of which non-family planning components total	16	31	17	30	32 ^{/a}
Percentage of health/ population total absorbed by child survival and population programs	61	63	71	67	65

^{/a} In FY 1989 a new five-year \$17.5 million Maternal and Perinatal Health Project begins.

Agency for International Development
Washington, D.C. 20523

UNITED NATIONS DEVELOPMENT PROGRAM

The United Nations Development Program (UNDP) is prepared to support SM activities in the current four-year program cycle (1987-1991). Reflecting the reactions of other donors, UNDP notes that a broad range of development activities influence maternal health and warns of the difficulty of targeting programs without improved definition.

Twelve statistical categories were examined for SM content:

- Primary health care
- Maternal and child health
- Maternal health
- Maternal health services
- Family planning
- Women in development
- Women's participation (and organizations)
- Integrated rural development
- Adult education
- Agriculture
- Nutrition
- Disease prevention and control

The total five-year value of the examined programs was \$84 million or about \$16.8 million a year. On the basis of the criteria followed for this survey, UNDP expenditures for SM amounted to about \$4.3 million in 1987. Over the prior three-year period, net flows remained at the same level. Declines in all categories in 1988 were taken to represent incomplete expenditure reporting.

The UN Statistical Office has no financial database to track SM financial trends. National expenditure data, which do not permit SM identification, are collected directly from countries, not from international organizations. Specific health sector statistics, other than financing, are gathered largely from WHO. There is no attempt to disaggregate the sector into sub-components.

For population programs, financial trends are identifiable through UNFPA for its own program (see notes on UNFPA). WHO does not maintain a global financial trend database for maternal health except for its own programs.

United Nations Development Program
One United Nations Plaza
New York, NY 10017

UNITED NATIONS POPULATION FUND (UNFPA)

Expenditure levels of the Fund, based on July 1988 allocations, reached an all-time high of \$181.5 million, reversing the \$26.9 million decline in 1986 from 1985's \$128.2 million. The outlook for the future projects further increases.

The Fund has not specifically identified SM as a program initiative, although it co-sponsored the Nairobi Conference and supports the effort to reduce maternal mortality and morbidity. No efforts have been made to define the SM components of the budget. Family planning programs constitute about half of annual expenditures. In the wider definition of SM, one can rationalize the inclusion of all budgetary components -- data collection, population dynamics, policy, communication, education, and multisectoral activities. Within the Family Planning Program (health-related delivery systems, community-based delivery systems, fertility regulation, and program management), financing has increased since 1985 from \$64.8 million to \$102.5 million (1988).

Global financing for population assistance (all sources) was assessed in the Global Population Assistance Report, 1982-85. The document estimated a 1985 level of \$560.3 million. UNFPA has contracted with the University of Michigan to update this document for 1986 to 1988. The report is to be released in October 1989.

The Center for Population and Family Health, Columbia University, has published financial trends for some 45 developing countries in "Family Planning and Child Survival." But as only 10 of the 45 data sets have 1987 information on population programs, and only eight have 1987 health expenditures, the global contributions of developing countries are difficult to assess.

Estimated Financial Flows to Developing Countries \$ millions

	1985	1986	1987	1988
Total UNFPA Project and Program Expenditures	128.2	101.3	106.9	181.5
Safe Motherhood activities /a	81.8	68.3	70.8	119.8

/a Safe Motherhood components are derived from two statistical categories: family planning programs, and communication and education.

United Nations Population Fund
220 East 42nd St.
New York, N.Y. 10017

UNITED NATIONS INTERNATIONAL CHILDREN'S FUND (UNICEF)

The UNICEF Annual Report for 1988 describes the distribution of \$374 million in 1987 program expenditures by functional category. Within the broad definition of SM, all activities may be contributory, including water supply, formal and nonformal education, emergency relief, and project planning support. If SM content is limited to family planning (100 percent) and maternal and child care (50 percent), the total would be on the order of \$9.5 million, or about 2.5 percent of the budget. This level would be increased to the extent that water, sanitation, health education, and disease control are considered directly contributory.

A policy of benefiting the mother is explicit within UNICEF's primary attention to child health. For the purpose of this review, it is assumed that approximately a third of all program expenditures directly or indirectly benefit the mother. This assumption is not statistically verifiable and should be examined.

For African countries south of the Sahara, the Bamako Initiative offers conditional provisions for inclusion of maternal health components, such as prenatal health, control of anemia, safer motherhood, child spacing, and training of traditional birth attendants. It is still premature to estimate the actual program emphasis of maternal health within the proposed \$380 million 1989-1993 plan.

Total UNICEF expenditures have steadily increased since 1984. The outlook for the future is favorable.

UNICEF prepares periodic "Situation Analysis" reports for each UNICEF-cooperating country on the situation of children or the position of women and children. While these reports are often excellent with respect to technical data, there are only limited financial data and essentially no financial trends related to maternal health.

UNICEF
Three United Nations Plaza
New York, N.Y. 10017

WORLD HEALTH ORGANIZATION

In the context of this review, the World Health Organization (WHO) is not be considered to be a primary source of financial transfers to developing countries. First, all member states of the Organization contribute to the assessed budget, even though the annual contributions, assessed and extra-budgetary, originate predominantly from the industrial countries. Second, although technical services and functions are global, expenditures are predominantly for personnel that provide professional advisory services to developing countries. These professional services are supplemented by additional personnel, project finance, and other services through extra-budgetary financing, which constitute about half of the actual annual operating budget. These additional funds, in effect, permit WHO to operate as an agent on behalf of official organizations and NGOs.

Beyond the regular and extra-budgetary funds, WHO also assists in external financing for national projects in developing countries, a service which places the organization in the role of planner for the requesting country. WHO cooperates periodically with member governments to design projects and to identify sources of external financing, an effort that parallels work to improve financing mechanisms at the country level although these efforts have not yet been organized systematically on a global scale. To attract global financing for such priorities as maternal health, however, experience during the past seven years in the WHO Regions of the Americas suggests that a global system will require at least five components:

- Identify current external official and nongovernmental sources of finance and circulate this information to member countries and to regional and country users.
- Identify the demand for external financing at the country or regional level and assist in the articulation of this demand in the form of well-prepared, officially approved proposals.
- Match demand with potential financial supply.
- Negotiate financing.
- Provide technical assistance to develop the recipient's capacity to support national health, nutrition, and population sector priorities.

In a highly competitive international development environment, both within and outside the health sector, progress toward Safe Motherhood goals will depend not only on policy commitment and appropriate technical design but also on the rate at which financing can be mobilized. A decade of experience suggests the great potential for WHO to serve as a global catalyst to attract financing. In view of the strong endorsement by the World Health Assembly urging WHO to pursue this goal, the rate of progress could be substantially increased. WHO has viewed its constitutional role as requiring it to provide technical assistance and coordination in the health sector. The Organization has no constitutional role for development financing. Its budget authority is about 10 percent of total estimated global flows for health. The financial accountability for approximately 90 percent of health aid rests with the country and its major financial partners -- not with WHO.

Recognizing these constraints, the new leadership of WHO is planning to establish a more systematic approach to external financing which emphasizes integrated technical and financial planning at the recipient country level.

In view of the close working relationship between WHO and the World Bank, joint discussions might be helpful on ways to mobilize external financing for SM.

The percentage attribution for maternal health components within the WHO budget follows the criteria applied to this review. However, other major program categories would qualify for partial attribution, as in the examples of general health services development, primary health care and malaria control. The attributed data in this estimate are limited to the more specific maternal health activities.

Estimated Financial Flows to Developing Countries
\$ millions

	1986	1987	1988	1989
WHO budget	271.6	271.6	318.4	318.4
Extra-budgetary sources	260.1	260.1	228.5	228.5
Total	531.7	531.7	546.9	546.9
Of which maternal health estimated to include:				
50% of regular MCH budget	2.2	2.2	2.5	2.5
100% regular HRP budget	.3	.3	.4	.4
50% extra-budgetary MCH budget	12.5	12.5	8.5	8.5
100% extra-budgetary HRP budget	17.1	17.1	20.5	20.5
Total maternal health	32.1	32.1	31.9	31.9

Source: WHO Program Budgets for 1988-89 and 1990-91.

Note: The biennial budget has been divided by two to yield annual estimates.

World Health Organization
Geneva, Switzerland

THE WORLD BANK

There has been a marked increase in proposed lending for population, health, and nutrition in 1989. The estimated SM content (broadly defined) is about 50 percent of the total, about the same as in the preceding three years. The volume of estimated SM activities for 1989, however, has tripled over 1988.

These estimates are tentative. Most SM programs fall under family planning and maternal and child health services. The data are insufficient to estimate financing for direct medical services to high-risk mothers.

As the table shows, the trends in World Bank financing are favorable. Whether financing will increase for specific measures to combat the prevailing causes of high maternal mortality may be an issue beyond Bank lending policy. The decision may be largely dependent on the borrowing countries' ability to identify risks to maternal death and to incorporate adequate counter-measures within project design. Thus measures to support borrowing countries in identifying and articulating their demands are becoming far more critical than the supply of financing.

Estimated Financial Flows to Developing Countries
\$ millions

	1985	1986	1987	1988	1989/ ^a
Total population, health and nutrition lending					
• Asia	85.0	242.0	-	74.5	-
• Europe, Middle East					
• North Africa	41.9	-	13.1	-	-
• Latin America/Caribbean	-	96.0	10.0	109.0	-
• Africa	64.1	81.1	30.8	121.0	-
Total, PHN sector ^b	191.0	419.5	54.1	304.0	-
Total, PHN sector based on Staff Appraisal Report (SAR)	-	414.0	53.9	315.8	729.0
Estimated SM content based on SAR/^c	-	177.9	36.5	103.9	366.0
SM as estimated percentage of SAR	-	42.0	67.0	32.0	50.0

^a Data excluded prior to issuance of 1989 Annual Report.

^b Data from 1988 Annual Report.

^c 1988 estimates are tentative and reflect an increase in loan approval levels.

Note: The table is based on Annual Reports. Because of the limited detail on projects in these reports, the Staff Appraisal Reports for 1986-89 have been used to provide more information.

The World Bank
1818 H Street N.W.
Washington, D.C. 20433

B. *Summary of Donor Financial Trends*

Since bilateral data include government contributions to multilateral and United Nations organizations,¹⁰ expenditures from both sources cannot be added to provide an annual total. The available data are not sufficient to provide a precise disaggregation of programs, particularly those that apply to high-risk births and the complications of pregnancy. The data do, however, offer a baseline on the status of the current information. Donor organizations should seek a consensus on the need to strengthen the statistical criteria and establish procedures for future measurement.

1. *Bilateral Financial Trends*

For the 17 major bilateral sources, including the European Community, the net trend from 1986 to 1988 shows a gradual increase in current dollars for Safe Motherhood (\$691.5 to \$818.8 million) and for comprehensive health, population, and nutrition (\$2.221 to \$2.863 billion). Projects with direct and indirect effects on maternal health improvement represent about a third of all bilateral financing, including family planning¹¹, primary health care, nutrition, training, and disease control (Figure 1). Both multilateral and bilateral data exclude the formal water supply and sanitation sector. If these expenditures were added, the level of total health funding would double. Water and sanitation are not excluded where they are essential parts of an integrated health project.

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

2. *Multilateral Financial Trends*

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

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

¹⁰ Contributions by bilateral, multilateral, and nongovernmental organizations, for example, account for almost half of the annual expenditures of WHO and PAHO.

¹¹ Bilateral population programs cost \$472 million in 1985.

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

C. Safe Motherhood Financing by Developing Countries

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

- WHO's Maternal and Child Health Offices do not maintain global data on local currency expenditures for maternal health at the country level. At the World Bank's request, WHO is distributing a questionnaire to selected WHO country representatives to solicit this information. In Latin America and the Caribbean, PAHO estimates that about a sixth of national health expenditures may be attributed to maternal care, including hospital expenditures.
- One of the few studies available was conducted by Sri Lanka's Marga Institute (1985). Based on 1982 data, health expenditures accounted for 3.7 percent of total government public sector expenditures and 1.4 percent of GNP. In the health sector, Rs. 976 million, or 20.7 percent, was directed to family health, of which Rs.72 million (64 percent) was spent on maternal health care. The study suggests that government expenditures for MCH are doubled by household expenditures. Approximately a third of all maternal and child health expenditures are related to transport. The study does not state the criteria for attribution.
- UNICEF Country Situation Analysis reports do not specify maternal health costs.
- Detailed WHO-sponsored health care financing studies on Jamaica, Costa Rica, and Mali do not contain information on maternal care.
- WHO Country Resource Utilization reports give only limited details on maternal health expenditures. The accounting categories are general -- salaries, transport, and drugs -- rather than by programs.
- A report on Malawi (1983) attributes about 4 percent of government health expenditures to "maternities" and "dispensary/maternities."
- A study on Liberia (1988) indicates that 90 percent of the health budget funds "curative medicine," of which the major cost is salaries. Within these costs, however, approximately 30 percent of hospital beds are used for pregnancy and its complications (40 percent in the John F. Kennedy Hospital in Monrovia). In addition, the study documented an extensive nonsalaried network of trained traditional birth attendants (approximately 2,500).

1. Trends in National Financing for Maternal Health

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

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

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

IV. CONCLUSIONS

A. Statistical Methods

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

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

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

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

B. Financial Trends

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

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

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

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

C. *Policies*

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

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

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

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

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

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

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

a) Improving the Data on SM Financial Trends

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

b) Strengthening Recipient Countries' Capacity to Articulate Project Demand

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

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

V. REFERENCES

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

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