

DFID's Maternal Health Strategy

Reducing maternal deaths: evidence and action

Second Progress Report



Report by the Department for International Development

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Headlines

- **Maternal mortality remains unacceptably high** in DFID-supported countries and access to skilled attendance is low.
- The main barrier to improving maternal health remains **poor access to good quality, comprehensive health services**. In **Africa**, the lack of trained staff is a particular barrier. In **Asia**, gaps in trained staff in rural areas, cost and exclusion related to caste, ethnicity and other social factors are important.
- Sustained **long term (10-20 years) investment** in health services and human resources is needed.
- A new **MDG 5 target on *Universal Access to Reproductive Health*** highlights its importance to development.
- The **Partnership for Maternal Newborn and Child Health** held the first partners forum in Tanzania.
- The Norwegian government is preparing **a major new initiative in MDGs 4 and 5** with support from the UK and the Gates Foundation.
- Progress made in improving access to safe abortion services through the establishment of the **Safe Abortion Action Fund**.
- Progress on ensuring **contraceptive commodity security** remains slow.
- Most DFID-supported countries use a **mix of investments** to strengthen general health services complemented by specific investments to target maternal, newborn and child health.
- **Major new commitments** made in Zimbabwe (£25m), Pakistan (£90m) and India (part of £252m RCH programme). New projects under development in Nigeria and Sierra Leone.
- **AIDS** is now the single largest cause of maternal death in some parts of sub-Saharan Africa.
- New ways have been developed to better **measure maternal mortality**.
- The **20th anniversary of the Safe Motherhood initiative** in 2007 offers an unprecedented opportunity for advocacy.
- The **priority actions identified in the maternal health strategy remain valid** and will require sustained investment in health services and human resources over at least a decade.

Introduction

1. Achieving the fifth millennium development goal - to **improve maternal health**, and to meet the associated targets to reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio and ensure universal access to reproductive health by 2015 - remains perhaps the greatest development challenge.
2. The primary determinant of maternal mortality is how well national health systems function, in ensuring that every woman can be delivered by a skilled birth attendant (a nurse or doctor with midwifery skills), backed up by ready access to emergency obstetric care when needed. This requires an effective functioning health service, reliable supply chains for medicines and equipment, communications and transport system.
3. Delaying marriage and first birth, preventing unwanted pregnancy and eliminating unsafe abortion will avert at least one third of maternal deaths. Worldwide 41% of all pregnancies are unwanted with 22% resulting in induced abortion¹, representing 68,000 deaths each year.
4. Maternal health has been long neglected and underlying the failure to act are broader social, cultural and political factors: the low status of women; the failure to fulfill their sexual and reproductive rights; and the lack of political commitment to address the problem.
5. In 2004, DFID launched the strategy ***Reducing maternal deaths: evidence and action***. The strategy identified four priority areas for action.

Priority areas for action

1. Advocate – raise the profile
2. Scale-up evidence-based intervention
3. Address wider social and economic barriers to access
4. Develop and apply new knowledge

This document provides the second update of progress in implementing that strategy and builds on commitments made in 2005/06.

¹ Campbell O. Graham W. Strategies for reducing maternal mortality: getting on with what works. Lancet Maternal Survival 2006

Progress

Priority 1: Advocate – raise the profile

6. Reducing maternal mortality requires above all, **political leadership to stimulate action**. DFID works with others to raise the profile of maternal health in our partner countries.

New MDG target for reproductive health

The UN Secretary General, in his 2006 Annual Report, recommended the inclusion of a new target, *Universal Access to Reproductive Health by 2015*, under MDG 5 – to improve maternal health. DFID is supporting work to agree appropriate indicators and it is expected that progress will be reflected in the 2007 edition of United Nations Millennium Development Goals Report.

The UK and like-minded governments lobbied hard to ensure that the commitments made at the 1994 International Conference on Population and Development were adequately reflected within the MDGs.

7. DFID is supporting the **Partnership for Maternal, Newborn and Child Health** (PMNCH) which brings together UNFPA, WHO, UNICEF, the World Bank, bilateral agencies, NGOs, researchers and Professional Health Worker Associations to promote the concept of the continuum of care and the need to address maternal, newborn and child health together. While the PMNCH is playing a significant role in advocacy, it is not designed to intervene directly at country level, where the international health aid architecture is already too fragmented. The PMNCH is bringing together stakeholders across maternal, newborn and child health and is effectively a merger of 3 previously existing partnerships.
8. **In 2006, the Norwegian prime minister launched an initiative to accelerate progress on MDGs 4+5.** Supported by the Gates Foundation, the UK Treasury and DFID, this initiative brings a high level political focus on efforts to improve the health of women and their children, and for greater gender equality. Work is underway to develop this initiative with the PMNCH supporting the development of a global high level political advocacy strategy.
9. **UNFPA launched a global campaign to end obstetric fistula.** DFID is one of the largest donors to UNFPA, providing £80 million core funding over four years and £10 million specifically for reproductive health, including work on fistula. DFID also provides £700,000 to NGOs working on obstetric fistula in Africa.
10. DFID championed the establishment of the International Planned Parenthood Foundation (IPPF) administered **Safe Abortion Action Fund** (SAAF) which was launched by Gareth Thomas MP at an event hosted by the UK All Party Parliamentary Group (APPG) for Population, Development and Reproductive Health. DFID has initially committed £3 (US\$5.9) million over two years and advocacy by the PUSS has led to

commitments from Denmark, Norway, Sweden and Switzerland. The scale of unmet need was demonstrated when the \$11.9 million fund attracted 222 applications totalling \$43m in the first call for proposals.

In a study of 12 hospitals in Benin, Cote D'Ivoire and Senegal, **almost all** deaths in early pregnancy were due to induced (unsafe) abortion and a third of all maternal deaths were due to unsafe abortion.

Lancet Maternal Survival Series, Sept 2006

11. In September 2006, African ministers of health agreed a progressive plan of action to implement the ***African Union Policy Framework on Sexual and Reproductive Health and Rights*** that, for the first time addressed sensitive issues such as female genital mutilation (FGM), adolescent sexual and reproductive health and unsafe abortion. Ministers highlighted the importance of broader sexual and reproductive health and rights (SRHR) programming to the AIDS response and called for greater support to fill the SRHR supplies gap. DFID funding to IPPF, UNFPA and IPAS supported this process.
12. DFID supported advocacy events in Geneva and 28 African countries to mark the UN International Zero Tolerance of FGM Day, to raise global awareness of **female genital mutilation** (FGM).
13. DFID actively promoted the **International Coalition for Reproductive Health Commodity Security** which brings together UNFPA, WHO, the World Bank, bilateral donors, implementing agencies and countries to co-ordinate supplies, including condoms and other contraceptives and equipment for safe delivery. Coalition efforts have accelerated development of the new WHO-UNFPA list of essential reproductive health commodities, and helped establish a WHO scheme to ensure quality in the generic hormonal contraceptive market.
14. The UK APPG on Population, Development and Reproductive Health held hearings to explore the impact of population growth and concluded that **unless high fertility and population growth in the poorest regions of the world is addressed, there is little chance of achieving the MDGs**. The Group recommended an increase in support for family planning.
15. In 2006, the Lancet journal produced special series on **Maternal Survival** and on **Sexual and Reproductive Health**. DFID supported the development and dissemination of the reports, and DFID ministers authored an editorial in the special issue on sexual and reproductive health.

Lancet series on maternal survival – key points

Gains in reducing maternal deaths in some countries from around 1,000 to 10 per 100,000 live births are comparable to major public health interventions such as polio eradication and oral contraception.

Politicians, donors, UN agencies, and professional bodies have the real power to advocate and take action.

AIDS is a leading cause of pregnancy-related deaths and in some countries has reversed previous gains.

Nearly one in four women in developing countries delivers alone, or with relatives. This has not changed since the early 1990s

Progress in reducing maternal deaths will depend on strong health systems that ensure high coverage of midwifery services. Providing basic obstetric care at a health centre remains one of the most cost-effective options for saving women's lives.

Lack of cash is a major constraint to accessing services for almost half of households in West Africa. Transport costs account for half the total costs of a normal delivery in Nepal and Tanzania.

Lancet series on sexual and reproductive health (SRH) - key points

Disability and premature death due to SRH problems are growing. Unsafe sex is the second most important cause of morbidity or untimely death among the world's poorest populations.

Despite commitments made at Cairo in 1994, the visibility of SRH on the development landscape has decreased. Between 1995 and 2003, donor support for family planning supplies and services fell from \$590 million to \$460 million.

A preoccupation with ABC (Abstinence, Be Faithful and Use Condoms) distracts attention from the need for broader, integrated programmes in which all components are mutually reinforcing.

Although lower fertility and stable population growth alone will not guarantee achieving the MDGs, their cross-cutting contribution to poverty reduction, better health, enhanced education and gender equality can have a broad impact.

When abortion is made legal, safe and accessible, women's health improves rapidly. In South Africa complications resulting from unsafe abortion decreased significantly (from 16.5% to 9.7%) in the year following the 1996 legalisation of abortion.

Every year there 340 million new cases of curable sexually transmitted infections (STIs), yet almost all global funding for STIs is directed towards HIV infection.

16. DFID remains the only major bilateral donor to have **a strategy** specific to improving maternal health and continues to be seen as a leading advocate. The Gates Foundation, Japan and France are preparing maternal health strategies and have drawn on the DFID paper.

Priority 2: Scale-up evidence based interventions

17. DFID supports efforts to scale up interventions to improve maternal health through a range of approaches and aid instruments. The commitment to increase spend year on year has been maintained. In addition to direct expenditure on maternal and newborn health, general and sector budget support also make a significant financial contribution to the health sector. For example, in Africa in 2005/06, it is estimated that general budget support contributed some £50 million to the health sector, in addition to sector budget support for health.

Table 1 DFID bilateral expenditure (excluding poverty reduction budget support - PRBS) 2001/02-2005/06 (in £ millions)²

	2001/02	2002/03	2003/04	2004/05	2005/06
All health spend	196.5	242.4	272.1	329.4	385.4
Maternal and newborn health	0.9	2.5	3.3	15.4	16.2
Maternal and newborn health + reproductive health	37.6	41.4	46.1	53.9	32.3

18. Core support provided to **WHO, UNFPA, UNICEF** and the **World Bank** contributes to global and country efforts as does support to agencies that specifically support work on sexual and reproductive health, such as the **International Planned Parenthood Foundation (IPPF)**, the **Partnership for Maternal, Newborn and Child Health (PMNCH)** and a number of non-government organisations.
19. In countries, DFID supports the implementation of national health plans through a range of instruments, including general and sector budget support, specific projects and technical assistance. Employing a mix of instruments enables countries to deal with sensitive or marginalised issues, such as abortion and adolescent sexual and reproductive health, outside of the mainstream. The appropriate approach is best defined at the country level but in every case it is important to establish maternal health at the core of the health plan.
20. The main barrier to improving maternal health is access to good quality comprehensive health services. In most countries, expenditure remains too low to provide basic health services - obstacles are not specific to maternal health but common across all health services. The lack of

² The figures presented above are significantly lower than those presented in the 2005 Maternal Health Progress Report. DFID is changing the way it reports thematic expenditure. The above figures capture the actual amount of money within a programme that goes specifically to maternal health. The previous methodology identified all projects and programmes contributing to a policy or programme, such as maternal health, and included the total expenditure.

trained staff, essential medicines and equipment are common barriers to providing better care.

Scaling Up in Africa

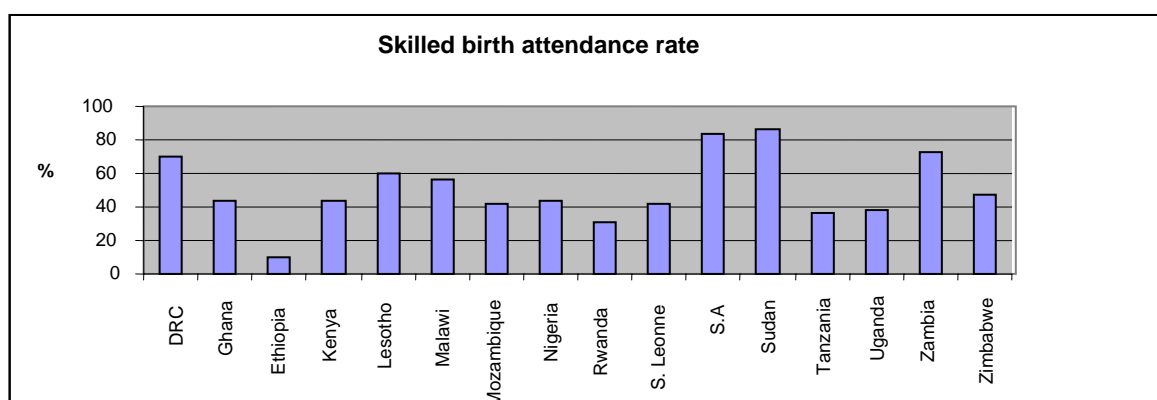
21. Pregnancy, and its related complications, remains one of the major causes of morbidity and mortality in sub-Saharan Africa. Every year over 250,000 African women die because of complications related to pregnancy and childbirth. Twelve of the thirteen countries with the highest maternal mortality ratios in the world are in sub-Saharan Africa.
22. DFID supports health programmes in 16 African countries. In more than half of these, part of that support is provided through general or health sector budget support which is regarded as the most effective way to provide long term, predictable and flexible finance to support the implementation of national health plans. DFID is looking to develop ten year development partnership agreements in a number of countries. In many countries this support is complemented by specific funding for maternal health interventions.

2005-2008 DFID Public Service Agreement for Africa (PSA)*:

An increase in the proportion of births assisted by skilled birth attendants by 11 percentage points, against the year 2000 baseline.

* Public Service Agreement countries: DRC, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Nigeria, Rwanda, Sierra Leone, South Africa, Sudan, Tanzania, Uganda, Zambia and Zimbabwe

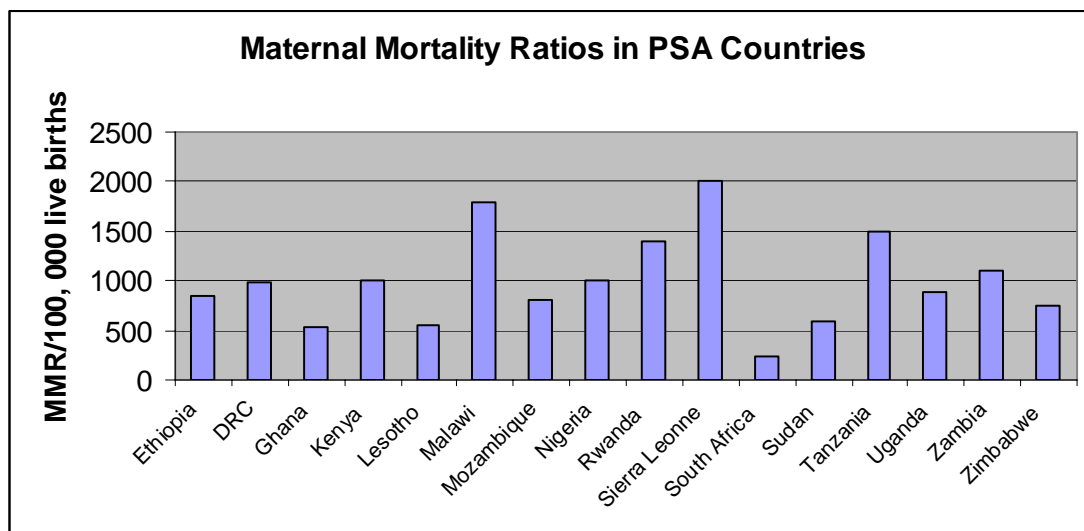
23. Progress, however, is slow. Only 50% of all deliveries in the 16 PSA countries are attended by a skilled health care worker (ranging from 10% in Ethiopia to 84% in Northern Sudan) although this is an increase from 41% in 12 countries with data from 1990. The figures (see box 1) mask wide disparities between urban and rural areas. Given many countries do not report using the international definition of a skilled birth attendant, the figures are also likely to be an overestimate. In rural sub-Saharan Africa as a whole, skilled birth attendance rates have stagnated at 32% since the 1990s.³



Box 1 Source: UNFPA (www.unfpa.org)

³ Koblinsky M, Matthews Z, Hussein J et al. Going to scale with professional skilled care. Lancet Maternal Survival 3 2006

24. Despite data inadequacies, it is clear that maternal mortality remains unacceptably high in PSA countries. The data in box 2 are based on estimates made in 2000. More recent data from demographic and health surveys show significant declines in maternal deaths in only Mozambique and Rwanda (the latter reflecting equally significant reductions in overall adult mortality post-conflict).



Box 2 Source: UNFPA, UNICEF, WHO.

25. The lack of human resources for health is a key limiting factor to progress in many African countries. There is no single intervention or quick win to resolve this crisis due to the complex mix of “push” and “pull” incentives (e.g. poor salaries and working conditions) and context specific issues (e.g. conflict, HIV and AIDS) which lead to undersupply and mass migration of health workers. Within countries, recruitment, training and retention of health workers are complex issues and must be tackled within the context of broader health systems and macro-economic reform. It is important to ensure that interventions reflect country context and fit with existing planning and resource allocation processes.
26. DFID is working to address these issues in a number of countries: providing technical assistance to develop human resource plans in Nigeria, Somaliland and Kenya; supporting broader civil service reforms in Tanzania; financing projects to train health workers and develop institutional capacity in Somaliland, Zimbabwe and Uganda engaging in health sector policy dialogue in Ghana, Uganda, Zambia and Mozambique and supporting the post conflict reconstruction of health services in Sierra Leone. The main earmarked investment is the Malawi Emergency Human Resources Programme (see box 3)

Box 3: Malawi health sector programme

Between 1992 and 2000, maternal mortality in Malawi increased from 620 to 1120, and is currently 984⁴. Fewer women give birth in health facilities in response to the deteriorating quality of care related to the critical shortage of health care workers in Malawi.⁵ Vacancy rates for doctors and nurses exceeded 60% across the country.

DFID is providing £55 million over six years to fund the **Emergency Human Resources Programme (EHRP)**. This has three main elements:

- improving incentives for recruitment and retention of Malawian staff through salary increases for eleven professional and technical groups;
- expanding domestic training capacity by over 50%, including doubling the number of nurses and tripling the number of doctors in training; and
- using international volunteer physicians and nurse tutors as a stop-gap measure while more Malawians are being trained.

Provisional results show that the programme is beginning to have an impact:

- staff in eleven cadres increased by 450 in the first nine months and 465 health professionals who left public service have registered their willingness to return;
- 60 volunteer medical specialists and nurse tutors have been recruited to fill critical gaps until more Malawians are trained, many from VSO; and
- training schools have increased intakes and the programme to increase physical capacity is well underway.

There has been a significant decline in the number of nurses leaving the country to work abroad.

DFID is also providing £45 million to the new **health sector programme**. Districts have been able to 'kick start' action on maternal health using flexible funds from the SWAP. Forty-five service level agreements (SLAs) have been agreed with the Christian Health Association of Malawi (CHAM), who provide 35% of health services, to provide free access to maternal services. In its first year of SLA, one CHAM hospital has seen a 20% increase in new antenatal care visits and a 44% increase in institutional deliveries. District managers have also used additional funding to rehabilitate and upgrade health facilities and provide locum payments to midwives to go to health centres to cover staff shortages. One district, Dowa is training traditional birth attendants (TBA) to refer patients using an incentive fee of 200MK (70p) per patient. This has proved extremely effective and lessons will now be applied across the country.

27. There has been a slow increase in the proportion of women of reproductive age who use modern methods of **contraception**, with an average of 19% of women in the 16 countries doing so. This is up from 12% in 14 countries in 1990 but ranges from 4% in Sierra Leone to 55% in South Africa. Despite this trend, high fertility remains one of the major development challenges facing Africa.

28. Several African countries have liberalised or legalised **abortion** in the past two decades including Benin 2003, Botswana 1991, Burkina Faso

⁴ Malawi National Statistics Office. Demographic and Health Survey 2004, NSO, Zomba

⁵ WHO. The World Health Report 2005: Making every mother and child count. WHO Geneva

1996, Chad 2002, Ethiopia 2004, Ghana 1985, Guinea 2000, Mali 2002, and South Africa 1996 (IPAS). Advocacy for increased access to abortion services is gathering momentum in Kenya, Mozambique, Nigeria and Uganda.

29. In **Kenya**, a regional Safe Motherhood Programme supported overall health system strengthening and was used to argue for more support to maternal and child health within the Essential Health Services programme.
30. In **Uganda**, DFID works with national partners to strengthen health services, particularly human resources for health, and is pressing for the expansion of sexual and reproductive health services.
31. In **Sudan**, DFID supports the provision of emergency obstetric care through NGOs such as Médecins Sans Frontières (MSF) and Merlin, who provide a basic package of services for women and children.
32. DFID funded projects in **Nigeria, Uganda** and **Malawi** provide pregnant women with insecticide-treated bednets or medicines to prevent malaria in pregnancy.
33. AIDS is a leading cause of pregnancy related deaths in many counties including Zimbabwe.

Box 4: Maternal and newborn health in Zimbabwe

The risk of HIV infection is much higher in pregnant than in non-pregnant women. A study in Uganda showed that pregnancy doubled the risk of HIV acquisition.⁶ In turn, the maternal mortality ratio was five times higher in HIV positive women. In Pointe Noire, DRC, the maternal mortality ratio for HIV positive women was four times higher than non-infected women.⁷

Maternal mortality in Zimbabwe has risen from 395 deaths per 100,000 live births in 1992 to an estimated 1,068 per 100,000 in 2002. One of the main causes of this increased risk is HIV and AIDS. Zimbabwe's HIV prevalence rate is among the highest in the world at 18%, with some 1.6 million people infected with HIV or suffering the effects of AIDS.

DFID will invest £25 million over 5 years to improve maternal and newborn health in Zimbabwe. The project will reduce the number of maternal deaths and reduce the number of children becoming infected or dying from HIV infection.

The project will increase national access to family planning and reproductive health services; improve evidence-based policy planning, budgeting and monitoring; increase access to quality antenatal and postnatal care with a particular focus on the specific needs of HIV positive mothers and their babies and improve access to lifesaving essential obstetric and newborn care.

The project will be implemented by a joint UN Programme involving UNFPA and UNICEF, working in partnership with non-governmental organisations and will provide a useful model for UN reform and alignment of UN agencies at country level.

34. In **Nigeria**, the Partnership for Transforming Health Systems (PATHS) Programme (see box 5) provides a good example of how to retain a focus on sexual and reproductive health within a health system strengthening programme.

Box 5: Health systems strengthening in Nigeria

DFID provides £55 million to the PATHS Health Systems project to improve the quality and management of health services, increase consumer awareness and strengthen the oversight role of the government in partnership with six state governments. This has led to significant improvements in immunisation coverage, attended deliveries and uptake of emergency obstetric care

In Jigawa, Safe PATHS provided funds through the Ministry of Health to improve maternity, laboratory and operating equipment for eight facilities. Fifteen midwives were trained to train additional midwives. The initiative worked closely with communities to select emergency transport drivers to provide free transport in collaboration with the state's Road Transport Workers Association.

PATHS also established a network of "Community Identifiers" to link emergency cases to Safe Motherhood Centres. The cost of emergency obstetric care was tackled through an emergency loan fund that uses an existing scheme in the villages to which everyone contributes.

Key to the success of the Safe Motherhood Initiative is the **partnership** formed with

⁶ Gray RH, Kigozi et al. Increased risk of incident HIV during pregnancy in Rakai Uganda: a prospective study. *Lancet* 2005; **336**: 1182-88

⁷ Le Coeur S, Khat M et al. HIV and the magnitude of HIV-related mortality in Pointe Noire, Congo. *AIDS* 2005; **19**:69-75

local Islamic religious leaders whose support is essential in breaking down the barriers to women attending hospital. Most Imams now make the case to husbands unwilling to let their wives to go to hospital and also publicise the benefits when lives are saved.

In less than a year, the numbers of women in the two pilot Emirates attending hospital for emergency obstetric care has risen by 50%. A £16 million extension of this project is planned for 2006.

35. User fees are a significant barrier to use of services and a number of countries have taken steps to ensure free services are available for women and children.

Box 6: Removing barriers to access to health services in Burundi

Patients pay for 60% of healthcare costs in Africa and official user fees are a significant barrier to poor people's access to basic health services. User fees reduce utilisation of maternal health services and may delay the decision to seek care because of the time spent looking for money. It is estimated that in some African countries the final cost can range from 10% of household yearly income for a normal delivery to 50% for a caesarean section or for management of complications.⁸

In 2006, the President of Burundi announced free health care for childbirth and children under 5. This change of policy represents a significant "peace dividend" for the people of Burundi. DFID is supporting the ministry of health implement this policy with £1.5 million for supply of essential drugs for children under 5 and for child delivery services; development of a tracking and monitoring system for drug supply and distribution; and financial monitoring. This will buy time for government to place orders for subsequent deliveries, closing a gap in the pipeline and avoiding future "stock outs". Sufficient funding for subsequent increased supplies will need to be made available through government budgets drawing on Global Fund/World Bank support.

36. Post-conflict settings present particular challenges in improving maternal health where the entire health system needs to be rebuilt.

Box 7: Health systems strengthening and long term predictable financing in Sierra Leone

Sierra Leone has the highest maternal mortality ratio in the world, at 1800 deaths per 100,000 live births and a woman has a one in six chance of dying as a result of pregnancy and childbirth – 600 times that of a woman in the UK. Under-5 mortality at 283 per 1,000 live births is the highest in the world. Access to health care is constrained by a complex mix of lack of staff, particularly outside the capital, medicines and commodities, harmful traditional beliefs, lack of transport and communications, and affordability of services.

DFID will invest £50 million in the health sector over ten years to strengthen the health system as a whole; to strengthen policy and planning, increase the numbers of trained staff, ensure supplies of commodities, and contribute towards reducing access barriers. The World Bank will contribute \$30 million over 4 years for child

⁸ Borghi J, Ensor T, Somanathan A et al. Mobilising financial resources for maternal health. Lancet Maternal Survival Series; 2006; 51-59

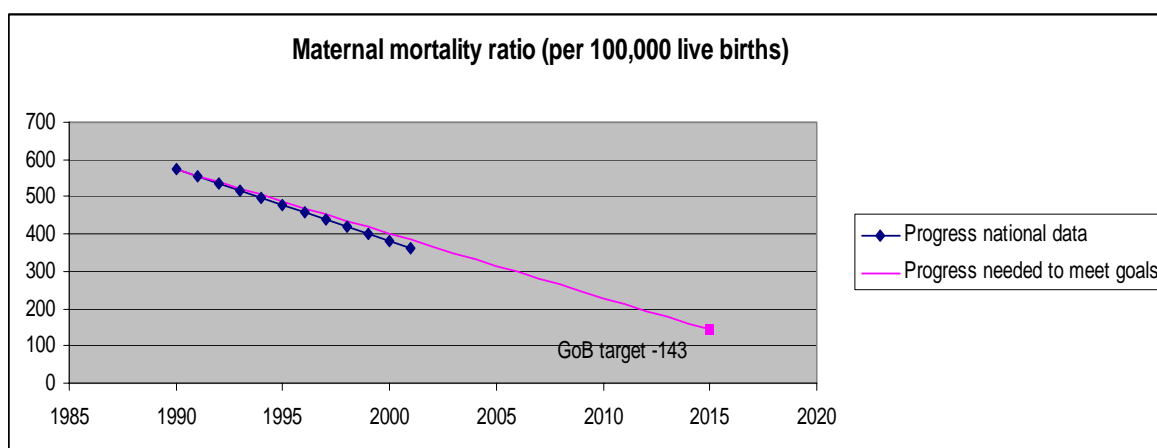
survival. Donors will coordinate with important non-health sector inputs such as the EC-funded road building programme and plans to improve power supplies. The environment is fragile with many complexities in scaling-up basic services in this context.

Scaling up in Asia

37. The lifetime risk of maternal death for women in South Asia is one in 43. This is lower than sub-Saharan Africa, but because of the large populations of South Asia, around 200,000 women die annually from maternal causes. India alone accounts for one fifth of maternal deaths globally.
38. In Bangladesh, India, Nepal and Pakistan, DFID provides specific funding for maternal health in addition to broader health sector support provided through sub-sector or budget support. While there has been progress in each country, the rate of improvement is inadequate to meet the 2015 MDG targets.
39. In **India**, the proportion of births attended by a skilled professional increased from 43% in 2000 to 48% in 2005-06. Maternal mortality remains high.
40. DFID has committed £252 million (2005-11) to the second phase of the National Reproductive and Child Health Programme - RCH2 - that aims to reduce social and geographic disparities in access and use of reproductive and child health services. The programme has led to increases in the proportion of institutional deliveries; in the state of Madhya Pradesh from 40.6% in 1998-99 to 50.8% in 2005-06; in Orissa from 22.7% to 38.7%, in West Bengal from 40% to 53%, and in Andhra Pradesh from 50% to 69%. Improved uptake of services has been aided by provision of transport for women to reach health facilities for delivery, and the use of financial incentives.
41. The National Ministry of Health and Family Welfare has developed guidelines for skilled birth attendants and for management of obstetric complications, and trained doctors to provide obstetric anaesthesia. Most states have embarked on programmes to upgrade medical facilities in order to provide access to 24 hour services for obstetric emergencies, but lack of specialist staff remains a key obstacle to increasing coverage of services.
42. Maternal health is also a key component of health sector programmes in DFID's focus states: West Bengal, Orissa, Andhra Pradesh and Madhya Pradesh. In West Bengal (population approximately 80 million), DFID is providing sector budget support to the Department of Health and Family Welfare (DHFV) to help implement its 10 year Health Sector Strategy

(HSS). Progress has been made towards developing and staffing 26 priority rural hospitals to provide 24-hour emergency obstetric care.

43. **Bangladesh** has made significant progress in reducing maternal mortality, although the maternal mortality ratio was 320 in 2004, with newborn deaths accounting for 66% of infant deaths (i.e. deaths under 1 year). However, both skilled birth attendance at 14% and institutional deliveries at 8% are very low. **Halving of the fertility rate over two decades and reduction in deaths from unsafe abortion has contributed to the reduction in maternal deaths.** Non-health sector improvements have also contributed including reductions in income poverty; improved education levels (particularly of girls); rural electrification and the efforts of a vibrant NGO sector.
44. In addition to supporting (£100 million over 5 years) the health, nutrition and population sector programme which has a focus on maternal health, DFID plans support for a joint UN maternal and newborn health programme and a community based programme delivered through a large national NGO.



Box 8: Maternal mortality ratio in Bangladesh

45. DFID applies a three track approach : direct support to the government of Bangladesh to improve systems and access to services (through HNPS and Urban Primary Health Care Project); ring-fenced support for 'hard to reach' MDGs (maternal and newborn health and HIV prevention) and efforts to target the health needs of the extreme poor.
46. Current estimates of maternal mortality in **Pakistan** are between 350 and 500 per 100,000 live births. Skilled birth attendance is estimated to have increased from 23% in 2001 to 31% in 2004-05.
47. DFID has committed £90 million over 5 years to the National Maternal, Newborn and Child Health programme which will expand maternal and newborn care. DFID is setting up a research and advocacy fund for maternal and newborn health. DFID's support has been instrumental in securing the government's own investment in this programme, and in building consensus between national and provincial governments on implementation. DFID has helped secure agreement from the Norwegian government to invest in the programme.

48. DFID also provides £7.5 million (2003-08) to a contraceptive social marketing programme in partnership with UNFPA and USAID and also provides sectoral budget support of £68.5 million over 4 years for national public health programmes. More than half this support goes to activities that directly benefit maternal and newborn health, including for family planning, maternal nutrition and immunisation, and community-based antenatal and postnatal care through the Lady Health Workers Programme.
49. In **Nepal**, the most recent maternal mortality estimate was 539 per 100,000 in 2001. The maternal mortality estimate from the Demographic Health Survey is yet to be published. However, the Health Management Information System shows that skilled birth attendance has increased from less than 5% in 1999 to 23.5% in 2005-06.
50. In addition to financial support to the health sector programme (sector budget support) DFID provides financial assistance (£11.25 million) as sub-sector budget support, technical assistance (£7.4 million) plus direct support through UNICEF (£1.2 million) for implementation of the national safe motherhood programme.



Nepal Safer Motherhood Project

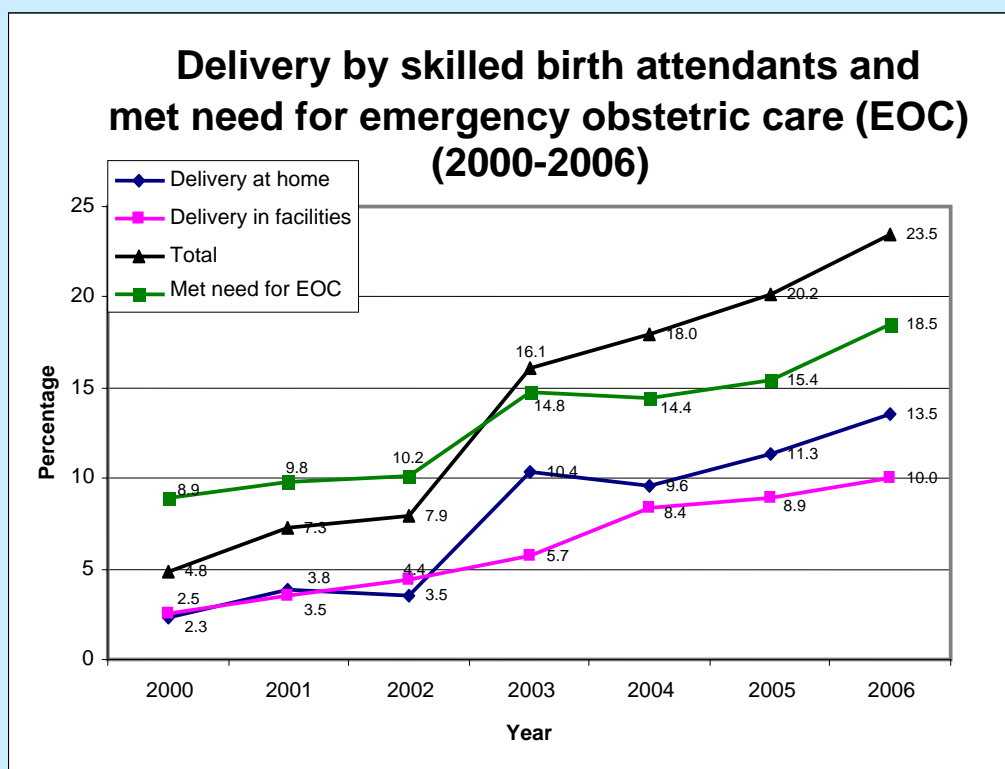
Box 9: Nepal Safe Motherhood Programme

DFID has scaled up support from 9 of Nepal's 75 districts (1997-2004) to national level support through the Family Health Division of the Ministry of Health and Population (MOHP). Achievements include the development of a national safe motherhood plan (2006-2017), the implementation of a national maternity financial incentive scheme, the significant expansion of safe abortion services, and an ongoing plan for the construction and development of emergency obstetric facilities.

Investments in maternal health are strengthening the wider health system with greater access to emergency care (including surgery, anaesthesia, laboratory support and blood transfusion), more trained staff (doctors, anaesthetic nurses, skilled birth attendants), a working referral system (transport and communications), and strong community level involvement supported by NGOs.

District hospitals supported by the programme are recording a sustained increase in access to emergency obstetric care, specifically caesarean section and blood transfusion and to comprehensive abortion care. This has also resulted in better medical and surgical care for a range of different health areas.

Improvements in access to obstetric services in Nepal



51. In Nepal, India and Bangladesh, DFID is testing **financial incentive schemes** for mothers including cash payments, vouchers and other demand side approaches.

52. DFID supports **family planning** in all countries, as part of a broader programme (RCH2 in India, HNPS in Bangladesh, National Health Facility in Pakistan) and through a social marketing project in Pakistan.
53. In **Indonesia**, DFID has provided funding to UNICEF to assist the government to implement its National Safer Motherhood Strategy, covering nine provinces of this very densely populated country. Some 450,000 women will directly benefit, in 24 selected districts that have experienced high levels of maternal ill health and mortality in the past. DFID is working with GTZ and government in two other provinces of the country, to ensure a rapid start-up to an urgently needed maternal mortality prevention programme.

Box 10: Lessons learned in Asia

In **India**, the lack of trained health workers remains a key bottleneck. It will take several years to deploy adequate numbers in those states that are accelerating nurse training and deployment. Monitoring needs to focus more on the effective functioning of facilities, and less on inputs. The division of responsibilities for health service delivery between federal and state governments remains a challenge to rapid acceleration of progress on maternal health.

Evidence from **Bangladesh** suggests that the decline in fertility and a reduction in abortion-related deaths have significantly contributed to a reduction in maternal mortality. To further reduce maternal deaths, increased access to skilled attendance at birth and to emergency obstetric care are key with more effort needed to target the poorest and excluded groups.

In **Nepal**, the focus on **universal access** to maternity services has been more easily accepted by government than a strategy of social inclusion, which is more fundamentally challenging to the existing social order. In **India**, implementation of the declared policy of equity of access to reproductive and child health services challenges vested interests and will take time.

Lessons from **Pakistan** highlight the intensive efforts needed to secure high level political commitment to maternal health. This is time-consuming, and needs to be factored into DFID timescales for programme design. With hindsight, even more could have been done to ensure better communication between different parts of government.

Basic services – not only **health, but water, sanitation, social protection, and girls education** – are essential building blocks for maternal health as well as **infrastructure, transport and communications**

Scaling-up in Europe Middle East, Americas, Central and East Asia Division (EMAAD)

54. Maternal and neonatal health is not a DFID priority in EMAD countries with the exception of Yemen where there is a specific project addressing the issue. However it is also addressed through health sector reform programmes in Kosovo and Georgia, a health SWAp in Kyrgyzstan and budgetary aid to Overseas Territories.

The Yemen Maternal and Neonatal Health project

This is being redesigned with our partners, the Netherlands and UNICEF. The inception phase provided a number of lessons that will be addressed in the redesign. The project was considered too top-down, primarily focused on the supply side and there was inadequate involvement of the Government in the inception stage.

The capacity of implementing UN partners and complexities of joint UN working were overestimated. DFID will make a better assessment of partners and more formal implementation plans and contingency arrangements.

DFID needs to agree the extent to which we wish to devolve management to silent partners including policy decisions; we need to make case-by-case judgements on how far DFID policy is likely to be implemented on the ground when we work through and with other partners.

Priority 3 – Address wider social and economic barriers to access

55. DFID and other partners are supporting **innovative financing mechanisms to scale-up basic services**, including helping more women access maternity care. This includes providing cash, or vouchers to pregnant women to pay for transport, medicines and services. A DFID review of *Experiences in Demand-Side Financing for Maternal Health*, concluded that more evidence is needed on the impact of demand-side financing for maternal health (for example, we do not know what perverse incentives – such as an increase in the cost of transport and of drugs at local shops – may occur). An evaluation of the DFID-supported Nepal government's cost-sharing scheme for safe deliveries will be undertaken in early 2007.
56. DFID supported a workshop on ***Protecting Girls from Female Genital Mutilation and Harmful Traditional Practices: Challenges and Opportunities for Legal Intervention in Africa*** organised by the NGO Foundation for Women's Health, Research and Development (FORWARD) and the WHO Africa Regional Office. The workshop aimed at developing a legal framework for child protection that brings together legislative, welfare and social services, police and justice systems and basic service providers (teachers, health workers, local leaders and civil society) to protect girls in a comprehensive way. The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) will be taking forward the recommendations in 2007, working with legislators and those involved in child protection within the region and in pilot countries. The recommendations have also fed into the revision of the joint WHO/UNICEF/UNFPA statement on female genital mutilation.

Female genital mutilation – a violation of human rights

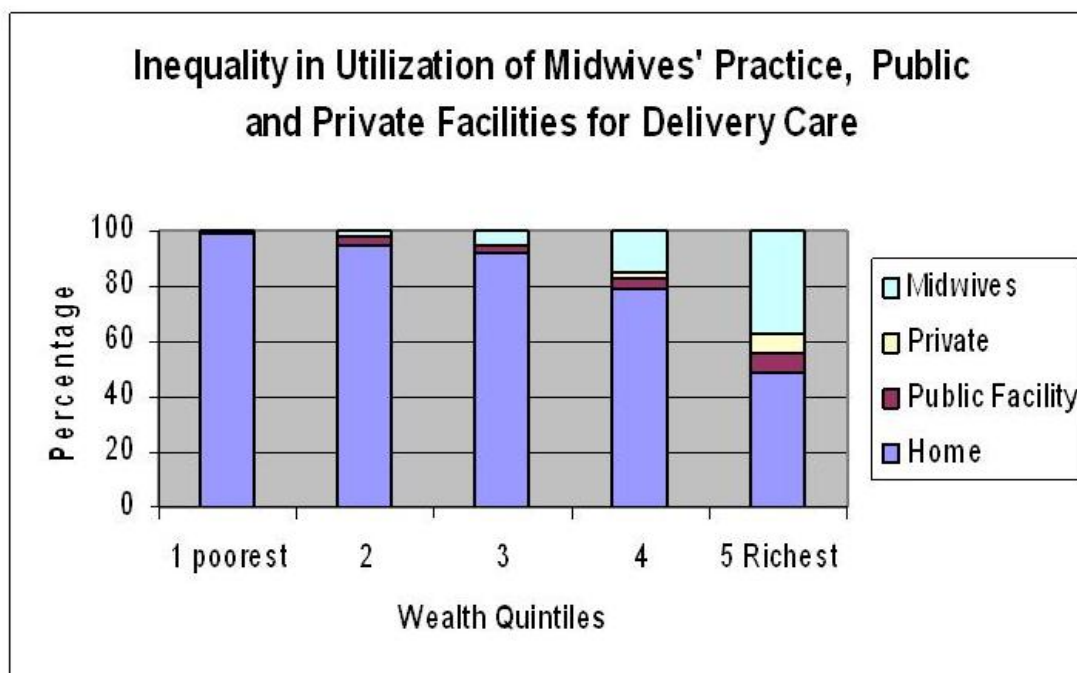
Every year, up to 3 million girls are subjected to female genital mutilation, some of whom die as a result of the procedure. Others may be left with long-term health problems and are at risk of life-threatening complications during childbirth.

57. The Lancet Maternal health special series notes that a '**link between poverty and maternal health** has been clear for more than a century'. New data indicates that in Peru, for example, there is a six-fold difference in mortality between rich and poor.

Priority 4 – Develop and apply new knowledge

58. DFID, the Gates Foundation and USAID, support the Initiative for Maternal Mortality Assessment (IMMPACT) that has developed new evidence and tools. Research in Burkina Faso, Indonesia and Ghana is demonstrating that:

- progress towards MDG 5 **can** be measured and IMMPACT has provided new and better ways of measuring maternal deaths such as sampling at service sites; and
- increasing coverage of skilled care at delivery is necessary, but not sufficient in itself, for achieving MDG 5.



Box 12: Findings from Banten province, Indonesia. Source: IMMPACT Indonesia Evaluation Question report.

59. Poverty undermines the effectiveness of skilled attendance strategies, so action to reduce inequalities in access to and quality of care is also needed. The graph above (box 12) shows that the richer you are the more likely you are to have skilled care at delivery.

IMMPACT sampling at service sites (SSS) method

IMMPACT has developed a new method for measuring maternal mortality in which information on maternal deaths is collected from women where they gather in large numbers – market places, hospitals and health facilities.

This faster and cheaper SSS method is proving as effective as other large and expensive surveys.

60. DFID funds three research programmes on maternal and newborn health, sexual and reproductive health and sexual health rights. The research consortia led by the Institute of Child Health (ICH) and the London School

of Hygiene and Tropical Medicine (LSHTM) is the first maternal-neonatal research consortia. Early evidence is demonstrating the **value of working through women's groups**.

61. The DFID supported Research Programme Consortia on 'Realising Rights: Improving Sexual and Reproductive Health for Poor and Vulnerable Populations' is providing **evidence on the economic costs of unsafe abortion related mortality and morbidity**.
62. DFID organised an expert group meetings on **maternal mortality measurement**. This focussed on the prospects of using the 2010 round of population and housing censuses to get robust empirical data on maternal mortality, particularly at sub-national levels. An active group of international experts is taking this work forward. DFID has provided £500,000 over the next 3 years through the **Health Metrics Network** to support this work.
63. DFID is applying new knowledge and tools to prevent unsafe abortion.

Medical abortion is safe, affordable and effective. It involves taking a combination of tablets (mifepristone and misoprostol), both of which are included in WHO's *Model List of Essential Medicines*. Yet few women have access to these medicines, few providers and policy makers have a full understanding of medical abortion, and the two drugs are unavailable in a single package to enable correct prescribing and provision.

DFID is funding (£450,000) catalytic work through the Concept Foundation to **support the finalisation of a regulatory dossier for the provision of medicines for safe medical abortion**. The Foundation is working with Sun Pharmaceuticals in India to develop a single package of mifepristone and misoprostol to be made available at low cost to developing countries. The Foundation is also developing links with providers such as IPPF and IPAS to enable the process from regulation and production to product availability in low income settings where abortion is legal.

In addition DFID is funding (£180,000) the **International Consortium for Medical Abortion** – to strengthen global advocacy for medical abortion and to develop ICMA's role as a source of high quality and accessible information on medical abortion for policy makers, providers and users.

64. A series of DFID-Netherlands studies in 2006 highlighted the failings in ensuring reliable supplies of SRHR (including family planning) commodities that have led to supply crises in a number of countries. These included short term, volatile, and uncoordinated funding, lack of prioritisation and poor procurement, logistics and forecasting capacity at country level. With DFID support in Uganda, the availability of the most popular contraceptive in clinics has become one indicator of performance and SRHR commodities are being integrated into government systems.
65. A DFID study exploring the linkages between SRHR and the global response to AIDS demonstrates the urgent need to address: the financing of AIDS programmes in a way that also supports SRHR efforts; the

strengthening of institutional structures to ensure links between HIV and AIDS with SRHR; as well as the way in which religious and ideological conservatism separates the AIDS response from sexual and SRHR.

66. The DFID-funded Population Council 'Adolescent Girls' Transitions to Adulthood Programme' has conducted research in nine countries. In Ethiopia it has used this to work with the Ministry of Youth and Sport to **protect highly vulnerable young girls** living without their families in the slums of Addis Ababa. The research has also informed the development of interventions aimed at delaying early marriage and child bearing and to reduce the social isolation of young married girls, and has strongly influenced the new Ethiopian National Adolescent and Youth Reproductive Health Strategy.



Woman and child outside maternity clinic, Ho, South-eastern Ghana.

Looking forward

67. The priorities defined in the strategy remain valid.
68. 2007 provides a number of extraordinary **advocacy** opportunities to make progress.

- 2007 marks 20 years since the first 1987 Nairobi meeting on Safe Motherhood. London will host the **international '1987-2007 Women Deliver' conference** which is aimed at high level political advocacy. **DFID ministers will play a full part.**
- A new initiative on '**reducing maternal mortality as a human rights imperative**', initiated by the UN Special Rapporteur on the Right to Health, will be launched at the Women Deliver conference.
- Following agreement on the new **MDG target on reproductive health**, DFID country offices will work with national governments to ensure that an appropriate level of focus is given to **improving access to sexual and reproductive health services and rights.**
- Norway, the UK and the Gates Foundation will further develop and implement an initiative for accelerated action against **MDGs 4+5.**
- The **first PMNCH Forum on MDG 4+5** was held in Tanzania in April. This brought together politicians, donors, foundations, UN agencies, NGOs, professional associations and researchers on maternal, newborn and child health.
- The international conference to mark the **40th Anniversary of UK Abortion Legislation.**
- DFID will develop an **Advocacy Action Plan** to provide strategic guidance on how we can better support advocacy.

69. The primary determinant of maternal mortality is how health systems function. The priority is to tackle low levels of financing to the health sector, along with recruitment, retention and deployment of human resources. DFID argues for **health systems strengthening to be addressed systemically** in a way that benefits people seeking a full range of health services.
70. DFID will press for bilateral and multilateral funds to support **national health strategies and plans** to enhance effectiveness of resources and to mitigate fragmentation of support to the sector. Ministers have a key role in pushing for targeted health initiatives to work more effectively in support of national health programmes.
71. Ways need to be found to keep political attention focused on reducing maternal deaths – which in general is not prioritised. DFID ministers will continue to engage in **high level political advocacy** to reverse the

neglect of maternal health and to argue for the prioritisation of integrated maternal, newborn and child health efforts (MDGs 4 and 5) in national development plans.

72. DFID will continue to work with others to improve the availability and reliability of data for tracking of progress towards MDG 5 and sustain DFID influence in making maternal mortality indicators central to the **scaling-up services agenda**.
73. DFID will provide further support for UNFPA to increase its work on **SRHR commodity security, including in fragile states**. We will work to ensure that other funding mechanisms, such as the Global Fund to fight AIDS TB and Malaria, includes SRHR supplies as part of integrated programmes to tackle HIV and AIDS.
74. DFID will continue to advocate for improved attention to SRHR within the global AIDS response – and work to see this reflected in funding mechanisms at country and international levels. The DFID policy teams working on AIDS and reproductive health will merge and will work to ensure that AIDS and sexual and reproductive health are not marginalised, and that sensitive issues such as abortion remain high on the agenda. DFID will press for greater action on the integration between the sexual health of women, men and their children and the impact of HIV infection on maternal and child deaths.

“AIDS is now the single largest cause of maternal death in some parts of sub-Saharan Africa”. (Lancet, 2006).

75. DFID will continue to support **research** in maternal, newborn and child health and SRHR.
76. The DFID **governance and transparency fund** under development will offer the possibility to support advocacy work with politicians, local leaders, civil society activists and the media.
77. Finally, improvements in maternal health will require long term investment in building sustainable health systems that fairly meet the needs of women and children. As in the history of the reduction of maternal deaths in Europe, there are no “quick fixes”.