

# UK Government

## Maternal Health Strategy Reducing maternal deaths: evidence and action

### Third Progress Report



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**Report by the Department for International Development (DFID)**

**Prepared by:**

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Reducing maternal deaths is important because women matter.

A maternal death is a death like no other.

The impact of a maternal death on families and communities is devastating – but is especially so for surviving children. A newborn baby is three to ten times more likely to die within its first two years without its mother.

The health of women is critical to a country's social, economic and political development. In rural Africa it is women who carry two-thirds of all goods that are transported – not trucks or planes. In South East Asia it is women who provide 90% of the labour for rice cultivation.

And you can't beat poverty without equal rights for women and girls.

The survival of women in childbirth reflects the overall development of a country and whether or not the health services are functioning.

In reality, the survival of women reflects whether or not women matter.

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## Global headlines 2007

- Every minute a woman dies in childbirth. 536,000 women continue to die needlessly each year at a time which should be joyous – just when they are bringing life into the world. A further 300 million suffer from avoidable illness and disability.
- The fifth Millennium Development Goal (MDG) which aims to ‘improve maternal health’ – is desperately off-track. We are not likely to achieve Millennium Development Target 5A which calls for a reduction by three quarters, between 1990 to 2015, of the maternal mortality ratio.
- The explanation for these deaths and health problems is simple – when a woman faces a problem, there is not a trained health worker on hand to help. High maternal mortality rates are the single most accurate barometer of how poor a health system is in a country.
- The shortfall in funds to meet the MDGs for maternal and child health amounts to only 2% of current development aid – a small fraction of world spending. Yet investing in women and their health strengthens families, communities and countries. Family budgets, local productivity and national wealth all flourish where maternal health is prioritised.
- Despite a decline in the worldwide abortion rate between 1995 and 2003, the proportion of abortion that is unsafe remains the same.
- To accelerate progress, a new Millennium Development Target 5B has been added to strengthen family planning and achieve, by 2015, universal access to reproductive health.

## Summary of DFID’s progress 2007

- In Asia there is progress, maternal mortality is falling in Nepal, Bangladesh and India (there are no recent data for Pakistan), but these improvements are not enough to be on track to reach the 2015 MDG target.
- In Africa, weak health systems, lack of access to family planning, unsafe abortion and HIV infection continue to delay progress against MDG 5. At present, all of DFID’s focus countries are off-track and will not meet the MDG target. Constraints to progress include the weak in-country performance of multilaterals and financial barriers to accessing health services.
- In Europe, Middle East and the Americas, China, Cambodia and the Yemen are on track, but additional focus on reaching the poorest is needed.
- The year 2007, the 20<sup>th</sup> anniversary of the global Safe Motherhood Initiative, was an exceptional year for advocacy. The Prime Minister opened the landmark *Women Deliver* Conference in London.
- In September, the Prime Minister launched the International Health Partnership (IHP). Strengthened health systems are central to the IHP and core to improving MDG 5.
- The Norwegian Initiative for MDGs 4 and 5 was also launched in 2007. Gordon Brown is engaged in Prime Minister Stoltenberg’s Network of Global Leaders initiative.
- DFID has updated its strategy on HIV and AIDS and will give greater attention to the impact of HIV on maternal health.

## Forward look 2008

In 2008, we will focus on four priority policy areas to accelerate progress on MDG 5 – improve maternal health. These are:

- health systems strengthening – with greater focus on demonstrating progress on maternal health;
- targeting investments in interventions with a high impact;
- high level international advocacy through UN, G8 and EU; and
- support for civil society advocacy in DFID's focus countries.

Further details on these priorities are set out below.

### **1. Health systems strengthening**

To provide the life-saving emergency obstetric care that an estimated 15% of all pregnant women will need requires a functioning health system. This includes: human resources (particularly midwifery but also referral level skills such as obstetric surgery and anaesthesia); essential drugs and supplies; infrastructure (hospitals, clinics); transport and communications for referral; power, water and sanitation. Our support to health system strengthening is increasingly funded through budget support in stable environments and through a range of instruments in fragile states. There is an opportunity to maximise our investments by improving data availability and using progress on maternal health as an indicator of overall health systems improvement.

DFID's new AIDS strategy emphasises the importance of long-term predictable funding for health systems strengthening. The UK will be calling on the G8, EU and others to commit to build effective health services and systems and increase investment in health workers – see box on page 6 – priorities for UK international lobbying during 2008.

### **2. Targeting investments in interventions with a high impact**

In addition to our efforts to strengthen overall health systems we will target investments in areas with a high return on maternal health and/or which are neglected or politically unpopular areas – specifically:

- **Family planning:** An estimated 32% of maternal deaths could be averted through family planning. It is one of the most cost-effective interventions in public health. Research has shown that every US\$ 1 million spent on family planning can avert 360,000 unwanted pregnancies, prevent 150,000 induced abortions and save the lives of 800 mothers and 11,000 infants.

DFID's Policy and Research Division, in liaison with regional and other divisions, will prepare a new position paper on how to address the unmet need for family planning. We will work with other like-minded donors (particularly in the EU), the Bill and Melinda Gates Foundation and the Hewlett Foundation to increase global support to family planning.

- **Preventing unsafe abortion:** 13% of all maternal deaths are caused by unsafe abortion – this means that around 70,000 women (often the youngest and most vulnerable) are dying needlessly each year. Abortion remains one of the most politically contentious issues of our time and extreme divisions of views on women’s reproductive rights have constrained an effective global response.

DFID is one of the few donors to actively support efforts to prevent unsafe abortion and plays a leading role in focussing attention – and challenging policies – on the issue; most recently at the Global Safe Abortion Conference in October 2007. DFID has provided £4m to the Safe Abortion Action Fund (SAAF) and a £6.5 million contribution to IPAS.

- **Sexual and reproductive health (SRH):** Universal access to SRH services (particularly for adolescents) would significantly improve maternal health. Maternal death is the leading cause of death for girls aged 15-19 in the developing world. The integration of SRH with HIV and AIDS services would also reduce maternal mortality. An HIV-infected pregnant woman is four to five times more likely to die in childbirth than one who is not infected.

### **3. High level international advocacy**

2008 provides a number of opportunities for the UK to provide continued international leadership on maternal health (a role for which we have been credited by the recent International Development Committee (IDC) Inquiry on Maternal Health). The major opportunities for us to continue to influence others will be during the run up to the G8 and the UN High Level Meeting on MDGs:

- At the **G8 summit in Japan** in July, the UK Government should continue to build on the Japanese Government’s steer to address MDGs 4 and 5, and press for commitments on health spend and on addressing the health workforce crisis.
- At the **UN High Level Meeting on MDGs** in New York on 25 September, we should increase pressure on all countries to make specific commitments.

The box below provides a list of the 4 key priorities for which we will be seeking international agreement and commitment during 2008.

## **Priorities for UK international lobbying during 2008**

### **Health systems strengthening**

**Priority 1** – increase aid to build up effective health services and systems – the G8 and other partners should commit to a clear timetable to meet the Heiligendamm commitment to provide \$60 billion for health<sup>1</sup>.

**Priority 2** – increase investment in the health workforce to ensure there are at least 2.3 trained health workers per 1,000 population by 2015 – this will enable 80% of deliveries to be attended by a skilled birth attendant (SBA).

### **Complementary targeted investments**

**Priority 3** – increase international efforts to halve unmet need for family planning (including for male and female condoms) by 2010, and provide universal access to family planning by 2015.

### **High level advocacy**

**Priority 4** – scale-up global efforts to register every birth and death and certify every cause of death.

## **4. Support for civil society advocacy**

Supporting civil society groups is crucial to advocating and holding governments to account for the delivery of effective maternal health services.

DFID will be working with civil society to advocate for using progress in reducing maternal mortality as the key measure of success for health system strengthening. This would be a more stretching goal than, for example, immunisation coverage and would raise the profile of maternal mortality.

The unique advocacy opportunities in 2008 such as the G8 summit in Japan, the UN High Level Meeting on MDGs in New York and the high political profile of the White Ribbon Alliance for Safe Motherhood provide a key impetus for DFID to intensify its support to key global advocacy partners this year and beyond. DFID is working to prepare for the upcoming opportunities by:

- Supporting the Partnership for Maternal, Newborn and Child Health (PMNCH), along with additional specific support to a specialist advocacy consultant. This is to enable the PMNCH to build upon a global maternal health advocacy mapping exercise (jointly funded by

DFID and Norway) and to work with partners to develop critical messages for the G8, and beyond.

- Supporting Women and Children First (WCF), a UK based NGO, who have swiftly gathered UK advocates together. The intention is to ensure that all UK partners in advocacy for maternal health are coordinating with each other to ensure strength in messages through clarity and consistency across civil society.
- The UK government is also continuing to support civil society groups in many countries to advocate and hold governments to account for delivery of effective maternal health services.
- DFID continues to work together with its own funded research programmes, and the Health Metrics Network (HMN), to ensure that research on measuring maternal mortality is playing a key role in our advocacy efforts.
- DFID is providing ongoing support to the Prime Minister in his capacity as a member of the Network of Global Leaders for MDGs 4 and 5.
- DFID is working with like-minded donors such as NORAD to bring together NGOs to support them in holding governments to account to deliver MDGs 4 and 5.
- DFID is working with others to facilitate a side event for NGOs at the upcoming High Level Forum on the MDGs in September in New York.

## Introduction to 2007 review of progress

This document provides the third annual update of progress in implementing DFID's 2004 maternal health strategy *Reducing maternal deaths – evidence and action*.

### Four priority areas for action in the maternal health strategy

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

1. Progress during 2007 reflects increasing activity and advocacy on MDG 5 at global and country levels, as well as work to address socio-economic barriers – in particular through innovative financing mechanisms (vouchers and cash) to help overcome the prohibitive costs of safe delivery for the poor.

2. Countries report that weak health systems (particularly lack of human resources, drugs and supplies, transport and poor communications), remain a major barrier to scaling up proven effective interventions.

3. There is increasing recognition of the value of a mix of aid instruments, in order to address MDG 5, particularly in Africa.

4. Country offices report a mismatch between DFID's policy of encouraging increased spending through multilaterals and their relatively weak performance at country level. Although there are some signs of progress, UN agencies in particular need to work more closely together rather than continuing their delivery of separate programmes. There is a particular need for UNICEF and UNFPA to collaborate more effectively on family planning. Improved and decentralised staffing of both the European Commission and the World Bank (WB) would enable these agencies to have a more effective role in influencing and advocacy. This would, in turn, enhance DFID's ability to do more. The WB in particular could play a more pertinent role in supporting governments, to define the optimum funding patterns for social sector funding.

5. The UK Parliamentary International Development Committee (IDC) carried out an inquiry into maternal health – and in particular DFID's approach to maternal health. The report issued in early March 2008. The major headline reported by the IDC was that:

*“...there has been a failure of international advocacy and political will regarding maternal health. We believe DFID will need to continue to play a leading global role - despite its headcount restrictions - in pushing this neglected MDG far higher up the global agenda.”*

DFID's detailed response to the IDC report was submitted in May 2008.

## Priority 1: Advocate – raise the profile

2007 has been an exceptional year for advocacy for maternal health, and 2008 looks set to be even more significant. So there is cause for some optimism, but much remains to be done.

6. The inclusion of a new target under MDG 5 to address reproductive health was finally agreed and announced on 9 October 2007, in the UN Secretary General's Report on the *Work of the United Nations for 2007*. This is a major step forward on political advocacy. DFID has pushed hard to include reproductive health in the MDG framework since 2000.

### The new MDG5 target on reproductive health

#### Millennium Development Goal 5 :

To improve maternal health

#### MDG5 targets:

**5A** To reduce by three quarters, between 1990 to 2015, the maternal mortality ratio

**5B** *To achieve, by 2015, universal access to reproductive health*

#### MDG5 indicators:

5.1 Maternal mortality ratio

5.2 Proportion of births attended by skilled health personnel

5.3 Contraceptive Prevalence Rate

5.4 *Adolescent birth rate*

5.5 *Antenatal care coverage (at least one visit and at least four visits)*

5.6 *Unmet need for family planning*

*(new additions in italics)*

7. The Prime Minister opened the landmark Women Deliver Conference in London with a speech relayed by video, marking 20 years since the Global Safe Motherhood Initiative was launched. Douglas Alexander, Secretary of State, announced to the conference that DFID will provide an additional £100 million over five years to the UNFPA Global Programme for Reproductive Health Commodity Security.

### Excerpt from Gordon Brown's opening video speech at the 'Women Deliver' conference

"And of course women are central to the achievement of the Millennium Development Goals because of the fundamental role women play in society – not just as mothers but also as carers, workers and leaders.

I wish you every success in your conference. Our task could not be more important – saving lives.

We know how to save them. Now we must all show we have the will and bring this global emergency to an end".

8. The Norwegian Prime Minister, Jens Stoltenberg, launched the *Global Campaign for Health MDGs* in September 2007. Arising from the Norwegian

Initiative on MDGs 4 and 5, this campaign brings a focus to both maternal and child health. DFID encouraged Norway to shift away from a focus on child health (MDG 4) only, to include MDG 5. Gordon Brown has joined PM Stoltenberg's "Network of Global Leaders" for increasing high level political advocacy on MDGs 4 and 5.

9. DFID provided support for special editions of *The Lancet* and *Reproductive Health Matters*, to coincide with the Women Deliver conference.

### **Key messages from *The Lancet* "Women Deliver" edition**

We know what works and is cost effective to reduce the death toll.

- A continuum of care is needed which starts with promoting good sexual health, making sure that contraceptives and safe abortion are available – right through to the care of women in pregnancy, childbirth and beyond to the care of the new baby and child.
- Only a few developing countries have made systematic efforts to scale up this continuum to reach all women and children – universal coverage is a distant dream.
- Health systems need strengthening at all levels – particularly district level.
- Building and integrating the continuum of care into functioning health systems will require political will, good management and most importantly investment in basic services, human resources and infrastructure.

10. Funding provided to the White Ribbon Alliance for Safe Motherhood (WRA) by DFID for a film made by Tanzanian midwives made a considerable impact, advocating at the highest level for maternal health. The film is now having an impact at a global level. Other initiatives from WRA included:

- WRA's National Coordinator for India gave a presentation on a panel at the United Nations, during the Clinton Global Initiative.
- Sarah Brown hosted a WRA fundraising reception at No. 10 Downing Street during the Women Deliver conference in October.
- The WRA has subsequently been funded by the Gates Foundation to raise political commitment at high level meetings during 2008, including the World Bank/IMF Meeting in Washington DC, the World Economic Forum for Africa in Cape Town, and the G8 Summit in Japan.

### **White Ribbon Alliance facilitates advocacy film made by Tanzanian midwives**

The film "Play your Part" was made by Tanzanian midwives. This has been aired several times on Tanzanian television, prompting responses from the Ministry of Health and Members of Parliament, and was shown at the first Partnership for Maternal, Newborn & Child Health Forum in Tanzania in April 2007. Tanzanian President Kikwete also responded by making a statement of commitment, to ensure MDG 5 is achieved in Tanzania, including issuing a Presidential Decree to hire more skilled health care providers.

11. DFID has supported the Health Metrics Network (HMN), a global partnership established to address the lack of reliable health information in countries, with £700,000 (2005-2009). HMN is encouraging countries to count all births and deaths through effective civil registration. A special series of papers on counting births and deaths has been published in *The Lancet*, which points out that maternal deaths in the UK started to drop only after effective civil registration was established and the scale of maternal mortality was fully recognised.

12. DFID and other agencies reaffirmed their commitment to provide additional support towards the prevention of unsafe abortion at the Global Safe Abortion conference, held in London. In response to a very high level of demand for funding, particularly from African countries, DFID has provided an additional £1 million of funding, on top of the initial grant of £3 million, specifically earmarked to the International Planned Parenthood Foundation (IPPF) administered Safe Abortion Action Fund (SAAF). DFID continues to support all five of IPPF's strategic areas of work: Adolescents, HIV/AIDS, Abortion, Access to SRH services and Advocacy.

13. DFID is recognised for its strong defence of women's sexual and reproductive rights and works closely with like-minded European partners (such as Netherlands, Norway and Sweden) to defend strong sexual and reproductive health and rights (SRHR) language in international negotiations and agreements. This is becoming increasingly difficult in a time of powerful conservatism. During 2007, steps had to be taken to protect effective SRHR language at the World Health Assembly and in official statements such as the EU Africa Strategy, the UN Gender and Development Statement and the EU World AIDS Day Statement.

14. The UK's new AIDS strategy emphasises the links between maternal health and health systems strengthening and goes beyond the health sector to look at rights, inclusion and empowerment of vulnerable groups.

15. DFID supported the Partnership for Maternal, Newborn and Child Health (PMNCH) with £1 million in 2007. Having served on the Board of the partnership since its inception, DFID has now rotated off the Board and is being represented by Norway. It has taken a longer time than expected for the partnership to become fully established and effective. DFID is also providing support to help the partnership clarify its advocacy strategy.

16. In African countries, the nature of DFID advocacy on maternal health is heavily influenced by whether or not we are actively involved in the health sector. Where DFID is actively involved in the health sector, (for example in Mozambique, Nigeria and Malawi), it is possible to engage both in technical and political advocacy to reduce maternal mortality. Where DFID is less directly involved in the sector, (for example in Uganda, Tanzania, Ghana) DFID works with other funding agencies and governments to agree monitoring arrangements to measure progress made. A number of country programmes (for example Sierra Leone and Malawi) are also supporting the advocacy efforts of non-government organisations.

## DFID advocacy in selected African countries

- DFID Mozambique had been participating in the Sector Wide Approach (SWAp) working group on maternal and child health, which seeks to strengthen government commitment to maternal and child health. New opportunities to increase advocacy for MDG 5 are arising through new work to address the health workforce crisis and the development of a human resource strategy, jointly funded by DFID and DANIDA.
- DFID Nigeria has provided support to the development of the new Integrated Maternal, Newborn and Child Health (IMNCH) Strategy and provided support to the MNCH advocacy conference. The strategy is now being rolled out (with DFID support) across the country.
- In Ghana, how best to meet MDG 4 and 5 targets was a key theme of the 2007 Results, Resources and Partnerships annual review meeting (Consultative Group), co-chaired by DFID. Human development issues are frequently raised with Government partners by all the major funding agencies, and the impact of that was reflected in the 2007 budget statement which gave prominence to the Government's plans to meet MDG 4 and 5 targets.
- In the Democratic Republic of Congo (DRC) DFID have emphasised lobbying on the issue of addressing the financial barriers which prevent access to health services for the poor, particularly women and children.

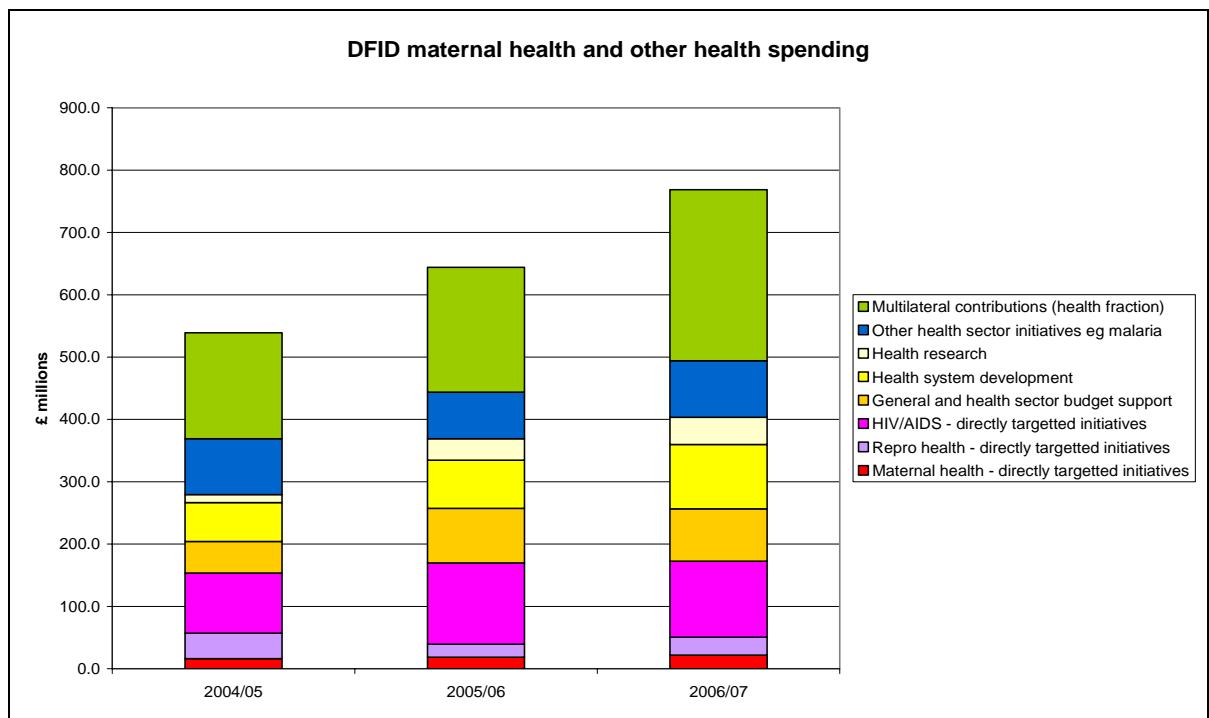


Mothers waiting outside Idabakuli health centre in Shinyanga, Tanzania (Crown Copyright)

## Priority 2: Scale-up evidence based interventions

17. DFID bilateral and multilateral spending for health and also for maternal health is steadily increasing. In financial year 2006/7, DFID spending on projects which exclusively tackle maternal and newborn health, amounted to £23.2 million, which is a ten-fold increase since 2002/3. The maternal health strategy, which was published in 2004, pledged year on year increases in spending. This has been achieved.

18. Direct spending on maternal health is only one way to support developing countries in achieving MDG 5 – DFID also finances health systems through poverty reduction budget support (PRBS) and health sector wide approaches (SWAp). These more general forms of funding are also increasing and they contribute directly to improvements in maternal health – they are included in the overall health spend figures and are shown in the graph below.



19. A key constraint to scaling up effective maternal health interventions remains weak health systems. Unlike access to bed nets or vaccines, increased access to skilled birth attendance requires a fully functioning health system with skilled personnel (midwives, obstetricians and anaesthetists) as well as drugs, supplies and equipment. The International Health Partnership (IHP) launched by the Prime Minister, outlines a new agreement to accelerate action to scale-up coverage and use of health services by all, and intensifies the focus on health systems that are core to improving maternal health.

## Scaling-up in Africa

20. Africa has the highest maternal mortality ratio (MMR) in the world at 900 deaths per 100,000 live births. Between 1990 and 2005 the proportion of deliveries attended by skilled healthcare personnel in sub-Saharan Africa rose only modestly from 42% to 45% (UN 2007 MDG Update).

### The mortality gap between Africa and other regions widens

"Maternal health remains a regional scandal, with the odds that a sub-Saharan African woman will die from complications of pregnancy and childbirth at 1 in 22, compared to only 1 in 7,300 in the developed world."  
*UN 2007 MDG Update*

21. None of DFID's focus countries in Africa are on track to meet MDG 5. The key drivers of maternal mortality in Africa include:

- Lack of good quality health services: human resources; drugs; commodities and supplies; referral mechanisms; and transport.
- Lack of access to modern methods of family planning (it is estimated that between 25 - 40% of maternal deaths could be averted through family planning). In sub-Saharan Africa a total of 63% of women at risk of unintended pregnancy are either using no method or only traditional methods (UNFPA, 2004). For example, in the Democratic Republic of Congo (DRC), the modern method contraceptive prevalence rate is only 6% while in Zimbabwe it is 58%.
- Unavailability of safe abortion (with unsafe abortion thought to be the cause of approximately 14% of maternal mortality in sub-Saharan Africa).
- In all countries, to varying degrees, progress with both maternal and under-5 mortality will be adversely affected by HIV and AIDS.

### Prevention of mother-to-child-transmission of HIV

Surveys of public antenatal clinics in South Africa in 2006 showed that 29.1% of pregnant women (age 20-24) have HIV. More than 6% of infants born each year will become infected with HIV by their first birthday. In South Africa, as in many countries, there needs to be more focus on prevention-of-mother-to-child-transmission (PMTCT) related services, including primary prevention of HIV in women.

22. Two significant constraints to progress on MDG 5 highlighted in this year's Africa Division review are the weak in-country performance of multilaterals (particularly WHO, UNFPA and UNICEF) and financial barriers to accessing health services for the poor.

23. In many countries DFID is the lead donor in the health sector. Within the sector we have particular strengths in: aid effectiveness; brokering harmonisation and alignment; and sustained support to overall health systems and health service development. In line with the direction of the Africa Director's Delivery Plan (2005 -2008), country programmes (such as Zambia) have increasingly supported improved health outcomes through general or

sector budget support (with or without direct engagement in health sector policy dialogue) and decreasingly been involved in separate health sector programmes and projects.

24. Previous experience of large 'safe motherhood' investments (for example Malawi) has been sobering, with short term results largely not being sustained beyond the duration of the project – usually because underlying health systems constraints remained unaddressed. Hence a greater focus in the current era on supporting PRBS, health SWAs and human resources.

25. Mozambique has been relatively successful in addressing maternal mortality: The Maternal Mortality Ratio has decreased significantly in recent years from a high of 1,000 per 100,000 live births in the early 1990s, down to 408 in 2002/3, and now recently reported at a level of 351 in 2007. If this trend continues, Mozambique has the potential to reach the MDG goal of reducing MMR to 250 in 2015. The DFID Mozambique programme exemplifies the use of a mix of aid instruments to address health outcomes.

### **DFID Mozambique support to maternal and child health**

- 70% of DFID support in Mozambique is provided as General Budget Support.
- In addition, DFID are contributing significant Sector Budget Support to the Health Common Fund - £3.7m every year up to 2009, £3m in 2010, and £2.3m in 2011.
- Budget support is complemented by an £8.5m insecticide-treated nets distribution programme for pregnant women and children under five up to 2010.
- DFID is also providing technical assistance to the Health Ministry for the design and costing of a Human Resources strategy - £120k in the first year.

26. Of the £100m DFID Malawi six-year support to the Health Sector Wide Approach, £55m supports the Emergency Human Resources Programme (EHRP), co-financed by Government of Malawi (\$50m), and the Global Fund (\$105m). This is DFID's most significant investment to address human resources for health.

### **Progress in human resources for Malawi**

#### **The Malawi Emergency Human Resources Programme (£55m)**

The annual enrolment of clinical officers, doctors and nurse/midwives, the key cadres for maternal health, has increased between 2003 - 2005. Increases in doctors (41%), clinical officers (50%) and nurses (33%).

In parallel, working with the UK Department of Health, the UK tightened the 'Code of Practice for the international recruitment of healthcare professionals', in December 2004, to stop the recruitment of health care professionals from developing countries suffering a shortage. It is reported that migration overseas by Malawian health professionals has slowed from a high of 108 per year in 2003 to only 13 in 2006.

27. In Africa, direct DFID programme investments to tackle maternal and child mortality, outside of PRBS and SWAp programmes, are more typically seen in 'fragile' contexts such as Sierra Leone.

### **Strengthening basic health systems in Sierra Leone**

DFID Sierra Leone's new programme (£50 million over 10 years) aims to strengthen basic health systems to increase access to quality sexual, reproductive and child health services. Preparatory activities have included assistance to develop the National Reproductive Health Policy, support to WHO to undertake National Health Accounts and technical assistance to the Ministry of Health to finalise and to cost the Reproductive and Child Health Strategic Plan.

28. Where a fragile state is unable to provide maternal and reproductive health services, due to conflict or a humanitarian emergency, DFID funds are most likely to flow through WHO, UNFPA and UNICEF. This includes the WHO's Health Action in Crises (HAC) (£6.2m 2003–07), UNFPA's provision of reproductive health commodities in fragile states (£5 million 2007–08) and UNICEF's programme for emergency feeding of children and pregnant/nursing mothers. DFID is encouraging better UN co-ordination of the health response in disasters.

29. A number of DFID country programmes are supporting the distribution of insecticide treated bed nets (ITNs), an intervention with a proven impact on both maternal and child mortality. These include:

- a joint UN programme in Northern Uganda, which has resulted in 70,000 women and 700,000 children being protected from malaria by ITNs;
- funding through the Sudan Multi Donor Trust Fund to disburse 1 million free ITNs in South Sudan, targeted at children and pregnant women;
- in DRC, a third £17m phase of ITN distribution aiming to distribute 2 million treated nets in 2 years through social marketing, two thirds of which will be targeted at pregnant women and under fives with subsidies largely through rural health centres; and
- between 2001 and 2007, DFID Kenya provided £47.4m for ITN programmes targeted on pregnant women and children.

30. Approximately 5.5 million African women undergo an unsafe abortion each year (WHO). DFID Africa Division has approved a £7.5 million contribution to IPAS and the IPPF-administered Safe Abortion Action Fund (SAAF). These investments aim to: strengthen regional organisations and networks that advocate for safe abortion; support advocacy and production of policy relevant research; have an impact at country level and regional level on policy change and service delivery; and increase utilisation of high quality, safe abortion and post abortion services.

31. The International Health Partnership (IHP) has been welcomed in Ethiopia, Uganda, Burundi and Mozambique, who are among the 8 initial countries participating. All countries have a strong sense of ownership and are positive about how the IHP will improve maternal health outcomes

including through attracting additional resources for health, improving coordination, effective utilisation and strengthening accountability.

### **International Health Partnership in Burundi**

The IHP in Burundi has helped bring financial and technical partners closer together and put government firmly in the lead. A government-partner Memorandum Of Understanding, based on the IHP compact, will provide an extra platform from which to advocate on maternal and child mortality.



Launch of the International Health Partnership at No. 10 Downing Street (Crown Copyright)

## Scaling-up in South Asia

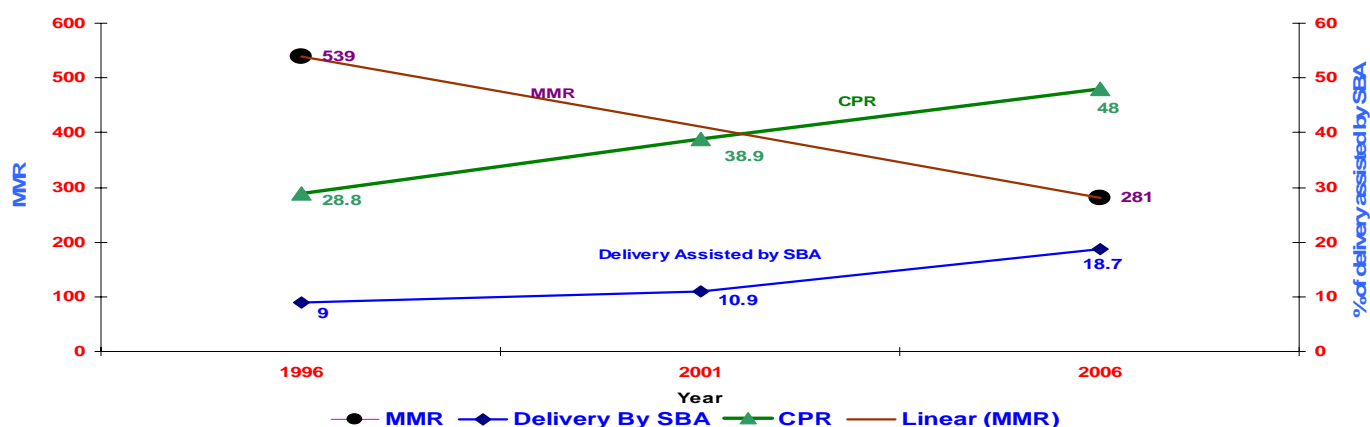
32. Although Bangladesh, Nepal, India and Pakistan are all off-track for the MDG5 target of a three-quarters reduction of maternal mortality by 2015, national data show maternal mortality has reduced in Bangladesh, Nepal, and India.

33. DFID provides substantial financial and technical support for maternal health and strengthening of health systems, through sector or sub-sector wide programmes in India, Bangladesh and Nepal. DFID also supports specific maternal and neonatal programmes in Pakistan, Nepal and Bangladesh. Financial incentive schemes for maternity services are underway in Nepal, India and Bangladesh, and a similar scheme is planned for Pakistan.

34. In Nepal, the 2006 national Demographic and Health Survey (DHS) reported the MMR was 281 per 100,000 live births, nearly a 50% decline on the figure of 539 per 100,000, a decade earlier. Further recent analysis suggests a decline of about 20% over the past 10 years, which is an impressive reduction in view of the armed conflict. Related progress includes:

- a 33% decline in fertility from 4.6 births per woman in 1996, down to only 3.1 in 2006 (DHS)
- increased access to emergency obstetric care (up from 7% to 18% in 13 focal districts) and also number of deliveries by a skilled attendant (up from 9% to 19% between 1996 and 2006)
- an increase in the caesarian section rate, up from 1% to 2.7%.
- Safe abortion services are being scaled up, which will also have a beneficial impact on MMR, but it is too early to attribute falls to this.

### Trend in maternal mortality ratio, contraceptive prevalence rate and percentage of deliveries assisted by trained health worker, Nepal 1996 to 2006

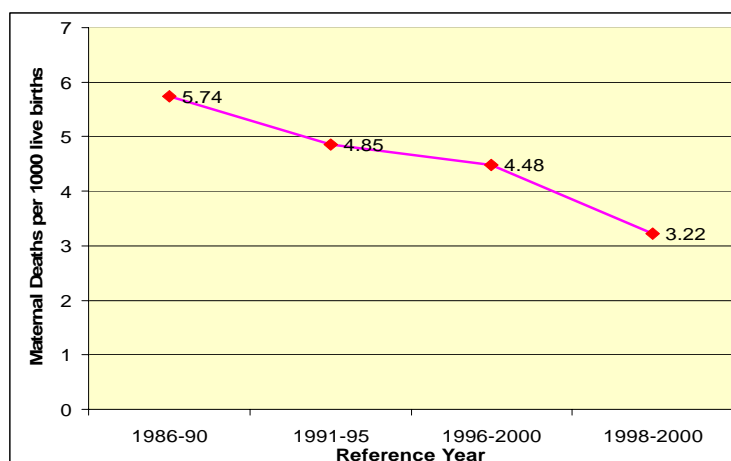


35. The DFID-funded Support to Safer Motherhood Programme (SSMP) (£20 million over 5 years) has provided technical support at national and district level, and financial aid to the government for in-service training, strengthening health facility management committees, infrastructure development including construction of Emergency Obstetric Care (EMOC) sites, and better monitoring of EMOC.

36. Nepal is a first wave country for the International Health Partnership (IHP). The IHP has galvanised energies into addressing the barriers to care for the poor, particularly financial barriers. The Ministry of Health and Population is developing a policy to reduce these barriers, including consideration of an option to provide free maternity care to all.

37. Bangladesh has also made significant progress towards achieving the MDG 5 target. The MMR has fallen from 574 per 100,000 live births in 1990, down to 322 per 100,000 live births by 2001, a 38% reduction. However, in order to reach the MDG target, the current rate of decline (3.2% per annum) needs to increase to 5.1% per annum.

### Trend in maternal mortality ratio, Bangladesh 1985 to 2010



Source: Bangladesh Maternal Health Services and Maternal Mortality Survey 2001

38. Evidence suggests that this progress can be attributed to a number of factors, including increased use of family planning, improved education for girls, a reduction in deaths from unsafe abortion due to the national menstrual regulation programme, and some improvements in access to EMOC.

39. The rate of skilled birth attendance (SBA) has increased to 18% in 2006 (up from 13% in 2003), but remains one of the lowest in the world. In 2006, survey data suggests that only 15% of births in the previous 3 years had taken place in a health facility. Bangladesh is remarkable because MMR has reduced substantially in the last 20 years, but without a commensurate increase in SBA.

40. Working in partnership with the EC, DFID is contributing £11 million over 5 years, to a joint UN (UNFPA/WHO/UNICEF) programme to accelerate

progress on maternal and neonatal health, with a focus on the district level. This is in addition to £100 million over 5 years to the Health, Nutrition and Population Sector Programme. DFID also supports the Urban Health Primary Care Project (£15 million over 6 years). DFID's programme to focus on relieving extreme poverty also includes financial assistance for EMOC.

41. In Pakistan, various surveys show declining fertility rates, an increase in the number of deliveries with skilled attendants, and an increasing trend in facility-based deliveries, in both urban and rural areas (up from 28% in 2004-05 to 48% in 2005-06). However, progress in Pakistan towards the MDG remains very slow.

42. The troubled political and security situation has slowed progress in carrying forward DFID's Maternal and Neonatal Programme (£90 million over 5 years) which will focus on increasing access to maternal health services for the poor and socially excluded groups in Punjab and North West Frontier provinces.

43. The Government of Pakistan's *Vision 2030* document places maternal and child health at the top of the priority list. In 2008, DFID's intensive advocacy for maternal health will continue with the launch of a Research and Advocacy fund (£11.5 million). This will foster rights-based approaches and test innovative proposals for demand-side financing.

44. The Government of India estimates the national MMR at 301 per 100,000 live births, based on its sample registration system. This represents a reduction from 398 per 100,000 live births in 1997/8 using the same methodology. There are wide disparities between the various states. In 2007, WHO, UNICEF, UNFPA and the World Bank estimated India's maternal mortality to be closer to 450 per 100,000 live births, assuming under-reporting in the sample system. Taking either figure, India is off-track for reaching the MDG target of reducing maternal mortality by three quarters by 2015.

45. The Government of India has set ambitious targets to reduce maternal mortality. Overall, progress on related indicators including contraceptive use, skilled birth attendants and institutional deliveries, is gradual and uneven. States such as Andhra Pradesh are doing well but others, such as Bihar, remain at a very low level. Four northern states (Madhya Pradesh, Orissa, Bihar and Uttar Pradesh) account for over 60% of maternal deaths. DFID provides health sector budget support in Madhya Pradesh and Orissa and is planning similar support to Bihar.

### **Emergency obstetric care in India**

A recent survey on provision of emergency obstetric care in 10 States, part-funded by DFID, indicated many public sector health facilities in India still lacked crucial skilled staff, equipment and supplies.

46. In India DFID supports maternal health outcomes in *three* ways:
- At national level, DFID supports the Government of India's Reproductive and Child Health II Programme (£252 million, 2005-2011) to improve access to skilled birth attendance and emergency obstetric care for pregnant women; improve newborn care, immunisation and other health services for children; and reduce unmet need for contraception. This programme is the core of the Government's plans to improve maternal health. DFID's support also includes technical co-operation funds (£4.5 million) for a National Health Systems Resource Centre and further support to strengthen health sector procurement (£2 million).
  - At the state level, DFID is supporting health sector programmes in its four focus states. DFID's support includes the West Bengal Health Sector Strategy (£100 million, 2004-2010), health sector support to in Orissa (£50 million, 2007-2012), Andhra Pradesh (£40 million, 2007-2010) and Madhya Pradesh (£60 million, 2007-2012). All include strong elements of support to maternal health services.
  - DFID also funds multilateral partners to help the Government of India towards meeting the MDGs. The largest such support is to UNICEF (£75 million, 2006-2010) to improve the implementation of government programmes for maternal and child health in eight disadvantaged and highly populous states, including Bihar and Uttar Pradesh.

### **Births in health facilities in India**

In 2005/6, for India as a whole, approximately 40% of births were taking place in health facilities – up from 33.6% in 1998/9. More than half deliveries took place at home.

Births in health facilities were approximately equally divided between those taking place in public facilities (18% of births) and private ones (20% of births).

Scheduled tribe mothers are least likely to give birth in a health facility with an institutional delivery rate of only 18% compared to 51% among mothers who are not members of a scheduled caste or tribe or other "backward caste".

Muslim women had a particularly low rate of 33% institutional deliveries.

Cost is one of the most frequently reported reasons for not giving birth in a health facility.

47. Although there have been improvements in contraceptive use in India there is still a large level of unmet need, with 13.2% of women who want to use a contraceptive not currently doing so. There is also an overwhelming reliance on sterilisation as a method. This weakens women's ability to delay and space births, and can also be a factor behind high levels of unsafe abortion. India's family planning programme still concentrates on sterilisation as a major method and greater efforts are needed to increase access to spacing (or reversible) methods of contraception. It is estimated that unsafe abortion is the third largest cause of maternal mortality in India.

48. Afghanistan is estimated to have one of the highest maternal mortality ratio in the world of around 1,800 per 100,000 live births (2005 UN/World Bank estimates). After decades of conflict, the health system has shown improvement in a majority of provinces between 2004 and 2006, including an increase in women receiving antenatal care from 5% in 2003 to 32% in 2006, and births assisted by a skilled attendant, up from 6% to 19% in rural areas.

49. The Reconstruction Trust Fund (RTF), which DFID supports, provides significant recurrent costs, including for health workers' salaries. DFID has a policy engagement on health through the RTF performance framework.



Mother and children, Orissa, India (Crown Copyright)

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

50. Some progress is being made, with China, Cambodia and Yemen on track to reach the MDG 5 target. DFID is using a mixture of aid instruments, including maternal health projects (Indonesia, Yemen), health sector support without earmarking for maternal health (Kyrgyz Republic), a joint donor project with earmarked maternal health support (Cambodia), and health sector reform projects (China).

51. The key constraints to delivering effective maternal health programmes at scale are health system related. In Indonesia insufficient and regressive funding of the sector, along with fragmentation of delivery with hospitals and health centres being managed separately and poor human resource management, all constrain scaling up efforts. In the Kyrgyz Republic, health system issues continually impede progress, such as insufficient and poorly trained staff and lack of commodities.

52. China: Progress since 1990 has been steady. Based on past trends we estimate that China is on track to reach the MDG target by 2015, but there are wide regional disparities. The latest data indicates that the MMR was 47 deaths per 100,000 live births in 2005 and that the rate continues to decline. In 2006, skilled birth attendance (measured as clean delivery) was high at 97.8% and institutional delivery 88.4%.

53. DFID China are addressing maternal mortality by looking at how to strengthen the health system in rural areas and address bottlenecks in accessing maternity services. DFID support includes:

- Six years of funding to a joint Government of China, World Bank health programme (£21 million 1999-2007), with £1.5 million of this targeted towards reproductive health, including specific interventions to reduce maternal mortality (such as skilled attendance).
- A new Rural Health Project is under design with £5 million from DFID, adding to a \$50m World Bank loan which will address maternal health through a comprehensive public health strategy.
- Maternal mortality is also addressed as part of the DFID-funded Urban Health and Poverty Project (£10 million DFID contribution, over 4 years), which aims to improve access for the urban poor to quality health services.
- DFID also supports the Health Policy Support Project (£4.8 million 2005-9) which will contribute to research related to maternal health and help develop the evidence base to be used for policy making.

54. Cambodia: The most recent figures show a slight increase in maternal deaths, from 427 per 100,000 live births in 2000, up to 472 per 100,000 in 2005. However, since levels were much higher in 1990 (at 900 per 100,000 live births), it is possible to say that, over the longer time frame, the Maternal Mortality Ratio in Cambodia is possibly reducing fast enough to reach the

MDG target by 2015, though there is no room for complacency<sup>1</sup>. Only 22% women deliver in a health institution.

55. In Cambodia, DFID support includes:

- the Health Sector Support Project (£15 million 2002-2008), jointly with WB, AsDB and UNFPA);
- the Reduction in Maternal Mortality Project (£2.3 million DFID funding), a sub-component of the Health Sector Support Project aiming to increase the quality of services, improve access (using equity funds), remove demand side barriers, improve abortion care and provide voluntary surgical contraception; and
- an additional £0.5million allocated to extend the health equity funds to cover maternal and reproductive health services.

## **Yemen**

56. In 2003, the MMR was estimated as 365 deaths per 100,000 live births and made maternal death the leading cause of death among women of reproductive age. Although still high, Yemen has reduced maternal mortality dramatically since 1990. (In 1990, MMR levels stood at 1,400 per 100,000 placing Yemen in the top 10 countries for MMR globally.) Although high levels of MMR remain, Yemen is on track to reach the MDG target by 2015. In 2003, skilled attendance was low, at only 21.5%, and there was also a low rate of institutional deliveries (15.5%).

57. DFID provides £3.7 million (2008-2012), of the total £7.4 million cost to the government to implement the Maternal and Newborn Health Programme (MNHP) managed through a delegated cooperation arrangement between DFID and the Dutch. After considerable delays, the programme is just about to start and will focus on improving coverage of skilled birth attendants and comprehensive obstetric care facilities, alongside improving demand and referral practices and family planning. Initiatives to improve local transport and communication systems will be piloted.

## **Indonesia**

58. The most recent national estimate for MMR was in 2002/3, showing a MMR of 307 deaths per 100,000 live births. Progress in MMR has been only modest, down from 390 per 100,000 in 1991. DFID staff estimate that it is unlikely that Indonesia will achieve the MDG target by 2015 unless there is further improvement. However, some sub-districts have reached 100% of women delivering in institutions.

59. DFID is assisting the Government to implement the national Safer Motherhood Strategy by contributing funds to UNICEF (£8.2 million 2006 – 2009), working in 9 rural and urban provinces and also providing funds to GTZ

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<sup>1</sup> MDG progress assessments are produced by calculating whether the MMR will have reduced by three quarters between 1990 and 2015, if trends were to continue at the rate seen between 1990 and the latest year. They were produced by DFID staff using data from the UN MDG database, supplemented with more recent local data if available.

(£4.2 million 2006 - 2009) to ensure an existing health systems strengthening project addresses high rates of maternal mortality in two provinces.

### **Kyrgyz Republic**

60. The most recent estimate for MMR was in 2005, at 150 deaths per 100,000 live births. This rate has remained fairly steady since the 1990s and so Kyrgyz Republic is severely off track as it has made no progress towards the MDG target. This is despite the fact that rates for skilled birth attendance and institutional deliveries were reported to be very high in 2005, 97.9% and 96% respectively.

61. DFID is contributing £7 million, out of a total joint donor support of £22 million (2005-2010), working with WB, KfW, Swiss, Sweden, to a Health Sector Wide Approach (SWAp) programme, led by the government. Maternal and Child health is a key priority of the health sector strategy. The Kyrgyz Republic has high rates of institutional delivery and skilled attendance at birth but still has high MMR, which varies between districts, with poorer districts having higher maternal death rates. This is related to practices, such as over-medicalisation of birth, inappropriate use of technology, unnecessary hospitalisations, and the use non-evidence based interventions.

### **Preventing unsafe abortion in the EMAAD regions**

In Cambodia the Reduction in Maternal Mortality Project works with the Cambodian Midwives Association to ensure midwives and provincial officials understand the implications of the 1997 Cambodian Abortion Law that legalised abortion. In the Kyrgyz Republic, although abortion is legal, the rate of abortions remains high, partly because there is limited access to contraception. The government has a plan to increase funding for contraceptives to ensure that at least 20% of the poorest and most vulnerable women have access to contraception. Abortion is illegal in Indonesia, but DFID works through UNFPA to ensure that policy dialogue is being taken forward.



Mother feeds baby, Dominican Republic (Crown Copyright)

### **Priority 3: Address wider social and economic barriers to access**

62. DFID promotes the rights of girls and women, in particular their sexual and reproductive rights. Maternal health is at the core of women's human rights. In support of this, DFID has agreed to provide £200,000 of start-up funding to support the new International Initiative on Maternal Mortality and Human Rights that was launched at the Women Deliver Conference in October 2007, involving the UN Special Rapporteur on the Right to Health. This initiative will work towards reducing maternal mortality as a human rights imperative.

63. DFID continues to support globally neglected issues in maternal health, for example the Obstetric Fistula in Africa Project (totalling £700,000). The Women's Dignity Project, implemented by Engender Health, is combating obstetric fistula in Tanzania and Uganda, through raising awareness, and ensuring that women receive treatment and rehabilitation.

#### **Tackling obstetric fistula in the Democratic Republic of the Congo**

In Democratic Republic of Congo, DFID provides support to health services through the Humanitarian Pooled Fund, including support to the Norwegian NGO Christian Relief Network to set up and run a wing in Panzi hospital, South Kivu treating women suffering from fistula. This is one of the most serious and devastating consequences of severe sexual violence. High levels of non-obstetric fistula cases are emerging in DRC, due to the extreme levels of sexual violence.

64. DFID views Female genital mutilation (FGM) as both a denial of girls' and women's human rights and an important maternal and neonatal health issue. DFID is represented on the FGM Donor Working Group and was engaged in supporting the first resolution on FGM passed at the UN Commission on the Status of Women, in 2007.

65. DFID's support to the Women Deliver Conference also encouraged a much needed focus on defining the economic costs of poor maternal health.

## **Key points from the Women Deliver background paper *Women Deliver for Development, October 2007***

### **Poor maternal health creates huge economic costs for the household and the economy as a whole**

- Women
  - provide half of the world's food; in Africa this ratio could be as high as 80%.
  - provide 70-80% of healthcare in developing countries
  - are estimated to be the sole income earner for 25-33% of the world's households
- Poor maternal health reduces productivity, which can lower wages and income. In Ghana pregnant women lost an average of 26 days of work due to reduced productivity, arising from poor maternal health.
- Global losses from maternal and newborn mortality could be as high as \$15 billion, due to reduced potential productivity - half of which is associated with women and half with newborns. Total costs of productivity losses were estimated at \$85 million in Uganda and \$95 million in Ethiopia.
- The costs of maternity services – and maternal deaths - can be catastrophic for household finances and can deplete more than 10% of annual household income.
- Poor maternal health – and mortality - can push families below the poverty line, and prevent them from investing for the future in assets and children's education.

### **Generating economic opportunity for women can improve maternal health**

- Women's employment can boost maternal health: it is associated with lower mortality and morbidity, and higher usage of services. Women participating in credit programmes in Bangladesh are more likely to use health care.
- Poor maternal health is associated with poor economic opportunities, an indicator of lack of empowerment.

66. The burden of maternal mortality is borne disproportionately by the poor. The removal of financial barriers to delivery and emergency care is essential if MDG 5 is to be attained. The removal of fees for delivery and emergency obstetric care – when addressed alongside out of pocket expenses and poor quality of care – is urgently needed (IMMPACT 2007).

67. DFID's position on user fees and maternal health is that user fees are not a good way to finance health systems in developing countries: minimal revenue is raised, administration costs are high, and poor people are excluded. In its 2006 White Paper, the UK Government made a commitment to: *“help partner governments to abolish user fees for basic health services, and help them tackle other barriers to access, including discrimination against women”*.

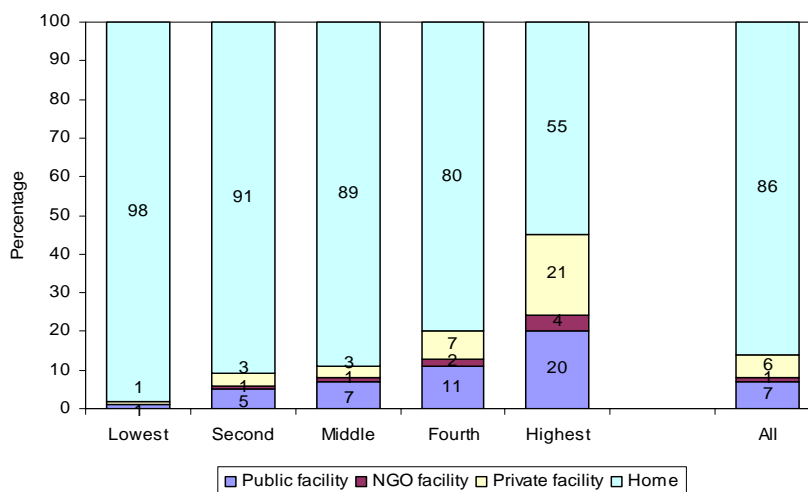
## Catastrophic payments for maternity care

Social tensions arising from catastrophic payments were felt very strongly in women's daily lives according to research in Burkina Faso and Indonesia. These tensions were reflected in women's efforts to cut back on their own spending to avoid being blamed for being 'too expensive', increased work activities to replenish depleted funds - even when they were still unwell, and increased perceived dependency and guilt. In some cases marital or other social relationships disintegrated as a direct result of the financial burden of emergency care (Impact 2007).

68. DFID and other partners are supporting innovative work in a number of countries to overcome economic barriers to access to maternity care for the poorest and excluded women. As shown in Figure 4 below, the richest women in Bangladesh are *ten times* more likely to have skilled attendance at birth or postnatal care than the poorest. The single most catastrophic health shock is caesarean section, the greatest reason for a household falling into poverty.

### Place of birth by wealth quintile in Bangladesh

Figure 4: Place of delivery by wealth quintile



69. The Bangladesh Ministry of Health and Family Welfare has launched a pilot scheme that will give vouchers to pregnant women to allow access to antenatal care, delivery and postnatal services. The vouchers will also cover the cost of transport for emergency obstetric care. The scheme aims to give vouchers to 100,000 women in 2007/08. DFID is funding WHO to ensure that the impact of the scheme is properly monitored and evaluated prior to it being scaled up.

### The real cost of maternal care in Nepal

In Nepal, a normal delivery in hospital, including transport, comes to about 26% of average annual income per capita. Complicated deliveries can cost up to 10 times more and can plunge poor households into poverty.

70. Early findings in Nepal show that the maternity (financial) incentive scheme has led to increased deliveries by health workers in government health facilities, and over 60,000 women benefited from the scheme in 2006-07. But the distribution of incentives was found to be unequal. For women who were unable to read, the administrative barriers to receiving the cash are significant and it was found that those who had attended women's groups were much more aware of their right to the cash (ICH 2008).

71. In India DFID works with central and state governments to increase access to maternity services for excluded groups including scheduled castes and scheduled tribes, whose maternal health indicators are particularly poor, and to monitor impact, particularly for these groups.

### **Increasing equity and overcoming economic barriers to maternity care in India**

Preliminary reports suggest that the government's new national cash incentive scheme Janani Suraksha Yojana (Maternity Security Scheme) under the RCH2 programme, is resulting in increased deliveries in health facilities. A payment is made in the poorer states to pregnant woman for each institutional delivery, to cover transport and other costs, and to a Village Health Worker who accompanies her. This scheme is sending a signal that women's lives are valued. The challenge now is to meet the increased demand with quality maternity and newborn care services. These need to be close enough to be accessible to all women, particularly the poorest and most vulnerable, whose risk of death is much higher, such as women from low castes and tribal groups. More robust monitoring is needed to assess the scheme's impact on maternal and newborn health.

Incentives to health workers to work in more remote areas. Some states are testing salary incentives for staff to work in rural areas.

Improved referral transportation. The Government of Madhya Pradesh has piloted a referral transport scheme. Self-help groups purchase a vehicle and implement the system, ensuring that the driver is in contact with all pregnant women in the locality. On the basis of a successful pilot programme, the scheme is now being scaled-up across the state, with a state-wide common telephone number.

Mapping and distribution of facilities. Orissa has used GIS to map the distribution of health facilities in order to identify areas which have less access to health facilities, and to ensure that first referral units are well distributed.

Improved data on inequities in uptake of services and health outcomes. Some states are reporting data, disaggregated by scheduled caste and scheduled tribe status, in order to identify where these groups are excluded from services. The NFHS3 (National Family Health Survey), which DFID supported, has also provided data by religion, caste and tribe status.

The RCH2 programme design includes performance bonuses for states which are making progress in increasing institutional deliveries among scheduled caste and scheduled tribe women.

DFID is also supporting the Ministry of Health to establish community monitoring of reproductive and child health services which will help to identify those social groups who are currently not able to access healthcare.

72. In China the joint GoC/WB/DFID project has piloted a number of mechanisms to address financial barriers to care, including subsidised or free transport in rural areas and subsidised or free access to institutional delivery, antenatal and postnatal care. Issues of gender and minority status are still important. In one pilot area, the institutional delivery rate is still only 60%, even with free transportation and hospital delivery.

### **Addressing financial barriers to access in Africa**

In DRC, a planned new Access to Health Care Programme with an allocation of £30.7million will implement Ministry of Health minimum and complementary packages of services (including maternal and child health) to 2.15 million people free of charge. A significant operational research component will document the impact of free health care.

In South Sudan, where it is apparent that different NGOs are adopting different charging policies, DFID has engaged the NGO forum in collating data on charges and utilisation rates. This will inform ongoing discussions with the Government of South Sudan and partners on health financing policies.

Within DFID Malawi's six year £100 million contribution to the health SWAp are 56 service level agreements with the Christian Health Association of Malawi to provide maternal and neonatal health services free of charge.

In Ghana, where there is strong political commitment to health insurance, DFID is playing a role in supporting the scheme to improve access for the vulnerable and poor to basic health care.

DFID Rwanda is focusing on issues related to improving aid effectiveness in the health sector and developing pro-poor domestic health financing policies. This support is being provided directly by DFID and indirectly through funding of an Overseas Development Institute fellow in the Ministry of Health.

## Priority 4: Develop and apply new knowledge

### Research

73. DFID, USAID and the Gates Foundation have provided support to the Initiative for Maternal Mortality Programme Assessment (IMMPACT) research programme, which has demonstrated that progress towards MDG 5 can be measured using cheaper, more reliable methods of measurement, that are appropriate to developing country contexts. The IMMPACT programme is moving towards a conclusion and achievements thus far have included:

- developing enhanced methods and tools for measuring and attributing maternal health outcomes;
- strengthening capacity for conducting maternal health research; and
- providing new knowledge on effective and cost effective strategies.

### Maternal Death from Informants/Maternal Death Follow-On Review

**“MADE-IN/MADE-FOR” (Maternal Death from Informants / Maternal Death Follow-On Review)** enables the measurement of maternal mortality down to community level, together with an analysis of the causes of maternal deaths.

Where there are suitable networks of informants available, this tool is not only suitable for intensive surveys and even censuses, but can also be used in large surveys to give precise estimates. The tool is

- less costly than household surveys; and
- goes beyond simply counting deaths, it develops an understanding of why they happened and how they can be averted.

74. Through a Research Consortium involving the Institute of Child Health (ICH) and London School of Hygiene and Tropical Medicine (LSHTM), DFID is supporting the first major research programme that jointly addresses MDG’s 4 and 5. The Research Consortium, called *Towards 4+5*, also has partners in Bangladesh, Burkina Faso, Ghana, Malawi, Pakistan and Nepal, and is

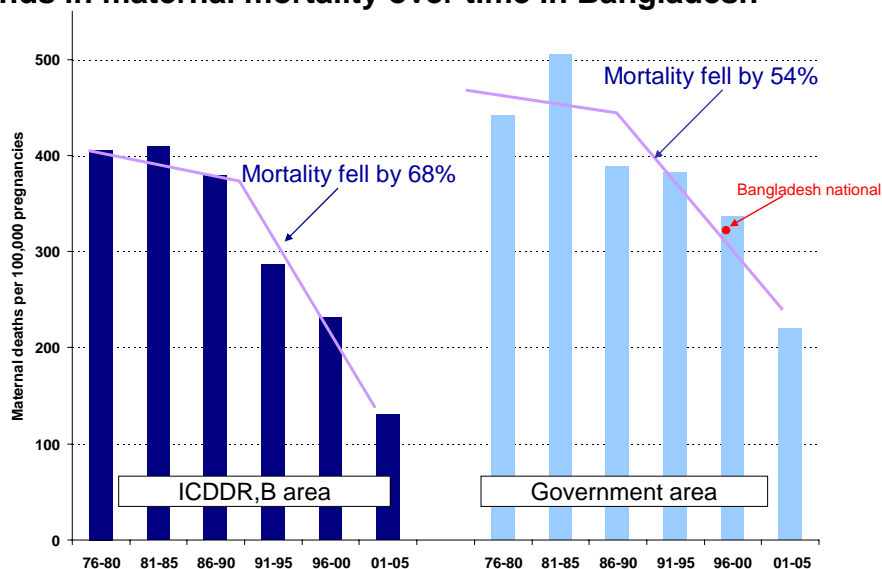
- developing the evidence base for mother and infant care at facility and community level;
- working with collaborating institutions to enhance their capacity in research development; and
- communicating research findings to policy makers and other stakeholders.

75. In rural Bangladesh, *Towards 4+5* has analysed maternal mortality data, between 1976 and 2005, for a population of 200,000. This compared the maternal mortality reduction in an area served by the government with one served by a more intensive research programme (ICDDR-B). The graph below shows that :

- investment in midwives, emergency obstetric care and safe abortion are important; and
- the reduction in maternal mortality, over 30 years, occurred despite a low uptake of skilled attendants at birth.

76. Part of the decline was due to a fall in abortion related deaths and improved access to emergency obstetric care. Female education, improved financial access for the poor and poverty reduction are essential to sustain maternal mortality reduction.

### Trends in maternal mortality over time in Bangladesh



77. Two new research programmes are being supported by DFID:

(a) Working with men: The International Planned Parenthood Federation (IPPF) is developing an information package on men, gender equality and health, working with WHO, Engender Health and others.

(b) Sexuality and development: The Institute of Development Studies (IDS) is undertaking research in India, Brazil, South Africa and China to demonstrate more clearly how sexuality relates to gender inequality, poor sexual and reproductive health and rights and the spread of HIV.

### Generating better data

78. In addition to specific research programmes on maternal health, DFID is continuing to support efforts to improve the availability of better data on maternal deaths to help measure progress (or otherwise) as well as to advocate for increased resources. Relevant DFID support in gathering such data through surveys and other mechanisms in Africa includes the following:

- In Nigeria, DFID intends to co-fund (with USAID) the 2008 Demographic and Health Survey to obtain, for the first time, disaggregated data at state level. Such data is vital to improve health service planning and secure political commitment in Nigeria's highly decentralised federal system.
- In Zimbabwe, DFID is supporting a national maternal and peri-natal mortality survey to inform policy options. The survey will combine two approaches, firstly directly observed mortality over 9 months, and secondly following up on the outcomes of 45,000 births with verbal autopsies.
- In Malawi, working along with the Ministry of Health, DFID commissioned a series of studies on equity of access to health services, including maternal health and immunisation. The studies were published in a special edition of the Malawi Medical Journal in 2006 and provide information to create baseline figures, against which the equity impact of the Sector Wide Approach will be assessed.
- In Tanzania, DFID has supported the "Fair's fair" report on health inequalities. This has proved to be an important resource document, which has subsequently been used to inform debate on policy options.
- In South Africa, DFID has provided funding for research to help government develop a better understanding of the effects of HIV on maternal and child health.

## **Getting rid of poverty will make for a better world for everybody.**

Nearly a billion people, one in 6 of the world's population, live in extreme poverty. This means they live on less than \$1 a day. Ten million children die before their fifth birthday, most of them from preventable diseases. More than 113 million children in developing countries do not go to school.

In a world of growing wealth, such levels of human suffering and wasted potential are not only morally wrong, they are also against our own interests. We are closer to people in developing countries than ever before. We trade more and more with people in poor countries, and many of the problems which affect us - conflict, international crime, refugees, the trade in illegal drugs and the spread of diseases - are caused or made worse by poverty in developing countries.

In the last 10 years Britain has more than trebled its spending on aid to nearly £7 billion a year. We are now the fourth largest donor in the world.

## **DFID, the Department for International Development, is the part of the UK Government that manages Britain's aid to poor countries and works to get rid of extreme poverty.**

We work towards achieving the Millennium Development Goals - a set of targets agreed by the United Nations to halve global poverty by 2015. Millennium Development Goal 5 is "Improve maternal health".

With 64 offices overseas DFID staff work in some of the most difficult places in the world to protect the vulnerable and help countries recover from conflict. We work with organisations like the United Nations, European Union and the World Bank to find international solutions to international problems.

We give money and other help to governments in developing countries to support their own action plans to reduce the number of people living in poverty. And we fund charities, including the White Ribbon Alliance for Safe Motherhood, the International AIDS Alliance, Save the Children Fund, Actionaid, VSO and Oxfam, to work directly with communities. We spend our money where it is most needed and where it will make the most difference and every year the UK Government helps cut the number of people living in poverty by three million.