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International Development Committee

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Contacts

All correspondence should be addressed to the Clerk of the International Development Committee, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 1223; the Committee's email address is indcom@parliament.uk

Witnesses

List of written evidence

List of unprinted written evidence

The following written evidence have been reported to the House, but to save printing costs they have not been printed and copies have been placed in the House of Commons Library, where they may be inspected by Members. Other copies are in the Parliamentary Archives, and are available to the public for inspection. Requests for inspection should be addressed to The Parliamentary Archives, Houses of Parliament, London SW1A 0PW (tel. 020 7219 3074). Opening hours are from 9.30 am to 5.00 pm on Mondays to Fridays.

Nel Druce et al, *'Strengthening linkages for sexual and reproductive health, HIV and AIDS: progress, barriers and opportunities',* DFID Resource Centre, 2006

Kent Ranson, Tim Poletti, Olga Bornemisza and Egbert Sondorp*, 'Promoting Health Equity in Conflict-Affected Fragile States'*, The Conflict and Health Programme, London School of Hygiene and Tropical Medicine, 2007

Chapter 9, Adult and Maternal Mortality from *Nepal: Demographic and Health Survey 2006*

R.Keith and P.Shackleton, *Paying with their lives: the cost of illness for children in Africa*, Save the Children UK, 2006

Bucking the Trend—How Sri Lanka has achieved good health at low cost: challenges and policy lessons for the 21st century, Save the Children, 2004

WHO HIV Technical Briefs, 'Strengthening Linkages between Sexual and Reproductive Health and HIV', April 2007

Oral evidence

Taken before the International Development Committee

on Tuesday 16 October 2007

Members present:

Malcolm Bruce, in the Chair

John Battle	James Duddridge
Hugh Bayley	Ann McKechin
Richard Burden	Sir Robert Smith

Witnesses: **Mrs Thoraya Ahmed Obaid,** United Nations Population Fund (UNFPA) Executive Director, UN Under-Secretary-General, and **Dr Francisco Songane,** Director, Partnership for Maternal, Newborn and Child Health, gave evidence.

Q1 Chairman: Good morning. It would be helpful if you gave an introduction about who you are and your background for the record. Thank you for being here. I appreciate you are here for other reasons as well but it is fortunate for us.

Mrs Obaid: Thank you for having us here today. I am Thoraya Ahmed Obaid and I am the Executive Director of the United Nations Population Fund. I have been in this post since 2001, basically working on our areas of concern, which are population and development, issues of data and statistics and so on. A major part of that is promoting sexual and reproductive health. We work in almost 140 countries where we have country offices. Our staff doing this work are one-third international and two-thirds national.

Dr Songane: I am Francisco Songane. I am the Director of the Partnership for Maternal, Newborn and Child Health. I am a medical doctor, an obstetrician and gynaecologist. I started this job in February of last year. The Partnership for Maternal, Newborn and Child Health is a new partnership which was launched in September 2005 as a way of harmonising and co-ordinating activities around maternity, newborn and child health. As you may be aware, there were three partnerships addressing children: the Child Survival Partnership, the Safe Motherhood and Newborn Partnership and the Healthy Newborn Partnership. Of course all these things are interrelated, particularly when we are on the ground. We do all these things together. It was found useful to merge these partnerships and form one. That is how we were created. Before I became the Director of the Partnership last year, I was the Minister of Health in Mozambique from January 2000 up to January 2005. Before that, I worked as an obstetrician in district and provincial hospitals and in the central hospital co-ordinating activities in maternal and child health.

Q2 Chairman: Thank you for that. The Committee did make a very interesting visit to Mozambique 18 months ago and we saw some of the co-ordination that was going on there, which was good, although we were not particularly looking at aspects of health; it was more about general development. It was an interesting and worthwhile visit. This is the first formal evidence session that we are taking in this inquiry, which we have undertaken fundamentally because of all the MDGs,[1] this is the one that most often turns up and causes most concern as to why that should be and why it is proving so difficult to get it on to target, and indeed in some cases it appears to be going backwards rather than forwards. I wonder if you can perhaps give us a general feel, both of you, as to why you think that is. We had an informal teach-in last week when we saw some of the challenges and heard about them. What came out of it all the time was that two things are needed: one is resources in a whole variety of different ways; and the other is political will. I have probably put those the wrong way round in the sense that the resources are no use if they are not backed up by political will. I wondered if you could give us your thoughts on that: which is the greater and where you think the problems lie. Perhaps I can push this a little bit further. If it is political will, whose political will needs to be jacked up? By definition, as you have already said, there are quite a lot of initiatives—our own government has taken initiatives—but none of it seems to make any difference. That may be political will on some kind of round the world platform but it does not translate to realities on the ground. I wondered if you could give us a flavour of what you think. Is it political will or resources? Where is the problem? What do you think might move us forward?

Mrs Obaid: Political will is certainly a very important part. It is political will on both the national governments as well as on the donor side. On the national governments, basically—I think my colleague, Francisco, can testify as a health minister—the investment from the national budget into the health sector is not as it should be to meet all the needs. From the donor side, we know that to deal with maternal health, and particularly maternal death and maternal mortality, there are three interventions: family planning, emergency obstetric care and skilled birth attendance at birth. In terms of family planning itself, I will give you some figures.

[1] Millenium Development Goal (MDG)

We know that there are 200 million women who would like to plan their families but they have no access to contraceptives to be able to plan. If a woman can plan the spacing and number of her children, then her survival will be much greater. In terms of investment, in 1995 of population assistance as a whole, 55 % was going to family planning and in 2004, the figure was 9%, so investment in family planning including contraceptives has gone down, which means one of the three interventions to save mothers is not there. That is a political commitment issue, which is to invest in terms of ensuring that contraceptives are available.

Q3 Chairman: If I could press you on that, is that commitment or is there prejudice?

Mrs Obaid: From the donors' side it is commitment but also competing demands; that is part of it. It tends to shift from one area to another. That is why now that there is the new initiative by DFID[2] in terms of health sector reform and health sector support, we need to ensure that this will go on, as they say in their strategy, for 10 to 20 years, with consistent support for that. That is one thing. The second, which is related to our work, is the whole issue of gender. That is one of the MDGs, the issue that women are of low status; they are not a priority politically; and the whole issue of maternal health and gender empowerment is not yet on the political agenda at the national level. There is that exclusion also: denial of rights and not enough recognition of the human rights of women, and certainly health is a human right. This is the second challenge: political commitment on the health issue. The third one is the capacity of the health system to deliver. Here, as we are talking about health systems, we are talking at the national level, but women die at the community level where the poor are, and therefore the ability of the health system to deliver primary health care and to create a package of reproductive health that takes women throughout their reproductive age is a very important component and there is not enough investment there.

Dr Songane: Thank you for that good introduction by Mrs Obaid. This is an important occasion and we welcome it profoundly, particularly now that you are marking 20 years of the Safe Motherhood Initiative this week here in London. We have a conference with the title "Women Deliver" exactly to address these concerns. A committee is trying to go into the details. Political will is very important. We need this political will at all levels: at the country level and internationally. Things are happening but they are not happening fast enough and not with the comprehensiveness we would like to see. As my colleague has said, there are three important deprivations. There is no doubt that access to family planning, skilled attendance at delivery and prompt access to emergency obstetric care when needed are crucial. If we do not put these things in place, there is no way we can lower the high levels of maternal mortality. We can make an assessment through the publication this week of the paper in *The Lancet* on estimates of maternal mortality. Sadly, we have not made progress. The figures we had in 1987 when the Safe Motherhood Initiative was launched in Nairobi are exactly the same today. Half a million women die every year, which is one woman per minute every day. That is the picture. Why have things not changed? It is partly because the political commitment which was required to bring about this change was not at the level of the challenge; secondly, it is because there has been too much talking and concentration on activities which were regarded as simple, cheap and easy to do. In particular, there was a push to train traditional birth attendants only and no proper attention given to the need to increase the number of skilled attendants at delivery and the number of institutions providing the services in order to allow women to be there and be taken care of by a skilled attendant. You need a small maternity unit. The emergency obstetric care was not there. I can judge by the experience I went through in my own country. As I said, I am an obstetrician by training; I worked in the district, provincial and central hospitals. I remember well the long tedious discussions we had with many funding institutions, including the World Bank, to convince them in the Eighties that we needed to increase the number of maternity units and the number of district hospitals offering emergency obstetric care in order to provide better outcome.

Q4 Chairman: That is an important point. What you are saying is that in the context of Mozambique, for example, there was political will within the country but international institutions did not respond appropriately.

Dr Songane: Exactly; it took a long time for them to change and adopt a different approach and agree that they should fund the kinds of interventions we were advocating. It is important to know that. In terms of the overall co-ordination internationally, if you wanted additional resources to get the services improved, to train more staff in the procedures of which they should have profound knowledge to take care of women, you would have a hard time as compared to the resources to train traditional birth attendants. It is not that the traditional birth attendants are not needed; they are important but that has to be put in context as part of a team where there is a continuum from what they get at the house in the village and in the community and they bring the woman to the nearest maternity unit or where there is a station where she could have a midwife or a nurse. This is the process. In terms of resources, the resources are needed internally in countries and internationally to add to what we are doing now. The issue of additional resources has not been addressed properly. There has been resistance to putting resources where they are needed. For instance, the WHO[3] World Health Report of 2005, which addressed maternal, newborn and child health, pointed out that we need an additional US$ 9 billion per year to address the basic services in

[2] the Department for International Development (DFID)

[3] World Health Organisation (WHO)

maternal, newborn and child health and we are not near that figure. Then *The Lancet* issued a series on maternal health in October last year. There was an exercise to assess how ODA (Official Development Assistance) is doing in different countries. Sadly, we found that only 2 % of ODA is going to maternal and child health. If you break these figures down you get the staggering figure of only half a billion that is going to maternal health and newborn health. There is neglect in terms of maternal health. This is the situation we have to change. There is a new momentum and Britain is part of that. We should commend the UK on the initiative to try to get things fixed. The International Health Partnership which was launched here in London has to be seen within the context of the whole effort which is made to address MDGs 4 and 5, relating to child and maternal health. This is being done together. The honourable Members of Parliament will know that this is about the UK, Norway, Canada, the Gates Foundation and various countries, be they donors or countries in need. The Partnership for Maternal and Child Health provided a platform to reach out to a wider membership. These are the things we have to build on. Last month there was an announcement in New York at the launch of the Global Campaign for the Health MDGs by the Prime Minister of Norway and the Prime Minister of the Netherlands of US$ 1 billion over 10 years from now as additional money from Norway and US$125 million for three years as additional money from the Netherlands. We have to seize and build on these things. I am sure that this week at the Women Deliver Conference we will add to that and it will be the focus of conference. We hope to get ministers of health and the ministers of planning and other leaders worldwide to come to terms with the issue that we have to remove this shame; we have to take a different stand and address this as a human rights issue and say that it is not permissible when we know what to do, when we have the resources and when women are dying in the same number as in 1987.

Q5 Hugh Bayley: In relation to maternal and child health, what are the respective responsibilities of UNFPA, WHO, UNDP[4] and UNICEF[5]? Who is responsible for what?

Mrs Obaid: WHO did an exercise, all of us together, to discuss where we are. They produced a nice graph of the continuum of services, which we are all in the process of agreeing upon. Each one of us agreed on where we can play the role of a focal agency. For example, family planning is UNFPA; antenatal care is UNICEF; skilled birth attendants, is UNFPA, which includes midwives as well; emergency obstetric care is UNFPA and UNICEF jointly (we work together on that); post-partum and care of mothers, et cetera, is UNFPA; and management of newborns is UNICEF. In a sense, UNICEF gets the children and we get the mothers but there is an overlap when we are talking about emergency obstetric care and we do that together. WHO is very much the normative; WHO sets standards for us; they do the protocols and guidance notes and we work with them on that. They provide technical assistance to governments but in the field they are not as operational as UNFPA and UNICEF and we consider them as our reference points basically. Of course the World Bank deals with the whole area of finance, strategic planning, poverty reduction strategies and so on. We want to ensure that within these national processes maternal health finds a place. We try to be at the table to be able to advocate with the governments when these big funds are being allocated that appropriate funds go to UNFPA. UNDP does not necessarily deal with issues of maternal health. They deal with issues of governance as a whole where systems are in place to deliver. It is really the three organisations—WHO, UNFPA and UNICEF—and we are working together. We already have a coalition or a partnership among the three of us to continue to work together with an agreement that whoever has the most resources at the country level should be the lead agency. For example, in family planning, we are a lead agency but that does not mean we are doing it alone; it means we are supposed to catalyse whoever is on the ground to work with us, whether they are NGOs,[6] bilaterals or UN agencies, and of course to support governments in that. That is how we are trying to function with one another.

Q6 Hugh Bayley: It seems to me that the fragmentation is part of the problem. Why does not the UN grasp the nettle and simply merge the three agencies? There needs to be a clear strategic lead and it does not seem to me, despite attempts at co-ordination, that that really exists.

Mrs Obaid: The way the UN is set up, if you are not co-ordinating, including them will not solve the problem. Already there are two important things happening to address exactly what you are saying. One of them is that now we have a group called the H8. All the agencies working in the area of health have a commitment to work together and to hold each other accountable for what we are committing. That includes GAVI[7] on vaccination; the Global Fund on HIV/AIDS, Malaria and Tuberculosis because it is sexual reproductive health that is related to HIV; the World Bank; the Gates Foundation; and of course UNICEF, WHO and UNFPA. The main purpose of this coalition of the H8, the eight agencies working on health, is to get together to do exactly that, to ensure that at the country level co-ordination is taking place, that there are comparative advantages in certain areas and therefore we can deliver. DFID is very much involved in is delivering as one and the eight pilots that are happening at country level. Those are led by the resident co-ordinator; often that is UNDP. Here Vietnam is an example where we have one programme with input from everybody; both budgets are allocated together as is the leadership in the different areas so that we are not doing fragmented programmes but rather an integrated programme that looks at poverty. When you look at

[4] the United Nations Development Programme (UNDP)
[5] the United Nations Children's Fund (UNICEF)
[6] Non-governmental Organisation (NGO)
[7] the Global Alliance for Vaccines and Immunisation (GAVI)

poverty, you are also looking at population size, at the bulk of young people who want jobs and healthy lives, and also at sexual reproductive health needs that are not being addressed. As you look at reproductive health, you are looking at issues of gender, empowerment and violence against women. What is important at the country level where that take place is the fact that we can deliver as one. Now we have eight pilots for the 'One UN' Initiative. The General Assembly has taken a decision to study the eight pilots to see what we have learnt from them before proceeding further. Lots of the decisions are also Member State decisions that are made in the General Assembly that impact on all of us.

Q7 Hugh Bayley: It seems to me that politicians need to take a share of the blame because we set up all these agencies. We have the benefit in the UK of having one government development agency. We have mentioned already four separate UN agencies plus the World Bank plus a global fund plus GAVI. All are funded with governmental money. I suppose the Gates Foundation is not. Is the problem that we get so little money down to clinics in the field because we are supporting all the dozen or so international bureaucracies full of officials, full of policy planners, full of conference members? Should we not be cutting away the bureaucracy to enable what limited money is available—hopefully it could be more money—to actually provide more emergency obstetric care?

Mrs Obaid: Actually, you are moving that way. Many of the donors are going for budget support. There is money flowing to governments. It is important to ensure that the budget support itself includes maternal health. That is the challenge for all of us. Part of our role in these countries is, as I said, to ensure that sexual reproductive health does not fall between the cracks. This issue is still sensitive—politically sensitive, socially sensitive, culturally sensitive and religiously sensitive—and often it does fall between the cracks. We have made a great deal of effort even to buy a seat for example in health sector reform where we pay into that so that we will be at the table to ensure that the issues of sexual reproductive health and maternal health are on the table. Governments have an important role in this; donors have an important role; and national governments also have an important role to play. Part of this movement is to ensure health sector reform. When we talk about health systems, we do not remain at the national level, as I said before, but there is a push to go downwards. In terms of size, and you have mentioned bureaucracy, I specifically indicated where we are in terms of UNFPA; we are one-third international with 210 staff members and the rest are national. The whole organisation has one thousand staff members. Our numbers are not at six or seven thousand like other organisations. The whole idea is to move the dialogue to the national level where there are the skills to do the work. There is emphasis now on the new aid modalities, the Paris Declaration on aid effectiveness, to look at capacity-building at the country level so that at some point they will not need us. They need their own people to develop. If I can diverge a little to return to what Dr Songane has said, the issue here is not just money; it is the fact that some national capacity has been lost; either people are not trained or they migrate if they are well trained. In this whole area of human resources in the health system, no matter how much money you pour in, you do need the system in place and people who are not only trained but enjoying good working conditions. Things are always greener outside. The whole area of retaining them, training them and giving them incentives, including social status to remain, is a big challenge. I believe DFID is now experimenting in Malawi in the whole area of human resources. That is something we should all look at, analyse and learn from because we have to go that way. We should emphasise national capacity.

Chairman: I do not want in any way to constrain your replies because they are extremely helpful but we do have a second evidence session. I ask colleagues to keep their questions short. I do not want in any way to hold you back.

Q8 John Battle: I want to explore the MDG targets. It is acknowledged that for the MDG 5 target there has been no progress, deterioration and reversal. In 2006, Kofi Annan announced that there would be a new reproductive health target under MDG 5 "to achieve universal access to reproductive health services by 2015". It is as if another target has been tagged on to the original one. What is the status of that and has it been formally agreed? How will it work? Are there timetables and pathways now for implementation to get this MDG lifted from being the lowest achiever to one of the highest?

Mrs Obaid: Thanks to DFID and other donors as well as the co-operation and alliance with the UN organisations especially UNFPA and the NGO Co-ordinate, the target has now been approved. The report of the present Secretary General has come out. It has been presented to the General Assembly and now the target has been approved by the General Assembly. We are working on the indicators. There are already proposed indicators for it. We hope by March that the indicators will be finalised and become officially part of what the national governments have to report on. The struggle we had previously to get a target is now practically finished. Importantly, it is politically finished. Now we need agreement on the indicators and then to put it to the national governments for reporting.

Q9 John Battle: Is there a plan to get that target to catch up with the others. Is there a timetable and a percentage to get it increased?

Mrs Obaid: The deadline is 2015. We want to be able to decrease maternal mortality by 75 % by 2015.

Dr Songane: Part of your question covers why MDG 5 is lagging behind. The issue is that not enough attention has been paid to this aspect and it has not been done comprehensively. We very much welcome the agreement of this target in terms of health. We are looking to family planning as one important intervention. We have to see family planning within

the context of the whole of reproductive health. If women do not have this at the primary health care level, how can they access the Pill and other means of contraception in order to avoid a multiplicity of pregnancies? The more pregnancies you have, the more prone you are to the risks. There is another important aspect that we have to address within the context of an overall health plan. As Mrs Obaid has said, it is important to make sure that maternal and child health issues are put into the country plan. This brings me to what Mrs Obaid said earlier, that things happen at the country level. We need to gain acceptance that countries should lead the process. The UK should be commended on the approach it is taking with regard to giving this back to the countries so that they can track the process. We need to exert pressure. Some institutions in Britain have seats on the boards of these big institutions and you could exert influence to change the way institutions behave, particularly at the country level. Britain is part of the Global Fund and part of GAVI. It donates money to the institutions. It could exert pressure on those institutions to make sure that they do not cause problems at the country level with various mechanisms, ways of reporting and protocols to access the money. Let us all take the country plan as our guiding document and all of us accept that this should be the guiding document. If there are insufficiencies, then the representatives of the different partners at the country level should work together with the country to improve the situation and facilitate the work of the country. If we could get that help from Members of Parliament to change the situation, that would really be wonderful. Members of Parliament may realise the neglect to which this report has referred. One important thing it shows is that where there is slight progress is amongst the countries that are doing better. In the countries which are really doing badly, there is no change at all; the situation is getting worse. That means that the neglect is such that those countries are not managing to get to the bottom of the problems. We need to move quickly. The other plea is that within this International Health Partnership framework which is being suggested we should take as many countries as we can. It is important to learn from pilots but we need to make sure that all the 75 high burden countries move quickly to reach the assigned targets under the MDGs. It is not enough to take seven or eight countries to start with and assess them at the end of 2008. We have to learn from the process already in place in many countries. Numerous countries have done this but they did not go further because they did not get backing or resources. Our drive is to take on this process. We should not accept that these figures will only be improved by 2015. We have to do what we know that we should be doing. We know the causes of death and disability; we know the aggravations at work. It is possible to deliver and to train people to do this. We can do it.

Q10 Sir Robert Smith: You have emphasised the need for skills and a lot of the written evidence has said that skilled intervention at the time of birth and just after birth can make a huge difference to survival rates and reaching these goals. Has any estimate been made of the number of extra trained health professionals needed to reach the millennium target?
Dr Songane: It is a huge number. Last year the World Health Report was devoted to human resources. It was estimated that an additional 300,000 nurses and midwives will be needed as a minimum to address the issue of maternal health. The other finding reported in the document I have referred to is that the place where we have the highest burden is where resources are lowest. The highest figures for mortality are in Africa. Africa has 24 to 25 % of the burden of disease world-wide and less than 3 % of all the world-wide health workforce. In terms of resources, with this burden Africa has less than 1 % of the overall resources for health.

Q11 Sir Robert Smith: That is the figure for midwives and nurses. Is there a figure for specialist doctors?
Mrs Obaid: The figure from WHO is 700,000 more midwives in 57 countries where there are critical shortages. There is a global deficit of 2.4 million doctors, nurses and midwives altogether.
Dr Songane: This is a critical issue. We see this within the context of health systems. These are critical interventions. If we do not have the people to run the programmes, there is no way forward.

Q12 Sir Robert Smith: Is there any strategy developed or in practice to try to encourage or increase the number of midwives and obstetricians working in the developing countries?
Mrs Obaid: We are certainly working with the International Confederation of Midwives and there is a strategy in place to train midwives in many of these countries. We are also working with the International Federation of Gynaecology and Obstetrics. It is a joint effort to do exactly that. As we have said, part of the problem is that even if these people are trained, if they do not have good working conditions and financial incentives, they will migrate. They are wanted. That is why it is very important to change the social status of midwives to ensure that they have good financial compensation and good working conditions. There is an experiment in Malawi by the UK and it is important to look at that. Not only are they topping salaries and training but they are bringing in volunteers to fill in while the midwives are being trained. They are also building housing in some communities to make it attractive to live in the rural areas. This is an integrated and complex issue.
Dr Songane: May I add this to the issue of training? We should not wait while we are training doctors. There are ways of bringing the skills needed to people who are not specialists, who are not doctors, and train them in life-saving procedures, be they midwives, nurses or assistant medical officers. That is being done in Mozambique, Tanzania, Malawi, and Burkina Faso, to cite a few countries. There are publications on this. This came out in the *British Journal for Obstetrics and Gynaecology* and the *WHO Bulletin* and the *Human Resources Bulletin*

showing that they are as effective as specialists in providing emergency obstetric care. Those nurses and assistant medical officers can be trained to give those services. We build as we go along: it is ideal to reach a certain level but we need to find out how to deal with existing resources to make sure that the care we are providing is safe and of quality.

Q13 Hugh Bayley: How many developing countries have effective manpower, i.e. training plans, for health workers that identify the numbers they will need in different disciplines and match training to that? Is there a problem for instance with the emphasis on universal medication for HIV/AIDS that one agency will tip in a salary incentive to get people to transfer from maternal and child health to AIDS work? How do you overcome that problem of one international agency in effect poaching staff from another international agency?

Dr Songane: That is a very good question. It addresses the issue of how the different institutions operate at the country level. If we accept co-ordination and know that we are there not to raise the flag of HIV, malaria or tuberculosis but to be part of the building of the health system and to address that country's plan, then whatever resources we bring, we should put those to the use of the country under the leadership of the government. That is a major undertaking. If everyone agrees to do that, saying that there are these resources and they will be used only for HIV, then paying more to poach staff could be minimised. I think that is the way to do it. It needs a change in attitude in the various institutions and an acceptance that this should be done under government leadership. If you want to address HIV/AIDS without addressing the development and strengthening of the health system, you are bound to fail. You cannot secure the person who is under ARVs.[8] That patient needs proper care, home care and social support. If you do not build in all these things, you cannot be sure that he or she will live a normal life and that person could die anyway, even with ARVs. It is not with HIV alone; we do have other elements, particularly the subject we are discussing today. In maternal and child health we have more burden than HIV, Aids, tuberculosis and malaria together but yet that is not recognised as an issue in terms of the number of deaths and number of disabilities. It is not recognised because it is not fashionable or a flag raising matter to be seen as good to provide money for maternity and child health. That is why we are quite pleased to be getting this hearing and this commitment from Members of Parliament in the UK to help us to raise the voice of those women and children. Countries have plans. The issue of the long-term plan is that of predictability of funding. We have a plan today; we are thinking about two or three years. After those two or three years, we do not have the resources we were counting on three years previously when we wrote the plan and to know how to build on it. Let us revise this plan and make a new one. The new way of doing business is to provide the country with the possibility of predicting the money they have and do their long-term planning. We should address the development process of that country. Sustainability of resources is another element to make sure that if they plan ahead for 10 years, they know that they will have the money to get the workers they trained today making progress in their careers. Progress in their career is a very important element if we want to pay attention to the status for the workers themselves. As Mrs Obaid has said, working conditions and proper salaries form another element. I would put that in this context.

Mrs Obaid: Can I add that the traditional way of supporting governments is by vertical programmes, and this is already happening. You support family planning alone and you support HIV alone. Now we are moving towards linkages; that has been adopted. It is within the UK strategy. All of us have come together to integrate sexual reproductive health plans with HIV because they are related. There is no way to look at HIV and not at sexuality and reproduction. By integrating those, you are increasing the workforce. If you train the family planning people in HIV/AIDS and vice versa, you will then have increased the human resources base that addresses communities and works on that. That is one way of doing it. Family planning is a long story that has been quite successful in the past. You build on the institutions that already exist and go with them. The reason we want to integrate is that there is mother-to-child transmission. Often the child gets the treatment and survives but the mother does not get the attention and she dies. We say that if you integrate these, then you will catch the mother very early if she is HIV positive and you start working with her and you do not wait for delivery and for retrovirals. We were very pleased when we saw in the UK strategy that it is talking about exactly what Dr Songane has said. They are saying that investment in the health sector should be long term, 10 to 20 years. There should be predictability of resources and of course monitoring and ensuring accountability over a longer period because this kind of change does take a long time.

Q14 James Duddridge: Our principal role as a select committee is to hold the Department for International Development to account. On maternal health where our Department for International Development works, if we could send our minister away on two, two-day trips, one to a country and one to an international donor, to learn best practice, which country and with which donor would you suggest the minister spends time?

Dr Songane: That is a tricky one because then we risk missing the countries that are doing well. The committee has visited Mozambique. I do not say this because I am Mozambican but the minister should definitely visit Mozambique. I am just talking about what we have done there. Mozambique is one of the countries. Another country is Tanzania. Uganda is another country we could suggest if we are talking about Africa. If we go to other places like Sri Lanka, the state of Kerala in India or Vietnam, they are now coming up quite strongly and quickly. Take Egypt

[8] Antiretroviral (ARV)

and the Maghreb area: Egypt is moving quickly in terms of improving the figures and addressing in a comprehensive manner, although it is a Muslim country, maternal health and the figures are coming down quickly. That is one of the leading examples. Go to Latin America. Take Honduras or what Bolivia is doing with insurance schemes to make sure that women are not dying in childbirth. There are different examples we can list. In terms of institutions, I would highlight the progress which we are seeing now at GAVI, the Global Alliance for Vaccines and Immunization. There is now a drive to make sure that the distortion the different funding agencies cause is changed. I would plead with the Members of Parliament to help us address the issue of other institutions. We know very well the problems that are caused by the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria in countries. It has been a nightmare in some countries where they are putting in the largest amount of money. Because of the power to influence the process in countries through the amount of money they have, they are causing many disturbances in the normal processes. The UK could play a very important role there. Lastly, perhaps you could recommend additional money for DFID to help us address this issue so that women get support from DFID. I think we should see more being done at country level. DFID is clear about the way the money should be spent going to the countries; we need to get these resources at a substantial level. It is good to do things in a different way, to be co-coordinated and streamlined by doing one country plan but additional money is needed. Even in my country, Mozambique, we have progressed. We are almost reaching the Abuja target of 15 % of the budget allocated to health. Now it is around 12 to 13 % depending on the waves, but we need to do more and additional money is needed. If whatever is started is not consolidated, then there is risk of a breakdown and a return to square one because the economies and the institutions are not strong. We need to address this issue. It is like having an elephant in the room when the discussion on health systems takes place; everyone moves away because it is a huge subject, but this is basis. If we do not address the health systems, there is no way we can move the agenda in terms of health. Those countries which are successful are addressing the issue of health systems. Money is needed. DFID is well positioned to help this process through because they have demonstrated that they do what they say they will do.

Mrs Obaid: May I add two quick points? One is in terms of best practice. This is where DFID can give support. We do have the H8 and GAVI is a member. GAVI has decided to move into looking at the health system and not do a vertical programme of just vaccination. All the H8s are talking to each other about how to move together to be able to support health systems and work within that. No money is needed there. It is about us agreeing and moving forward. Because MDG 5 on maternal health and MDG 4 have become so focused, there are many initiatives coming up. The national governments are saying that they cannot handle too many processes, that we should integrate the processes. We cannot have a Canadian initiative and a Norwegian initiative. There is the important International Health Partnership promoted by Gordon Brown. There is no money there but it is a framework that will get all of us to look at how these initiatives work together and how they can support health systems. It is a co-ordinating framework more than additional money. I think we need to emphasise that. We cannot have so many different initiatives that the countries themselves cannot deal with them. We have to integrate the initiatives to help and feed into the national health plans, as Dr Songane has said.

Q15 James Duddridge: So the recent UK initiative is more than another initiative. It sounds to me like an initiative that brings together initiatives, exactly the opposite of what you are wanting.

Mrs Obaid: I am saying that it is very important that these various initiatives that bring money in are co-ordinated and support the national health plans. The International Health Partnership promoted by the UK is really, as you say, a framework to ensure that these are all co-ordinated and that there is joint accountability in what we are doing.

Q16 Ann McKechin: We have been speaking this morning about the danger of a plethora of international initiatives. I think there is some concern that this new initiative announced in September does not really make specific reference to maternal health sufficiently. It speaks about global systems in the round, and yet it will now have to co-ordinate with GAVI and with Dr Songane's initiative and with a whole range of other multilateral bodies. I wonder if we have got to the critical mass when we have to say stop and we need to rationalise the number of initiatives we actually have. In that context, I wonder whether you think that there is a growing danger of maternal health not deliberately but indirectly just beginning to be pushed back out. People will look at things which are easier to define to donor communities. It is easier to define vaccinations; it is easier to define antiretroviral drugs, but it is much more difficult to define accurately reproductive advice and facilities.

Mrs Obaid: Thank you very much for raising this question because we are one of the co-signatories to the initiative. We have been continually saying that there has to be reference to reproductive health in the agreement. Finally, it is there. I was at the launch of this initiative. In the discussion I had to bring up sexual and reproductive health and say that when you talk about mothers, there is sex somewhere in that. You cannot talk about mothers out of the air. We need to push this all the time and advocate it to ensure that whenever we are talking about MDG 5, we talk about the bigger picture of reproductive health before a woman becomes pregnant. Her health will impact on the pregnancy and the child. This is about nutrition, education, the complex way she lives, her access, customs and traditions, et cetera. I agree with you that in this larger initiative there always has to be voice and action to ensure that

sexual reproductive health is an integral part of these initiatives. It was mentioned at the launch of the International Health Partnership agreement and we would push for that.

Q17 Ann McKechin: Going a bit further, you say it is in the agreement and it is in the text but is there some agreement about what proportion of the funds raised under this initiative will go to issues such as preventative health? In our own health systems, prevention always gets cut away rather than drugs or treatments. So are we going to say it is 10 % or 25 % that needs to be in health prevention?

Dr Songane: You have raised a very important question. The Partnership for Maternal, Newborn and Child Health provides the platform for development of this process. We should see this in the context of a global campaign for health MDGs. The whole campaign was built with various pillars. One of the pillars was supposed to address the so-called global health architecture: how we do business, how we liaise with countries, how we avoid the disturbances we are causing. Another pillar was to see what we do to address specific issues on maternal and child health. When that was launched, the lead person was the Prime Minister of Norway. Our campaign was launched at the same time on 26 September called "Deliver now for women and children". The campaign started in New York. We have to take this campaign to the regions and to the countries to make sure that we do raise the issue and ensure that the resources are put in. It is a very important aspect and we must ensure that we are not distracted by discussions about global health architecture which could cause us not to put in the money, resources and drive where they should be. "Deliver now for women and children" will be the conduit through which we have to address this issue but we need the whole context because the International Health Partnership is supposed to provide the new drive for the global health architecture and how we do business. Your question and another one earlier are about countries receiving clarity. It is important to emphasise that this is the first time that leadership at a high level has addressed the issue of what are we doing in countries where we are probably causing more harm than good. Together the Prime Minister of the UK and the Prime Minister of Norway are saying that we should reflect on this. It is the very first time this has been dealt with at a high level of political leadership. I agree with the caution of Members of Parliament. We should not build this initiative as a big institution. We should not drive this in that process. It is a platform for discussion and we have quickly to get the different players really to change their attitudes and show the countries that they are changing the way they do things. If they admit that at country level different institutions are going in and doing their own thing and so they are not doing any good, that will be another addition to the partnership. You are absolutely right: we have to address the countries' priorities and have the country plans as the lead documents, and stop the proliferation of different initiatives. All the resources should go there. I would be glad to hear in the upcoming cycle of board meetings of GAVI, the Global Fund and our own institution that they are addressing the issue of what we have to change immediately so that next year the countries will have a new picture of the Global Fund and a new improved picture of GAVI—GAVI is doing well, as I have said—and other institutions addressing what the countries are asking for. Stop this proliferation and accept that the country planners will deliver the documents. Work with us so that the various groups do not function in a different manner.

Q18 Chairman: It is a big challenge. Louis Machel said last week that in Tanzania there were 600 health projects of under €1 million every year. He asked how the Tanzanian Government can do that and why are those not co-coordinated. It is a big challenge but I take your point.

Mrs Obaid: Can I raise one more initiative of which the UK is a member and that is the G8? They have committed themselves in 2007 to $1.5 billion of funding for maternal and child health and voluntary family planning. Your role, that of the Government of the UK, in this G8 initiative would be to ensure exactly what Dr Songane has said, that funds are pushed in the direction of the national roadmaps for maternal health. We cannot say 10 % or 20 % because it depends on the country. If we feed into the roadmaps of maternal health at the national level, then the appropriate resources have to go to prevention as well as treatment.

Q19 Richard Burden: Of the around 600,000 women who die each year from pregnancy-related causes, about one in eight of those will die through issues related to abortion-related complications. The concentration of those problems tends to be in those countries that have the most restrictive abortion laws. Obviously this has been in the news quite a lot over the last few days. Given the fact that those countries count for about 26 % of the world's population, how do agencies like yours deal with that? The UN operates on the basis of building consensus but there is this glaring issue there where a significant number of countries have laws that apparently run completely counter to trying to improve maternal health and women's health in the way that you are trying to achieve. How do you deal with that?

Mrs Obaid: Actually as you have said, death from unsafe abortion is the third cause of death in Africa, for example. Also it is not only death, it is the issue of disabilities that are associated. You have a larger number of women then suffering, not only dying but having disabilities, including infertility. For us as an intergovernmental multilateral organisation we are mandated by our Member States to abide by what was agreed upon in Cairo, which is paragraph 8.25 and we have learned it by heart because we are asked about it all the time. Basically our mandate is, one, to ensure that abortion is not used as a family planning method; and that where it is legal, which is all countries except four, all countries have some sort of conditions under which abortion can be

done; where it is legal it should be done under good medical conditions. This means that our role as the United Nationals Population Fund is basically, one, to provide data, analysis and the numbers based on evidence of what is happening in that area. Often they do not have the numbers. One is to give evidence to the countries, so that they have to understand the impact of unsafe abortion. That should lead them to take correct decisions in terms of that issue. In Cairo the consensus is that the decision on abortion is a national decision—it is not imposed from outside—so you have to work within that communication. The second one is when we strengthen the health system capacity to prevent abortion, have family planning, have planned pregnancies, you are decreasing the possibility of abortion, but working with health systems to ensure that we are developing the capacity to deal with the consequences of unsafe abortion, as well as post-abortion care. We are the United Nations Population Fund—this is what our Member States have told us are our limits. However, there are NGOs; we have partner NGOs who work in that area. As you know, the UK has established a fund for safe abortion, which is managed by IPPF.[9] We have our counterparts who have the ability to move in that direction. Our role is limited to dealing with the complications of unsafe abortion, providing data, developing the skills in the health sector to deal with that and, of course, helping the governments make the correct national decisions by providing evidence on the impact of unsafe abortion.

Q20 Richard Burden: Is there any evidence that it is working? I understand what you are saying, that the decisions are national decisions, but if you see your role as collecting the data to look at the incidence of unsafe abortions in particular countries, firstly, if I am right that the highest incidence of those are in those countries with the most restrictive laws, where technically abortion may be legal but in practical terms it is illegal, if that is where the concentration is and you present those countries with that evidence, what happens? Does it have any impact?

Mrs Obaid: I agree with you—we know it is a serious issue we are trying to deal with. The issue is not only where it is legal it can mean "illegal" in a sense, but also there is no information about the rights of women who have problems or will even meet the criteria. This is an area that is dark, let us put it that way. Women do not know that if they have a problem they can access these services. Even when they have unsafe abortions they do not know that they can go to the health system to save their lives; and if they do they are badly treated. It is just not simply the access and having the right; it is the whole system where it is a taboo. You are penalised if you have an unsafe abortion. Women are penalised and so on. I remember Fred Sai, who is an African from Ghana and a leader in the area of sexual reproductive health, said that the only human organ that has entered the penal system is the uterus. It is a very strong statement when we realise what we are saying. What we tell governments when we work with them, at least where it is working, where it is legal, is to let us ensure that the health system can provide lifesaving --- but then you need the civil society to inform and to advocate, so women know that they can have this access. This is still a dark hole. We are all working on it. It is not an easy one because you also have other groups that are anti-rights for women to access safe abortion.

Dr Songane: I concur with you fully. The other element here which is important, even in those places where it is legal, is the stigma. To be seen as someone who went to seek those services for the society is still a bad thing. This stigmatisation is important to the woman. As you say, to inform people, if we bring the statistics or whatever we have and show to the country, not only to the leaders but the public, and say, "This is the situation. It is a complex issue but we cannot hide. We have to deal with it. It is accounting for about 13 % of the deaths, apart from the disabilities, so this has to be addressed". The other element before the departmental committee is to use you as leaders to help address this issue. What is complicating now is the threat from some countries to remove resources for basic care because you just mention reproductive health, you just mention abortion. You did not do anything wrong but because you put that word in one of your papers you might get as a consequence the withdrawal of resources. This is being said publicly without any counterargument from the same level of institution. We ask you as Members of Parliament, this country is taking the right address in relation to abortion, but you should help us to counter those arguments of threat, of intimidation, not leaving the countries addressing their own issues. This is a much worse situation we are being faced with now. Even institutions, which should provide that technical advice and direction to the countries, are shy and afraid of putting those things on the table to discuss. We need to come out of this and say, "This is a problem and we have to act". The issue of the target of the sexual reproductive health services available to all women is a fundamental issue if you want to address abortion. Why do you have abortion: because there is a pregnancy. You should avoid the pregnancy. Where will the woman or the girl get the means to avoid the pregnancy without contraception, without local reproductive health services, without the services for the youth? The group of 15-17 teenage mothers are most at risk from abortion and from complications of pregnancy and we are not providing the services for them to avoid running into that risk. Those are the issues. It is a comprehensive issue, but it is complex. We are not dealing with it in a light manner, but it has to be addressed. We would ask you for your support.

Q21 Hugh Bayley: The question of empowering women of course is absolutely essential and it does not apply just to abortion, it applies to pregnancy, it applies to family relations, childbirth and child health. My question is: how do you, first of all, empower women's knowledge about these things; and, secondly, and I would say more importantly,

[9] the International Planned Parenthood Federation (IPPF)

money is power; if you are talking about empowering women you just put money, resources, into women's hands; how do you do that? Should you have a pregnancy kit for every woman, which includes a $20 note? How do you actually give women power to control the resources which are there for obstetric and maternity services?

Mrs Obaid: If I can quickly refer to a previous question. What Dr Songane has said is true. Since 2002 one major donor has not paid UNFPA any voluntary contributions. That is a fact. The words "sexual and reproductive health" are interpreted as euphemisms for abortion. That is an issue we face on a regular basis.

Q22 Richard Burden: Can we know which donor that is? I think we may have an idea, but just for the record.

Mrs Obaid: It is the United States. The other issue that is really very worrying is that now there is quite an attack on sex education in schools for young people. If you take that out of the school and you just have education on abstinence only and so on, we are further endangering teenagers in terms of early pregnancies etc. This is a new environment and we all have to deal with it. In terms of how do we empower women to be able to have the economic power that you are saying, we at UNFPA do some work with others who have the knowledge and the skills to do economic schemes of different types. We try to partner with ILO[10] and others who can do that; lots of the NGOs; and microcredit and so on is part of our work but we look where there is microcredit and we integrate sexual reproductive health information and services in it and so on. Also empowering women is having the money, but part of it is having the knowledge that it is her right, and that is dealing with the socio-cultural issues; and for the community to be able to understand that right to health is a right and women have to have access it. That requires working at the community level and working with local leaders, with the religious leaders and different ones to be able to get the message through the local set-up, to understand the rights of women to health education income etc. One area that we have not touched at all, and that also is the disempowering area, is the issue of sexual violence against women, especially in fragile states or conflict areas. That is the most disempowering element. The fact that we get countries where such violence takes place and perpetrators are still loose is a very tragic thing. Here I think the UK can help in ensuring that support is given not only to women who are victims of sexual violence but also that there is prevention of violence, which means working with the military; with the police, which we do, to educate them about it and so on. If you want to empower them the first thing is that they should stop being violated. That is a long process that a few countries are focussing on but not sufficiently to be able to empower women. That is the other side of your question. We empower through economics, through education, through partnerships, microcredit whatever, but we also have to deal with what is disempowering them—which is domestic violence and violence against women in wars and conflicts and so on.

Chairman: Can I thank both of you. It is clear to the Committee that you are two very powerful champions of the rights of women in this area. You have challenged us, I guess, to some extent to join your campaign. All I can say is that the Committee is quite shocked really about the statistics and, much more to the point, the individual suffering that is hidden within these statistics. That is one of the reasons we want to do this report so that in some small way we can perhaps increase awareness and reinforce what our Government is trying to do in this area and internationally. Thank you very much, fortuitous as it was that this conference was taking place, for coming to give this evidence—I think it has been extremely helpful as a start to our Inquiry. I thank you both very much for coming.

[10] International Labour Organization (ILO)

Witness: **Dr Grace Kodindo,** Assistant Professor of Emergency Obstetrics Care, Mailman School of Public Health, Columbia University, gave evidence.

Q23 Chairman: Thank you very much, Grace Kodindo, for coming in. Some of us did have an opportunity to see the first part, we did not see all of it, of the *Panorama* film of Chad in which you very much featured. I can say that I think it was powerful and moving, but also shocking in particular to me that people were not only required to pay but literally had to go and find the drugs while a woman was potentially dying under your care. That that sort of situation and that sort of trauma should exist I think is something which is important that we are aware of. I am very grateful and we are very grateful to you for coming to give us your personal testimony, if you like, about the challenges that you face and, of course, about the extraordinary good work you do in very, very challenging circumstances. I just wondered if, by way of introduction, you could give us some feel for the challenges you do face. In particular, our understanding is that one out of 11 women in Chad will die as a result of complications of pregnancy; that Chadian women have on average 6.7 children, which I think people in this country would find fairly stark, and yet only 25% of them get any kind of trained assistance during childbirth and much lower in rural areas. What do you see from your experience drives the high mortality rate that your country suffers? You heard the previous discussion about poverty, ignorance, lack of knowledge and the lack of skills and the supplies within the infrastructure; but from your personal experience what do you think is the central problem driving this; what do you think are the key areas which are causing this very high and tragic mortality rate?

Dr Kodindo: Firstly, I would like to thank you on behalf not only of women from Chad but women from all developing countries, especially ones from sub-Saharan Africa, from South Asia and also Latin America. I would like to thank you for the opportunity to hear our voices and, hopefully, to help our country to take action to improve our health. I would like to introduce myself. My name is Grace Kodindo. I am an obstetrician and gynaecologist. I have been working for the last 30 years in Chad first as a general practitioner, and then as an obstetrician and gynaecologist. Indeed, at the same time as I was working in Chad, I was also working for Columbia University as a monitor to implement emergency obstetric care. For the last six months I have also been working, again for Columbia University, in a programme called RAISE,[10] to improve the access to reproductive health for women refugees. What are the causes of maternal deaths in our countries? I would like to say that in our countries, just like the situation was in Europe, in North America, one or two centuries before, people die from the same causes you had here in Europe. In the 30s you started to have technology like Caesarean section, anaesthesia, blood transfusion; and then in the 40s you discovered antibiotics and then contraceptive methods, and then you started to make this available to all women everywhere; even the poorest of women in the West now can have access to them. That is not the situation in our country. So we need this kind of basic care with appropriately trained staff to be available to all women in our countries and we will come to the same result that you have reached here in Europe and in America. The problem is for that we need a stronger health system. My colleagues before me have said the same thing, because only a strong system can really provide all the basic drugs, even a drug that is cheap in the West like magnesium sulphate. This is the drug to treat eclampsia. You would not believe that it is still not on the list of essential drugs in many African countries—not only in Chad; I have seen that in Cameroon, in Nigeria, in Ethiopia. Two weeks ago I was in the Congo and they do not have that and this is a cheap drug, and this is the one drug that can treat eclampsia which is one of the main causes of maternal death in our countries. In many of these places that I have visited they do not have a functioning health system; they do not have a blood bank or anything like that. Haemorrhage is one of the first causes of maternal death; when a woman is bleeding it will only take two hours and she may die from that. When there is no blood to transfuse her she will die. If a woman is living in a very rural area, in remote places, with no transportation, sometimes the relatives have to take them on their shoulders and walk two or three days before reaching a health facility. She may die in the meantime, or if she does not die the baby will die. If she survives she will end up with a fistula. You had fistula in the West in the past. The first fistula hospital was in New York but it has been closed because you have produced care to all women everywhere but we still do not have that in our countries. If there is no action taken on that we still have a long way ahead of us. For a woman to end up with a fistula, and if you know what a fistula is—it is a hole in the vagina that produces a leakage of urine or faeces continually for the woman, and the woman smells so bad that sometimes the husband just leaves them, and their families just leave them and they are left as social outcasts. You still have a lot of these cases in Chad, Nigeria, in Sudan and Ethiopia even in 2007. The same problems are still there because we do not have a strong enough health system. In the film you have a 12-year old girl dying from an unsafe abortion because the access to family planning is still a luxury in many of our countries, especially in the rural area. In cities a woman may have access to family planning, but in rural areas it does not exist and it is not only in Chad. In June I was in Ethiopia, I went to the Tigray region and in the rural area they do not have that; no EmOC;[11] no family planning, and this is how the West has reduced maternal mortality. In the West we have maybe one woman out of 47,000 dying, whereas in Chad we have one out of 11. In Mali we have one out of 10. In Sierra Leone, in Afghanistan, we have one out of eight. You can see the difference. It is basic technology. It is not something complicated—I am talking about blood transfusions, Caesarean sections, some drugs like magnesium sulphate, only basic things that you have plenty of here in the West.

Q24 Chairman: What comes across loud and clear is that, as you put it and our previous witnesses put it, you need a functioning health service and more resources. In a sense it is a silly question but it is the huge number of resources across so many countries, and taking your own country, and given your professional qualifications, skill and experience, if you were to identify one particular thing from your standpoint that would most advance the cause, what would it be, or is that a naïve question?

Dr Kodindo: We need to increase our skills as providers and to increase the coverage of the work on this, especially in the remote areas, the rural areas. These kinds of people we really need to give them a very large widespread coverage of these basic things. We can take one health centre in a rural area with just a nurse; we do not need a doctor or a specialist. This example has been done in Burkina Faso, a nurse with two years' training in obstetric skills can be posted there with a few drugs, only antibiotics, IV[12] fluids and magnesium sulphate, to give the first basic treatment when there is any complication and then to help in referral. This is another problem, the referral system in Africa. It is not only a shortage of the skill provided but the referral system. This is why maternal mortality prevention will not only be a problem for the Minister of Health, it is a multidisciplinary problem. The Minister of Finance should help to give some incentives. The thing is these are very, very poor countries and the salaries are very low and as human beings these people need to have some incentive to

[10] Reproductive Health Access, Information and Services in Emergency Settings (RAISE)

[11] Emergency Obstetric Care (EmOC)

[12] Intravenous (IV)

be retained. Many African staff have immigrated but if you can train this medical provider and give them some incentive they will return. They need a medical environment and need to have some incentive because they have lots of families to raise. If they have that in these areas and you have roads, and means of transportation to take them to the referral hospital, and also have drugs and blood banks functioning, it should be functioning. As you have seen in my film that hospital is the referral hospital for the country and we have no blood bank functioning. Even syringes are needed, you would not believe it, there is nothing there. Syringes, needle catheter, they have to go outside to buy that. This is encouraging the nurses or doctors to start to steal things and go and buy them because if the hospital has nothing they will just steal and do some business with that. It is not helping the honesty in these places. The hospital really has nothing to help save a woman's life, women continue to die. The solution is very simple, just like you have proven in the West: in many countries in Asia and Africa which are doing well, as Dr Songane was saying, it is because they have strengthened the health system and they have also improved the access. The health system may increase but if the access is not there it will not happen. There are many problems with access. It is not only the lack of roads, but the financial access and the cultural access. Like in Chad, more than 80 % of women are illiterate so they cannot even make decisions for themselves. They need to be educated to improve their utilisation of the health service that will be strengthened, hopefully, in the future. I will give you one example that happened in Senegal. They have given some training for a literacy course to women in rural areas and they have trained them to recognise that they have their own right to defend. They did not even know they had a right to talk about whether to say yes or no. After that training without anyone telling them to come back, they came back in the morning and said, "Now we know that we can talk about our health we are going to put an end to female genital mutilation". That was only one literacy course. They have learnt that they have their own rights. They need to be educated. One other problem in our country is the condition of the woman. There is a very low status for women. The woman is good for being married and having children and that is all. She should have as many children as God gives. There is no limit. She does not even have a choice to limit the children. She has as many as God will give her. If she dies in the meantime they will say that God has also brought the death. Nobody will be shocked by that. All this is related to the condition of women. Maternal mortality prevention should be something multi-disciplinary, multi-sectoral, and should not only be the problem of the Minister of Health. They are not able enough to put an end to that.

Q25 Richard Burden: Can we explore the issue of access to basic medicines. You mentioned particularly about magnesium sulphate as being very effective in eclampsia. Objectively magnesium sulphate should not be difficult to get hold of; it should not be very expensive.
Dr Kodindo: It is very cheap.

Q26 Richard Burden: It is very effective.
Dr Kodindo: Yes.

Q27 Richard Burden: Given the incidence of eclampsia in Chad what needs to happen to make sure, for example, that magnesium sulphate could be freely available; and what internationally do we need to do to try to make sure that happens? You may want to expand to other basic medicines, but that one just seems quite a simple one but just is not happening. What do we need to do to make it happen?
Dr Kodindo: Firstly, accordingly to WHO this is the most effective drug for eclampsia. I think it should be included in the list of essential reproductive health drugs in all countries. It should be put in the political programme for reproductive health. The governments should start to import them. Until now even in sub-Saharan countries it is not even on the list of essential drugs in the countries, so they are not buying them, and these are very cheap drugs here.

Q28 Ann McKechin: Can I just clarify, that is the individual list of the Chadian Government; or is this a universal list of central drugs? Is this the Chadian Government's decision about what essential drugs are?
Dr Kodindo: No, this is from WHO. WHO has a list of essential drugs.

Q29 Chairman: It is not on the WHO list?
Dr Kodindo: That is recommended as the best drug for eclampsia. It should be on the list of each country. It is not on the international list of essential drugs, and this should be on the list so that the Government can start to import the drugs.

Q30 Hugh Bayley: Is it possible to put an economic cost on what it would cost to ensure a safe childbirth environment for a child in a developing country; and then run a global campaign and say, in the same way there should be universal medication at $200 per person for anybody with HIV, there should be a global campaign and there should be $10 or $20, whatever it costs, per child to be used in the health system? Who could give us that information?
Dr Kodindo: There is the Taskforce on MDG 5. My colleague Lynn Freedman is working on the Taskforce for MDG 5, and she has said that £4.5 billion per year could provide all effective intervention for maternal and newborn cases to 95 % of the world's population.

Q31 Hugh Bayley: How many births are there per year globally?
Dr Kodindo: 136 million.[13]

[13] Dr Songane volunteered this information from the Public Gallery.

Q32 Sir Robert Smith: You were talking about some of the solutions in rural areas and highlighting also how skilled intervention makes a huge difference to outcomes. I just wondered in terms of priority and stepping stones to try to improve the situation, is it mobile health workers, or is it training the local midwives, or even at a more basic level is it improving the transport so that the pregnant woman can get to a more major centre?
Dr Kodindo: Yes, I think that in a rural area we should start with some basic medical care, so that we do not need to have even a fully trained midwife; you can train mid level providers. In the health centre it should be nurses only. They should be provided with a few basic supplies and drugs; and they should be connected with the hospital where the mid level surgical technician, just like Mozambique, can provide the higher level technology like a Caesarean section. Even with these basic things it may make all the difference.

Q33 Sir Robert Smith: You think that basic intervention locally is probably more practicable than trying to get transport so people go to a more skilled centre?
Dr Kodindo: Yes. The health centre will provide basic obstetric care. If the woman arrives and she is already fitting and has eclampsia, the nurse there can start to give her magnesium sulphate. If she is bleeding she may start to receive some IV fluids and then put her in a position for her to travel. When they arrive in the referral system they will be in better condition and have even more chance to be saved. Sometimes they arrive in this condition which is already very, very bad, and it is very difficult to save their lives. We need to have a two-level health system and a means of transportation. Three months ago when I was in Ethiopia, women were living on the mountains and deep down in the valley there were no commercial cars, so sometimes they would just sit on the road waiting for an eventual car to go by, and that may take days. In an emergency there is no way—she or the baby would not survive. In the Congo it is the same problem. It is a huge country; the roads are very bad; there is no means of transportation; so accessibility is the real problem, plus the weakness of the health system. In the east of Congo when I was there two weeks ago there was one hospital covering the whole area. In this hospital they had only two delivery kits and sometimes three or four women went into labour at the same time. They did not even have time to sterilise the delivery kit before delivering another woman. This is an area where they have a high incidence of HIV pregnancies. When we strengthen the health system to prevent maternal deaths we are also strengthening to prevent the spread of HIV. If in this hospital they have the steriliser, they have more delivery kits, it will play on those things. It will help to save a woman's life and help prevent the spread of HIV. Women in this condition are coming to deliver and they will go back with HIV contamination.

Q34 Ann McKechin: Dr Kodindo, I think we can imply from what you have said this morning that the Government of Chad really places no priority at all on the status of women and the empowering of them. The question for donors such as DFID is, what steps can they take to improve sexual and reproductive health in countries such as Chad, where they face a government which places very little or no priority on it and where there is a very different cultural ethos around the issue of women? In what way do you think that donors can try to fund other civil society groups which are pressurising for the improvement of women? Are there women's organisations which exist generally where we can try and put these messages across? Which do you think is the best way donors can help?
Dr Kodindo: There are many things that they can do. The first step in empowering a woman is by improving their health. If we improve their health we will give value to their life. When we give value to the life of a woman, by preventing them from dying or having bad health, we give value to her life, and this is the first step in empowering a woman. DFID can also have some pressure on the government of the countries because until now it is sad to say but there is not much value to the life of a woman. You would not believe it but in many of our countries there is even no accounting of a woman's death. When I was in the Congo two weeks ago they had one labour room and we saw a register with 26 rows; even a row for placenta weight; but there was not one row for maternal deaths. They are not even counting maternal deaths. So, firstly, to have them start counting maternal deaths. Make audits on the maternal deaths and take action on that. Maternal deaths should not be something which is just a fact of life. It should be counted and audited.

Q35 Ann McKechin: You think that that should be a condition of any aid that is given by donors?
Dr Kodindo: Yes.

Q36 Ann McKechin: That there should be proper statistical data?
Dr Kodindo: Yes. Then there should be a cutting of the level of the maternal mortality in these countries. They should do something about that. Women should not be left just like that. What you have said about the women's organisations I like that because maternal mortality to me is a human life issue. The woman has the right to life. If we are left with a woman dying we are violating the human right to life. The woman has the right to good health. If you are letting them have a fistula, we are violating their right to good health. This is a question I want to ask you: why in the West when there is a risk of violation of human rights, especially political human life does it make headlines and people talk about it and are shocked, why not if it is about a woman's death? This is also a violation of human life. It should also make people react and judge and put some pressure on the government to start to do something.

Q37 Ann McKechin: It is about issues of governance or human rights in developing countries, and if we give funding then the issue of maternal rights and issue of women's rights are at the forefront?
Dr Kodindo: Yes, exactly. This shows them that the woman's life counts. It should not just be discounted.

Q38 John Battle: I want to ask you a particular question really about blood banks and blood donation, perhaps inspired by the film, because part of the drama of the *Panorama* film was watching the blood go down in the packet and there is no new blood coming in. I was reflecting on the film. There was a brilliant book by a sociologist in Britain called *The Gift Economy* in which he tried to spell out that one way of ensuring that society held together was that people did not sell their blood but gave blood to ensure that they or their families when they needed it would find there was a supply there. Quite a few people in Britain carry cards and give blood. If the blood banks go down there are appeals on television and people go from work, queue and give blood. I do give blood but the only time I cannot give blood is if I have visited a country with malaria. I want to know, is there a specific reason why that gift economy cannot work in African countries? Is it a scientific problem because of malaria? How could that problem and the lack of blood availability and blood banks be addressed?
Dr Kodindo: I do not think it is because of malaria. There is a very bad idea of giving the blood. In some places they think that if a man gives blood he will become impotent. There is some cultural belief. They think that if you give blood you will lose weight. Some cultures do not believe in talking about that. I remember the time when they used to provide some sandwiches to people and give them some food and people used to come to give blood. Maybe people should be more sensitised about that. Right now it comes down to the relative to give blood. If there is no relative then there is no way to give blood.

Q39 John Battle: Do governments not campaign or press it on blood banks?
Dr Kodindo: No, the government is not really campaigning.

Q40 John Battle: They do not see it as their job as ensuring there is a blood bank to back-up a clinic or hospital?
Dr Kodindo: Exactly. This is why I am saying there should be a stronger commitment from the government on this problem of maternal mortality. If there is a real commitment and a real political will to address the problem of maternal mortality they will do all this, factor that, go along with the prevention of maternal mortality and lack of blood transfusion. If there are blood transfusions in hospital it will not only benefit the women but the men and everybody.

Q41 John Battle: Let me ask you, is there a better blood bank in cities than in rural areas? Do the rich get access to blood? Do they store their own blood to make sure they have got a supply, because not everyone can guarantee perfect health and never needing some blood?
Dr Kodindo: In rural areas in most African countries they do not have blood banks. They do not have it. This is why many women are still dying from haemorrhage. The rich people, as you have said, they have a way and they also rely on the relative.

Q42 John Battle: They rely on their relatives as well?
Dr Kodindo: Yes. In some countries the International Red Cross is also providing some blood. In Ethiopia the Red Cross is one provider for blood.

Q43 Sir Robert Smith: On this blood issue, obviously there are all the cultural and other logistical issues. Is there also the practical expense and reality that you need to have storage, refrigeration and all that management?
Dr Kodindo: Absolutely.

Q44 Sir Robert Smith: In a sense fresh blood donated at the time it is needed is an easier thing to manage than long-term storage?
Dr Kodindo: Yes. Of course this is logistically is very important.

Q45 John Battle: That is why you would have queues of people at the time of a crisis outside a hospital giving blood, but if there is no pressure to do that—
Dr Kodindo: There is no pressure.

Q46 John Battle: Is the World Health Organisation pressing? Which of the UN agencies understands the need for there to be blood supplies and actually actively campaigns for it?
Dr Kodindo: This is why I think the role of the UN is very important in telling the government to make all that effort and campaign and to try to reduce maternal mortality and address the causes of maternal mortality.

Q47 John Battle: What I am specifically asking, just as for tackling some diseases—for example, I am thinking of the campaign for polio, the World Health Authority pushed very, very hard to get a very simple measure through as a means, and there were some cultural resistances—does the World Health Authority press for there to be blood available and for countries to take that seriously?
Dr Kodindo: Yes. That will really help to put pressure on them.

Q48 James Duddridge: Of emergency obstetric cases, what proportion are a result of abortions, attempted abortions or unsafe abortions, in Chad and generally?
Dr Kodindo: The proportion of deaths from unsafe abortion is very, very high in Chad. Generally it is about 13 % globally. In Chad I would put it as maybe the second cause of maternal deaths,

especially among adolescent teenagers. These are the ones with the least access to the contraceptive method.

Q49 James Duddridge: What are the medical complications, and how can they be treated? What do you need to be able to treat people presenting?
Dr Kodindo: Haemorrhage and infection, so we need antibiotics. For those who have seen that film of mine the 12-year old girl needed to have antibiotics and a blood transfusion but since we did not have them in the hospital her mother had to buy it. The small capital that she has she spent it in the first 24 hours buying, first, a small syringe and IV fluids. When it came to stronger antibiotics, which are much stronger against anaerobic infection, she just could not buy them. Only antibiotics will treat the post-abortion infection.

Q50 James Duddridge: Can you tell us more about the abortion laws in Chad and any proposals to change those laws?
Dr Kodindo: Chad, like many African Francophone countries, has inherited the law of France, some 1920 law, so abortion is illegal in Chad. Until now there is no talk about that. I am only a doctor. I do not know much about that. I can only talk about services that can help me save a woman who has had an unsafe abortion. This is what I need to save their lives. Being only a health provider I have really no power on that. There is no talk about changing it. It is the old law of France from 1920.

Q51 James Duddridge: Is there anything more that can be done to reduce maternal mortality in countries where the law restricts abortion?
Dr Kodindo: Again, as I told you, I work in countries but I cannot talk about changing the legal system. This is not really what I am supposed to do. I am just a health provider. For me when any woman who comes because of an unsafe abortion, or a spontaneous abortion, what I should do is treat them and try to save their life. I cannot change the legal systems of the countries.

Q52 James Duddridge: How formalised is the system of unsafe abortion? Who actually carries out the abortion? How formal is the system in various countries? Is it done at the local village level by family members, or is it a paid service although illegal?
Dr Kodindo: This is the big problem. Usually since it is illegal they do not go to the national health system; they use some people in their city. It is done in very bad conditions. When they are brought in it is the worst complication and we have to deal with that and sometimes you cannot save them. For some of the women we have to do major surgery on them in order to save them, like a hysterectomy.

Q53 James Duddridge: Are there some countries where it is illegal for proper medical professionals to intervene where there has already been an attempt at an unsafe illegal abortion?
Dr Kodindo: No, we do not have this problem, not in Chad. As a health professional you just have to provide the appropriate treatment to the patients. You have no right to refuse to treat her because she has had some induced abortion.

Q54 Hugh Bayley: First of all, what do you think is needed to change what donor countries and the governments of developing countries and international agencies are doing to catalyse change to give us a chance of meeting the MDG goal by 2015?
Dr Kodindo: It is a really important question because MDG is lagging. There is always something to start now. This is an urgent situation. The donors should work with the government and they should start up a real commitment—a commitment that should be translated into concrete actions, like putting some pressure on the governments to start to adjust and implement. We know what to do to prevent women from dying, and these are technologies that are not even sophisticated. It is possible to reduce maternal mortality. It has been shown here in the West; it has been shown in many countries that my previous colleagues have talked about—North Africa, Egypt and many of these countries. They should start having long commitments, a real commitment that should be translated into investing in infrastructure; also providing for supplies, and very simple basic supplies; antibiotics; magnesium sulphate; very simple supplies and drugs; work on the roads; work of the Ministry of Transportation; educating; and developing human resources, and the mid level human resources because you may not have enough specialists. You need the skills and medical care to cover the area where access is very difficult now like the rural area. Focus on these places, the rural area and the displaced person with the situation of insecurity and extreme poverty. Increase the coverage of these areas and it will make some change. In a few years you will see the change for yourself, but it is very difficult to achieve and we need a long-term commitment. It may not take days or months to register a reduction in maternal mortality; it may take more than that. This is why we need a really long-term commitment and accountability.

Q55 Hugh Bayley: It seems to me as a politician that if you want to drive an administrative and political change you need a very, very clear idea of what it is that you are trying to do. In this session I have become aware that this is a very complicated problem, with many difficult inter-related things—education, family relationships, medical interventions and so on—but also many, many agencies involved in the field. It seems to me that there is great confusion about what the priorities are. Your answer to an earlier question, helped by Dr Songane behind you, put a very simple idea into my head. You tell us that it would cost 4.5 billion to provide safe childbirth for 95 % of the world's population. Dr Songane tells us that there are just under 150 million children born a year—that is $30 per child. $30 per child born in the world would

provide safe childbirth for 95 % of children. Should we start at least with a campaign that says to each developed country government, "Unless you stump up $30 per child; put it into a fund controlled by women locally, which is transparent and open, you are not going to meet this target"? Is that too simple? $30 per child, should that be the campaign? What I have calculated, you say that some economist has worked out that $4.5 billion would provide safe childbirth for 95 % of children. Dr Songane tells us that there are 150 million children born a year, slightly fewer, but roughly. If you divide the amount it costs for safe childbirth by the number of births, it would cost about $30 per birth. Should we not just have a global target that the government of every developing country puts $30 per childbirth—they can estimate in Chad how many children are born a year?

Dr Kodindo: We have about 10,000 deliveries per year.

Hugh Bayley: For a community with 10,000 deliveries the government would need to provide a fund of $300,000.

Chairman: In the UK we provide a maternity allowance so would that help if you actually gave women money, for example?

Q56 Hugh Bayley: You have taken the idea even further than I have, but that is probably one way. So long as you find a way of averaging out between the cost of a Caesarean. What I am saying is: should we encourage all the agencies here to launch a campaign that will pledge, whether it comes from donors or country governments, $30 per birth?

Dr Kodindo: I think we should try. We should start to do something.

Q57 Chairman: I think the point behind Mr Bayley's question, and I think Ann McKechin was making the point, is that, sadly, in some countries you give the money to the government and it does not seem to get through to the women who need it. If you actually gave it to the women themselves who were pregnant in some form or another in a way that was guaranteed access you may cut through some of these problems—whether it is lack of will, corruption, or whether it is because at least you empower the women in a practical sense. The kind of people that we saw in your film having to go and buy blood, drugs and so forth, for a start with transport they would at least have some basic means of doing it, and not have to go to their husband or somebody else and get permission because they could actually do it themselves. Would that make a contribution to solving some of the problems?

Dr Kodindo: Yes, but I still think the health system should be strengthened. Without a stronger system nothing much can be achieved. We still need to invest in the health systems.

Q58 Hugh Bayley: I take your point about diverting money.

Dr Kodindo: The corruption is a reality, especially in a country where the maternal mortality is high. If you have to restrict the money because of that then we are not really helping the problem of maternal mortality.

Q59 Hugh Bayley: If you actually handed out bank notes the money would not be spent on maternal and child health, it would be spent by the men for good or bad other things. I understand it has to be kept within the health system, but somehow we need to focus people's attention on the fact that, compared with universal medication for HIV, this is a cheap and doable problem?

Dr Kodindo: Yes. This is why something should be done. Of course it is something that can be achieved; it is possible. You have shown it here. It is possible. It is not even asking for super-technology, as I say; but it is possible if only the donors and the government have the same commitment. If they have the same will and they have an integrated strategy, coordinated strategy within the donors and within the government, we will see the result. This is why something should be done, and now.

Q60 Hugh Bayley: How then would you get women's control? If you persuaded the Government of Chad, for example, or any other country, to allocate to the local maternity and child health fund $30 per birth, how would you give women of child-bearing age the control? How could you make that fund accountable to the women? Could you realistically set up a mothers' committee for each clinic in your country?

Dr Kodindo: Yes.

Q61 Hugh Bayley: How would you get the managers? You could require the managers to issue a notice, and put on a board of a clinic for those who could read to see that $300,000 has been made available for this clinic. How would you give them control over the money?

Dr Kodindo: Some organisation of women; some group of women, to start to educate them and then show them how to manage it.

Q62 Chairman: We might explore that with some other witnesses. What I do want to say is that I think your personal testimony is extremely valuable to us. Some of us have seen the film—I certainly have seen it. I think what concerns us, and you have summed it up in a simple sentence really, is that all of these things can be done, and they can be done affordably, and yet this is the MDG that is the most off course. In a sense, you are telling us from practical experience that it is really a disgraceful lack of will both nationally and internationally by the people who matter.

Dr Kodindo: Yes.

Chairman: I think Dr Songane has demonstrated that this is a job for men and women, very much so, although clearly women who wish to rise up and fight for themselves will find people who can support them. I think what we value from you is somebody

who is actually having to struggle in a very practical sense in the field and faced real tragedies every day, and the frustration of knowing that those individual tragedies are avoidable. We would just like to thank you very much indeed for coming along and giving us this evidence. I hope when we finish this inquiry that we will have made some contribution to identifying some of the key buttons to press that might just help certainly the UK to do what it can to really bring this MDG back on track. I do not think any of us should walk away from this accepting that it is not possible; it clearly is possible. It is a matter of getting the right decisions in place. Thank you very much indeed, you have been extremely helpful.

Tuesday 13 November 2007

Members present:

Malcolm Bruce, in the Chair

John Battle	Mr Stephen Crabb
Hugh Bayley	James Duddridge
John Bercow	Ann McKechin
Richard Burden	Sir Robert Smith

Witnesses: **Dr Tim Ensor,** Principal Consultant (Health Economics), Oxford Policy Management and Senior Lecturer, Immpact project, University of Aberdeen, **Mr Alec Cumming,** Chief Executive Officer, Immpact project, University of Aberdeen and **Dr Sam Adjei,** Principal Consultant, Ghana Health Service, gave evidence.

Q63 Chairman: Good morning to you gentlemen. Thank you very much for coming in to help us with our second session of public evidence on our inquiry into maternal health. I wonder, Mr Cumming, first of all, if you could introduce yourself and your team and then after that it might be helpful if you gave us a brief introduction to what Immpact has actually been doing and how it is set up.

Mr Cumming: Thank you very much, Chairman. I am Alec Cumming, the Chief Executive Officer of the Immpact project. I have been in that position since 2004. Prior to that I was chief executive of an NHS Trust and had worked in the NHS for 30 years. On my immediate left is Dr Sam Adjei who is the Chief Consultant to the Ghana Health Service but who worked with the Immpact project as a visiting professor in international health at the University of Aberdeen until last year. So we have had a long close association with Dr Adjei. On my far left is Dr Tim Ensor who is a health economist who works with the Immpact project. He is based in York and also works with the Oxford Policy Management Group, but in this context he is here to represent the experience and interests he has with Immpact.

Q64 Chairman: Thank you for that. If you could then give us a brief history of Immpact and what you have been doing.

Mr Cumming: Immpact was established in 2001/02. It was set up with funding from the Gates Foundation, from DFID,[1] from USAID[2] and from the European Community, with total funding amounting to £20 million. The aims of Immpact were to identify evidence of what is effective or what would be effective in reducing maternal mortality and also to enable that effectiveness to be measured by ensuring that we can actually count the number of women who die because the statistics were, and remain, very poor in this area. So it was established in 2001/02 to look for evidence of what is effective and during the subsequent five years we have worked extensively particularly with three countries, Ghana, Burkina Faso and Indonesia, to assess the effectiveness of strategies implemented in these countries and to identify universal messages from these strategies. We are now in a position to share that evidence which I guess is why we are here.

Q65 Chairman: Thank you very much. That is extremely helpful. As you know, the more you look at this issue the more people say that having an effective health infrastructure is a crucial part of it. DFID, where possible, does provide budget support to governments towards things like providing their own health service and education. How effective is budget support in delivering, and how can you ensure that there is a direct correlation between supporting the health service and improving maternal health?

Mr Cumming: I think my colleagues will answer that in more detail. I would reinforce the desirability of supporting health systems. It is quite clear from the evidence we have gathered that the key to improving maternal health is to improve health systems. Maternal health depends on good operating health systems and therefore, wherever possible, the best route to improving maternal health does lie in systems support. That cannot apply in every country's circumstances, but wherever possible, as DFID indeed do, we believe that systems support is the correct approach.

Dr Ensor: Obviously there are challenges with implementing systems of budget support, particularly with regards to the monitoring. The monitoring tends to be much more general than the monitoring you would get with project support. The key point that Alec made is that maternal health is something that affects the whole system. It is very difficult to set up vertical programmes that are only targeted at maternal health outcomes because maternal health tends by its nature to be something that covers the whole system. It is very difficult to set up individual projects that are only focusing on maternal health. Budget support for maternal health makes a lot of sense. The problems occur with monitoring budget support for maternal health in the same way that problems occur with any kind of budget support or any other health or indeed any other kind of programme. That is where the systems with the governments that we are working with are just not adequate to deliver the kind of broad, independent monitoring indicators required to provide the information on how the money is being

[1] Department for International Development (DFID)
[15] the Department for International Development (DFID)

used. In addition to the narrow maternal health monitoring indicators that are needed to monitor the outcome of maternal health programmes I think it is also important to put in place systems that allow much more general monitoring of public expenditure. If you do not have a system of public expenditure reviews that report on how money is spent and then used throughout the system it is very difficult to ensure that you are going to get good outcomes at the end of it. I think the point here is that in order to make budget support work you need both the independent indicators to monitor maternal health and you also need the much more general public expenditure framework and monitoring indicators to allow the system to function properly.

Q66 Chairman: Dr Adjei, I think DFID were involved in supporting the health service in Ghana. You have had direct experience of that. How effective were they?

Dr Adjei: DFID supported us very effectively. I must say at the outset that we at the country level tend to look at the health sector as one. We do not distinguish between the interventions and what is called systems because when you do that you create two health political parties, one the interventionist group and the other the systems group and it is not particularly helpful to us at a country level. We are interested in the strategies for service delivery and in integrating those strategies as much as the systems that are required to support the delivery of the interventions. We like to look at them as a whole. I think that is how we have been working with DFID. We would discuss the health system in the context of what are the priority interventions and then what are the important systems issues relating to technical resources or planning or even addressing poverty and looking at the resources that are required for women to access services. It has been quite effective in the sense that we can look at all the interventions that are critical and look at what the support system is that is critical to carry the interventions forward. Over the years we have had these health sector reforms going on and we have been dialoguing together. We have set up the systems to be able to track performance from the district right through to national level in terms of how the interventions are performing, like immunisation or access to maternal and child services, as well as tracking the human resource needs that are required for these, tracking logistics, tracking the financing and how funds are dispersed together as a team and we do independent reviews on an annual basis. We have monthly discussions with our donor partners, including DFID, we have business meetings on a quarterly basis and twice a year we have major summits where we bring all the donors and the governments and other sectors that have an interest together to look at the evidence and review the evidence that has been generated in the country. We even field independent review teams to look at what our performances have been in the previous years and bring this to the table.

Q67 Chairman: You are talking about the Ghana Health Service. In the evidence you say that the release of funds by DFID has been unpredictable and erratic, that DFID closed its health offices in Ghana without discussion and this created a vacuum in the policy dialogue and deprived the health sector of good quality technical support.

Dr Adjei: This has been the problem within the past few years. Where it has been very, very difficult—and this came up during our review and our dialogue and our discussions with a view to reducing transactional costs—is that DFID closed its office in the country without discussion and the Ministry was really concerned about that because they felt that having DFID at the table and discussing together was very important for us, passing on that responsibility to another government and it seemed not to have worked very well. So we were concerned about that. Now is the budget period and so this week we are having a meeting with all our donors, but it has always been difficult to confirm the monies that are coming in. People will pledge and say okay, we will give you so much, but when the time comes we have not really had the releases that we have been promised or been expecting over the past two or three years. It has been quite erratic over the last couple of years. It has been improving over the past few months, but that has been the problem.

Chairman: I think that is something we may want to ask DFID about themselves directly when we have them here to give evidence.

Q68 Hugh Bayley: I am interested in looking at what the priorities should be for DFID in terms of strengthening the health system as a whole or providing specific programmes and interventions on maternal and child health. If you look at their published statistics, overwhelmingly their spend is on health systems, excluding budget support. They spend a sum of almost £400 million on health overall, but only £16 million is spent on maternal and newborn health. In your evidence you say "the temptation to target resource through vertical initiatives, experienced by our Ghanaian colleagues, needs to be resisted by DFID and as far as DFID can influence them, by other donors."[3] It seems to me that DFID has the right policy, but you are saying it is not happening on the ground.

Mr Cumming: The reason for expressing ourselves so strongly is that maternal health, as I said earlier, does depend on a functioning health system. You cannot provide emergency obstetric care without having blood banks, without having decent transport for patients and without having sufficient hospital beds for emergency cases. These are all independent indicators of a functioning health system and it is not impossible, but it is difficult to see, if the governance of the country is adequate, that there is a case for vertical intervention in these circumstances. The temptation clearly is that you can guarantee returns if you put money in for a specific purpose and monitor the achievement of that purpose, but the experience of our colleagues in

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Ghana and elsewhere is that that undermines the efforts of local health services to develop the whole service and distorts priorities. Although clearly more is needed to be spent on maternal health, in our view and in our experience that should be in the context of supporting health systems, where the governance of the country permits the spending to be tracked and DFID to have confidence that the money is being properly spent.

Q69 Hugh Bayley: You seem to be saying 80% of the money should be channelled through the government and taken from the basic health system, but you may have some particular initiatives in a particular clinical discipline or other that you would want to support. The last time the Committee was in Ghana was probably about four or five years ago and we visited the Kintampo Health Research Centre just before the tragic death of the technical director, Paul?
Dr Adjei: Paul Arthur.

Q70 Hugh Bayley: He was an inspirational doctor. They were doing a lot of work on very, very cheap interventions, high doses of Vitamin C, which had a big impact on neonatal morbidity if I remember correctly. Are those lessons being taken on board? Have those lessons been fed in to the protocols for maternal and child health in Ghana? Do you need targeted funding for relatively cheap but effective interventions of that kind or would you still say "put the money in the health system and let the Ghanaian health system decide the priorities"?
Dr Adjei: The maternal assessment on Vitamin A will be completed next year. On the child health side, that is part of the overall package of interventions that we deliver to children. It is integrated as part of the primary healthcare package of interventions. We like to look at it as a whole so that the districts get the funding to organise how they deliver that without somebody coming in with the money and saying they should go out there and just give Vitamin A to the kids. The districts can organise it together as part of their whole healthcare delivery arrangements. That is how we would like to have resources organised.

Q71 Hugh Bayley: Has the government or the Department of Health in Ghana published any reports on the impact of spreading out this therapy more widely?
Dr Adjei: The annual review process will describe in detail all the interventions and how they are carried out and it will take measurements on implementing child nutrition. We do have evidence to show that the nutritional status of children has improved for a couple of years now.
Hugh Bayley: If you could share it with us that would be helpful.

Q72 Ann McKechin: I want to continue on this issue of integrating vertical funding with overall health systems. The Global Fund to Fight AIDS, Tuberculosis and Malaria obviously takes up a huge amount of donor funding. To what extent do you believe that government and donors alike are sufficiently alert to the need to integrate this properly with maternal health systems, and what has been your experience in countries such as Ghana as to whether or not there have been any problems about that issue of integration?
Mr Cumming: I would reiterate that insufficient resources have been made available to tackle maternal health. It is the single biggest measurable difference in health status between the developed and the developing countries. We clearly do not want to get into a debate of HIV/AIDS versus maternal health, but maternal health above all requires functioning health systems and is the least susceptible of all the conditions to vertical funding. In that sense its interests may not coincide with interests in tackling the specifics of HIV and AIDS and that is a problem because these priorities are set externally by governments and by donor agencies when they give money for these specific purposes and to that extent it is a distortion, one would have to say.

Q73 Ann McKechin: I wonder if Dr Ensor has any comments about how integration of these systems is working in practice.
Dr Ensor: International agencies are generally quite good at working together at one level. They are pretty good at working together in investing in primary care. Where I think that international agencies are much weaker at working together is at the hospital level. One of the reasons for that has been that primary healthcare has become such a political necessity to invest money in and rightly so because that is where most diseases can be tackled, but as a result the secondary level tends to be a bit neglected. This maybe does not directly answer your question because you are asking about general donor co-ordination perhaps. My observation would be that certainly in a couple of countries in Asia where I have been working the emphasis from the donor side is all about putting money into the primary level. The government is left on its own to try and do the best it can with the secondary care level.

Q74 Ann McKechin: Would this be one of the reasons why mother to child transmissions of HIV, for example, are still very high, because there has been such an emphasis on the primary care level rather than at delivery?
Dr Ensor: It could be. The other related observation to this is that I have observed that a number of development partners, possibly DFID in some countries but certainly some of the other European development partners, have then begun to realise that coverage for catastrophic care is important, that coverage for things like Caesarean sections and other emergency obstetric needs are important and they have begun to think how they can develop almost parallel systems of financing and sometimes delivery. So the government is struggling along trying to develop its district hospital structure and you end up with a parallel structure. I think that is an important issue for the development community.

Bangladesh is a good example of this where there has been far too little focus on that level by developing partners.

Q75 Mr Crabb: Let us move on to the issue of user fees for maternal health services. What complementary policies should donors like DFID be promoting and supporting in those countries which are looking to abolish user fees in order to ensure that lost revenues are replenished?

Dr Ensor: It is very difficult. When we are looking at user fees we should not only focus on the fees that are faced by the user once they have reached the health facility. It varies from context to context, but in some contexts by far the greatest burden on households is the cost of getting to the facility, having to give up time, having to travel. Nepal is a very good example of this where studies have shown that 60 % of the cost is in getting to the facility. Any policy for free delivery has to focus on the main financial barrier. In Nepal it is transport. In other countries it will be other things. A policy needs to begin with the biggest barrier. I think the second part of that is that in a resource-constrained environment it is very tempting to target and probably some sort of targeting is almost inevitable. You cannot implement a policy that allows free delivery in all circumstances for everyone immediately. However, the type of targeting is very important. The experience with individually based targeting where you try and work out who is rich and who is poor on an individual basis does not have a very good pedigree. It has worked more or less in some countries, but in many contexts it has not worked well. I think the experience from Immpact and from elsewhere suggests that in designing a careful policy of targeting there is almost a hierarchy of targeting that begins by looking at the poorest areas and targeting those areas with universal obstetric care. That will mean the rich in those areas benefit, but the cost of targeting areas tends to be much less than if you try and work out at an individual level who is rich and who is poor. The second part of it is that for emergency obstetric care individual targeting does not work well at all because there is plenty of evidence that shows that even the non-poor can be pushed into poverty as a result of large charges. Our evidence from Indonesia, for example, shows that without free emergency obstetric care at a couple of district hospitals 13 % of users would have been pushed into poverty if they were not exempt. They were the near poor that would have been pushed into poverty. The beginnings of any user fee policy must be, firstly, to look at the biggest financial barrier and, secondly, to look at the type of targeting, and then thirdly, which is perhaps where you started from, to ensure the resource flow. Maybe Sam would like to say something about this on Ghana. The Ghanaian policy for providing free delivery care failed almost entirely because the funds that were promised at the national level were not properly channelled to the facility level.

Q76 Chairman: Have you looked into the role of providing, for example, maternal grants, in other words to give a woman who is pregnant a sum that would help her to cover transport or other costs? Has that been looked into?

Dr Ensor: That is interesting. One of the problems with that is that the grant is not used for the right purposes. However, the Nepal intervention is actually very interesting in this area. The cost of transport is around 60 % of the overall cost to users. The Nepal Government a couple of years ago developed a policy that pays a cash amount to every woman that reaches a health facility. If she gets to the facility she gets money in her hands and it offsets the cost of transport. A full evaluation of that is yet to be done, in fact it is ongoing. Early results from the management information systems suggest that skilled attendance is increasing. We will wait to see whether it is directly caused by the system of grants to women.

Dr Adjei: User fees account for almost 20 % of their expenditure on health and if it is to be abolished then you have to find a way of replacing it because that is a minus of revenue for the hospitals using the procurement of grants and essential supplies. We started off with an exemption policy and a lot of the units supported that and we were paying from the debt relief money, but that became unpredictable. We were running out of funds from the debt relief money to pay for the exemptions. Now we have started an ambitious health insurance system so that we can get women enrolled into the health insurance system as a way of covering their costs for deliveries when they come in. Quite a number of them get exempted because of the nature of the laws. You can get exempted, but you have to go and get enrolled and get a card and then you are able to access insurance funds to cover your costs. One of the interesting observations is that the women come to the paediatric clinics four times and you have a coverage of about 80 %, but less than 50 % come to deliver. The difference for a long time between the two was the deliveries that are charged to it. Now that we are taking out the charge for the delivery we are hoping the utilisation rate will go up because it is within the same facilities that the prenatal and the deliveries take place. If they can come four times then perhaps they would come for delivery. We are already beginning to show that the exemption policy has increased uptake. There are still issues about the quality of the services and some cultural factors that we have to deal with as part of the overall policy of removing fees. We will have to go with information and education and ensure the poor have the confidence to use those services because if they go there and they are discriminated against because they are poor then they will not go even if the fees are removed. I guess the policy that I am talking about is support to ensure that other mechanisms come into play to provide for the cost of removing the exemption from the woman of having to pay.

Q77 Mr Crabb: What kinds of costs are built in to the user fees? Do they tend to be made up of drugs costs, other supplies, salary costs?

Dr Ensor: It varies considerably. If we are talking just about the facility costs, then the salary costs might be anything between 30 and 50 %, the drugs costs might be another 30 % and then the rest is the overheads and that is a supply side cost. In addition to that you have whatever demand side costs there are, such as transport, which, as I have indicated, can sometimes be the dominant cost in certain contexts.

Q78 Mr Crabb: Are you aware of any work that has been done to try and identify average costs for a birth in the developing world?
Dr Ensor: Yes. It varies enormously. The figures that I have seen show overall aggregates fall by continent and also for individual countries. The supply side cost is between perhaps $30 and $100 per birth. Obviously it is much higher where there are complications.

Q79 Sir Robert Smith: I want to pursue a bit more the issue of cash transfers or vouchers. In societies where women's status may not be that strong is there a concern that whilst the cash is made available to them they do not then get the ability to control it in that direction? Do vouchers have an added advantage in that they are for women?
Dr Ensor: There are pros and cons. Clearly with just giving cash to a family you run the risk that it will not be used for the right things. If you can somehow condition that cash, for example in Nepal you do not get the cash until you reach the facility, then that guarantees that at least the woman has got there and it is basically mitigating the cost of transport and provides some extra incentive. Vouchers lose that problem. In certain contexts I think vouchers can be appropriate. The problem with voucher schemes is that often they require the development of a parallel infrastructure, ie administration, that adds a lot to the cost. There are a number of examples. Bangladesh has a system of vouchers now for reaching a facility and they have three levels of committee which, firstly, filter the women because it is only targeted at poor women, so they have to decide who is poor, and then once the woman has received the care they allow the transfer of resources from a fund to the facility and also to practitioners in certain cases. With all of that you are adding an extra parallel structure. It is obviously not sustainable beyond the end of project funding unless somehow that structure can be absorbed within government. Sometimes— and I think this is true in Bangladesh— the parallel structure has not been created in order to serve the needs of the poor or to develop competition, but it has basically been set up to circumvent what is seen as a very bureaucratic and unyielding government system of financial distribution, so you create your own system, but that has problems.

Q80 Sir Robert Smith: Alec?
Mr Cumming: I just wanted to pick up the associated point. One of our key findings is that even if we were able to provide three pillars of a sound system to address maternal health, that is family planning, skilled attendance at delivery and access to emergency obstetric care, we have accumulated a great deal of evidence that unless we identify in an individual country's circumstances what it is that acts as a barrier to the poorest women accessing these facilities the provision of the facilities by themselves will not work. So we should not rule out any means of achieving that, and Tim is identifying possible means. Clearly the best means is if it can be system-wide support, but the crucial thing is that unless we are able to ensure that the poorest women can access facilities then we will not achieve MDG 5. There are huge discrepancies between the maternal death rates for the poorest women and the richest women in developing countries. In Peru, for example, the level of maternal mortality is eight times as high in the lowest income quintile as in the highest. Generally speaking in the countries we are looking at it is two and a half to three times. Unless the issue of addressing access by poor women is tackled then we will not succeed in achieving MDG 5. Vouchers, cash systems, supply-side provision, demand-side subsidies, all need to be looked at depending on the individual circumstances of the country, but what should drive it is ensuring that the poorest women in society are enabled to access facilities.

Q81 Sir Robert Smith: The advantage of cash over vouchers is that the person can be more flexible. There are so many costs, whether it is drugs, blood or the transport, that if they could maybe get a neighbour to help with the transport then they have got some in reserve for other things.
Dr Ensor: Yes. There were real doubts in Nepal when they introduced the cash a couple of years ago whether facilities would simply have the ability to manage cash because you have got to have the cash available when the woman goes for the delivery. If you think of a remote area of Nepal, perhaps at that time controlled by Maoists, there were severe doubts that they would have the ability to secure cash and I think those are very real problems. If you can get over that it does offer a more flexible and simpler way of directing resources.

Q82 John Bercow: Dr Ensor, in respect of vouchers you highlight the problems of bureaucracy and cost. I wonder if I can just ask you about two other issues and specifically your view on them as between cash and vouchers. One is the question of the scope for corruption. I do not know whether the scope is greater with cash, as one might think, or with vouchers, but I would be interested in the evidence based view or in any anecdotal impressions you have got on that point. The second is the issue of stigmatisation and what one might call transparency, but transparency in a bad sense rather than a good sense. Ordinarily when one talks in international development terms or public policy terms about transparency it is normally magnified as an objective to be sought, but in this context I mean more branding people. Although the service to be accessed is a service for which it is perfectly reasonable that people should get support, I wonder

whether in the context of the society it might contribute to labelling, abuse, discrimination, dehumanisation or whatever. I do not know if you have got a sense of that. Certainly in the very, very different circumstances of our own society and in relation to a different area of policy, namely the provision of support to certain categories of asylum seeker for example, it is sometimes said by critics, amongst whom I would number myself, that providing vouchers to people is, frankly, a rather inequitable way in which to proceed.

Dr Ensor: There may well be good evidence. I am not aware of good evidence one way or the other on the ability to corrupt either a voucher or a cash system. I think it is present in both systems. I am not sure which is more or less likely to be corrupted. In terms of the stigmatisation, I think that is an issue. It is a slightly tangential example, but in Vietnam, certainly when they introduced insurance, which was a kind of voucher for primary care for the poor in the 1990s, many hospitals just refused to take it. They much preferred to receive user charges where they could charge what they liked. I think the other observation there is that if you target poor areas rather than poor individuals then the problem of stigmatisation is probably lessened. If you say there are vouchers for every woman that lives in this area that happens to be poor then the relative stigmatisation of individuals disappears a little.

Q83 John Bercow: Dr Ensor, you have shown a prescience bordering upon a psychic quality which is greatly to be admired because I was going to come on to the question of insurance schemes. Are you arguing that intrinsically such insurance schemes would fail to reach poor people or should donors, such as DFID, in a sense refine and improve the model to ensure the community insurance schemes for maternal healthcare hit their target?

Dr Ensor: I think it is possible for community insurance schemes to hit their target. I do not think you can expect community insurance schemes to be sustainable in that you expect people that contribute to cross-subsidise those that do not contribute. The overwhelming evidence is that that does not work. If you are paying into a voluntary scheme then individuals are reluctant to make that much of a subsidy to the costs of other people's care. If you want it to work then you have got to be prepared to fully fund the same kind of coverage for the poor as is funded by individuals that are not poor. There is a colossal amount of evidence on community insurance and each scheme varies. Most community schemes do not cover normal deliveries because it is a predictable event. There is a problem with predictable events. Many also do not cover complex obstetric care because it is so expensive and community schemes tend to have small reserves so there is a problem there. That is not to say you cannot do it through community insurance, but it may not be the best vehicle to provide for the sort of very complex demands of obstetric care.

Mr Cumming: The stage that Immpact has now moved to— and it is in the final year of its activity— is in fact to work with governments in the three countries in particular that we have worked with to assess the most appropriate strategy to ensure that maternal mortality is reduced. We have the example of an insurance based scheme in Ghana, in Indonesia different sorts of insurance based schemes, and in Burkina Faso a rather different approach. We intend to go back. As both Dr Ensor and I have said, there is no single answer to this. It will very much depend on the social, cultural and governance status of individual countries, but our intention is to work with governments to identify those strategies which are going to be effective and then we hope to publicise universal messages from that work.

Q84 John Battle: I want to return to a point that was made earlier on about the budgets and monitoring the budgets. What is a maternal health budget? How does it get there? Why I am haunted by that question is that it seems to me budgets to improve maternal health may have to fund hospitals in an integrated way and even transport. The reason MDG 5 seems to be so far behind other MDGs is you can clearly identify provision of anti-retroviral drugs or mosquito nets, but in this area the budget seems so diffuse. How do we know it is ever going to get there? I was at a conference of the Voluntary Service Overseas and they were having a conversation north and south and it was suggested that rather than sending doctors and teachers, what were really needed were good lawyers, IT specialists and accountants to track and monitor the money. I want to ask you about that tracking and monitoring of the money. What can be done in-country by civil society to track the money effectively to make sure it reaches the parts that need to be reached? What could DFID do more of to ensure that that was a priority?

Dr Ensor: There are some very good regular public expenditure reviews accompanied by those less regular public expenditure tracking studies which summarise how money is spent in the public sector and even in the non-public sector and then look at whether the money actually reaches the facilities. Those tools are well publicised by DFID in some countries. What extra could be done is regularising those tools. There are a few examples where governments themselves or Ministries of Health themselves undertake annual public expenditure reviews, but there are not many of them. Usually it is something that is enforced from outside, often by the World Bank but also other agencies. Encouraging a home grown public expenditure review is a very useful tool. The second part relates to the second part of your question and that is the role of civil society. Unfortunately civil society has not been involved very much in using those tools, at least in my experience and the countries I have worked in. The public expenditure tracking studies, for example, are often extremely sensitive. They are often done reluctantly by governments because donors want them carried out. The one that was done in health and education in Bangladesh, for example, took several years to really see the light of day and to be properly disseminated because it raises sensitive issues. I believe there are now some

examples in India where civil society is actually involved in training people to undertake these studies and civil society are involved in those processes. I agree with you that that is one area where DFID could pursue more— I believe they are already— in pushing the role of civil society in the use of those tools.

Mr Cumming: I am slightly concerned at the first bit of your question, lawyers and accountants rather than health professionals. Tim is entirely right, we need good systems for tracking, but there is a gross deficiency of health professionals in many countries.

John Battle: I am not trying to set one against the other. I am just trying to raise the status of lawyers and accountants!

Q85 Chairman: Were we not told in Chad that 1 % of the budget reaches the end result?

Dr Ensor: There is a lot of evidence on that now in different countries.

John Battle: Even the theme is becoming a little bit of an 'in' word, a bit trendy. You have got participatory budgeting and civil society monitoring and budgeting even in the north is only beginning to happen. Perhaps I could just ask if there is information about the Indian example that would be helpful and maybe we will encourage DFID as well as the government in-house to encourage the civil society monitoring as well and look to see how they can develop instruments and we could do a bit more here as well.

Q86 Chairman: If there is any information on that it would be helpful.

Dr Adjei: In Ghana what we do is at the beginning of the budget year we all have targets set around expenditures, for example that 42 % of expenditure would be at a district level for different programmes and then at a regional and then at a national level. At the end of the year when the audit is done we can track and see if we are achieving these budgets. Then you can do costing studies within the various levels to look at where the money is spent in each area so that you can know exactly how the funds that went, for example, to the districts were spent because they will keep records of everything within the system. The support for that kind of expenditure to be done by the institutions themselves has always been the way to assess whether donor funds have been used appropriately. In addition we have independent audit systems which we agree with the donors and they will bring together independent auditors and they will go through the books and make sure that the funds are reaching where they should be, and then the public accounts systems bring to the public how funds that have been allocated to the governance sector have been spent and on what. It is a system that has been growing very slowly but importantly in ensuring accountability and the proper use of funding that comes into the system.

Q87 Hugh Bayley: I have been provoked by your comment to ask about nutrition. Do you have any idea about the cost-effectiveness in terms of maternal and child lives saved per dollar spent by putting money into better nutrition as opposed to into health? I am old enough to remember queuing up with my ration book for welfare support in this country. If you were to introduce food interventions, perhaps not so much in Ghana but in parts of Africa that have suffered severe food shortages in recent years, what sort of food interventions would you put resources into?

Mr Cumming: That is not something that our project has looked at. We have made the point about the link between poverty and maternal health and clearly nutrition is one of the factors that lead to the very, very heavy levels of maternal mortality in the poor, but I cannot answer that question.

Dr Adjei: At the moment the bigger problem area has got to do with anaemia in pregnant women. Much of the emphasis has been on more nutritional supplements, iron tablets and folic acid tablets to address anaemia because that is the greatest risk. If the anaemia is very bad and the woman has a small bleed then they can go into shock very quickly. The emphasis has been on nutritional supplements for pregnant women who come to us. Then there are associated factors like malaria in pregnancy which also causes severe anaemia very quickly. Making sure that you prevent malaria in pregnant women by treatment is one of the ways to address the problem. The government has started work in the whole area of nutritional messages called regenerative health. It is a new programme that is targeting pregnant women and what they must eat and the locally available foods that have been studied and are rich in nutrients for pregnant women to keep them well. That has also been promoted of late.

Q88 Sir Robert Smith: Just thinking about previous evidence sessions and some of the briefings we have had. Is not the reality that in relation to the survival rate for mothers in childbirth it is actually being able to intervene at the time of the birth that makes the dramatic difference? ***Dr Ensor:*** Yes. I am not sure I can offer very much on the nutrition angle. I do not think you would pitch the two together in an analysis of cost-effectiveness because both are needed and as you say, many of the deaths are because you cannot deal with the emergency as it occurs. Better nutrition certainly helps the final outcome, but the infrastructure for that emergency care is also important.

Q89 Hugh Bayley: Maybe it would have a bigger impact in terms of years of life gained with children rather than with the mothers.

Dr Ensor: Yes.

Mr Cumming: The main causes of maternal death are not directly nutrition related.

Dr Adjei: It is the haemorrhage which is the problem because if it is bleeding you have to intervene with the bleeding, but to the person who is anaemic and who loses a small amount of blood very quickly, that is where the link with nutrition comes in. You have better haemoglobin levels during pregnancy.

Q90 Hugh Bayley: Iron tablets rather than food rations?

Dr Adjei: Yes. Basically, that has been the approach but also malaria is a major cause of anaemia in pregnant women so that is also another one to deal with.

Q91 John Bercow: How widespread has the uptake been of Immpact's new tools for measuring maternal mortality such as the Sampling at Service Sites methodology?
Mr Cumming: They are only now being publicised so the uptake at the moment has been internal within the project. The aim now is that we are offering them as a public good. We published a revised version of the Immpact toolkit to coincide with the major conference, which I think you are aware of, that happened last month, Women Deliver. Subsequent to that there was a huge amount of interest in these tools and we are arranging for a series of training courses in the use of the tools with colleagues in developing countries. We expect to see these tools used widely. So far though they have strictly developed within the project. Given the huge cost benefit— for example, in the Sampling at Service Sites technique— compared with the population— wide surveys and given the very dubious nature of the evidence just now on maternal death, it is really important that these methods are publicised and made widely available. That is the aim.

Q92 Chairman: The effect of these methods is that you are identifying a worse situation.
Mr Cumming: It varies a little but generally speaking we are finding that levels of maternal mortality are higher than those that are officially recorded.

Q93 Chairman: You talked about the project being in its final year. What is its current situation? You have done the work. You are presumably now putting forward recommendations. What is DFID's engagement? Is there an absolute timescale? In other words, is it all going to come to a definite end?
Mr Cumming: The project was funded for a specific purpose, to identify evidence of what is effective at reducing maternal mortality. We have done the work. The last stage of what we are doing should be to prove that it works by going back to individual countries to work with them in developing strategies. The funding that we have from DFID, the Gates Foundation, USAID and the EC[4] will be fully exhausted by the end of August of next year. We do think a project should have a beginning, a middle and an end and it will come to an end at the end of August. There is a need to continue with research into maternal health, both in terms of measurement and in terms of effectiveness, but that would represent a new phase and we are in discussion with DFID about that. DFID are very positive about supporting the work that we do in making sure that our findings are implemented and they have said that if we come back with proposals for further research then they and others will be interested in that, but that is for us, to go back to them and make the case for further work.

Q94 Chairman: Will you be producing a final report on the project and, if so, is there a time frame?
Mr Cumming: Yes. We are working on that right now. The emphasis of that report is on freeing the poorest women in society from barriers which stop them attaining care. We expect to produce a draft of that by about the end of the year and to publish it in the spring of next year.
Chairman: I think that will be extremely helpful. Those of us on the Committee who have embarked on this report, to be honest, have been absolutely shocked to the core about both the figures and the appalling suffering and indeed major social consequences in terms of orphaned children and fragmented societies and indeed the interesting point that it can contribute to conflict and social breakdown. In other words, it is a fundamental contributor to poverty. Anything that helps focus on practical measures that can address this is much more significant than just isolating it as a single factor. Yes, it is terrible for women. Yes, it is terrible but it has much wider repercussions than people think. I am sure that your work is extremely helpful in understanding the problem and perhaps coming up with solutions and I hope our report may help contribute to that as well. Can I thank you all for coming in and helping us with our inquiry.

Witnesses: **Dr Tony Falconer,** Senior Vice-President, **Royal College of Obstetricians and Gynaecologists** (RCOG) International Office, **Dr Monir Islam,** Member, International Executive Board of RCOG International Office and Director, Making Pregnancy Safer, World Health Organization (WHO), and **Dr Nynke van den Broek,** Senor Clinical Lecturer in Reproductive Health, Liverpool School of Tropical Medicine and Director, RCOG International Office, gave evidence.

Q95 Chairman: Can I welcome the three of you. You have obviously been here for our previous evidence and have heard what issues we are exploring. We are grateful to you for coming in and giving us your expert advice. Just reading the background brief, it is clear that your organisation effectively sprang from these problems in the now developed world. Obviously we are interested in the extent to which what we might call the crisis or the shame of the developing world can be addressed. Could you introduce yourselves and say who you are and what your qualifications are for our record?
Dr Falconer: I am Tony Falconer. I am basically a practising clinician, obstetrician and gynaecologist in Plymouth. I have recently taken over the responsibilities of senior vice-president of the Royal College of Obstetricians and Gynaecologists. The principal brief of that job is international affairs. Our Royal College, as you said quite rightly, was instigated 77 years ago in response to the magnitude

[4] the European Commission (EC)

of maternal death in the United Kingdom. We are an international organisation. About 50 % of our members and fellows come from overseas, principally in the developing world, so we have a massive training, teaching and supervisory responsibility for that part of the world. Recently the International Office has also developed very close relationships with Liverpool and that has enabled us to become, I suppose rather late in the day, rather more adventurous about some of these very major issues that your inquiry is highlighting.

Dr van den Broek: My name is Nynke and I am a trained obstetrician and gynaecologist. I am a Fellow of the College of Obstetricians and Gynaecologists, trained in this country. I have spent most of my working life working with resources projects, mainly in sub-Saharan Africa but also in Asia. In 2001 I joined the Liverpool School of Tropical Medicine as a senior clinical lecturer and my work combines improving delivery of clinical services research with evaluation and management of programmes. I lead a small team in the School and, as you all know, the Liverpool School of Tropical Medicine is the oldest school of tropical medicine in the UK.

Dr Islam: I am Monir Islam. I am the director of Making Pregnancy Safer, a department in the World Health Organisation in Geneva. I am also a member of the executive board of the Royal College and that is our collaboration. We are responsible from our department with global responsibility of maternal health.

Q96 Chairman: Thank you for that. It is extremely helpful just to have that brief introduction to your own backgrounds. As you can see, what we are looking into is, in practical terms, how DIFD and donors like DFID can be more effective in helping developing countries to deliver improved maternal services. What do you think that an organisation like DFID could do that would help strengthen health systems in ways that would deliver results? In other words, are we talking about developing the infrastructure network, developing the expertise, the human resources, providing the drugs or the monitoring of all of that to make sure it happens, because we have evidence of resources being put in but not actually getting to the people who need them. We have had anecdotal and specific evidence for example in Chad of essential drugs simply not being available in the country. Could you give us a flavour of where you think the priorities are? They are probably everywhere but have you some thoughts as to how they can be channelled down and focused effectively by the intervention or support of an organisation like DFID?

Dr Falconer: Your question is very penetrating but I guess, from the position I am coming from— we will have different positions— it would be human resources. The bottom line of what I have heard in the previous hour is that the thing that really is missing in most of the provision of health care to labour in women overseas is people with the skills. The position that we are coming from I think is a multidisciplinary one to training. Our principal responsibility in the Royal College has always been training. Over the years we have been active in training doctors. We have a huge membership overseas, organised in networks. For instance, if you look at an old fashioned map, most of the countries that are pink on that map will have representative committees and large numbers of members and fellows, so there is a certain standard and quality for provision of care with the doctors in those countries. I think now we need to be more adventurous in this because the evidence is that SBAs[5] are the critical, key player in terms of provision of primary health care to women. New models need to be looked at for how you train other health care professionals. That is the position I come from. The issue you raise about drugs I guess perplexes most of us because the major obstetric drugs— be it oxytocin, although that has a problem because that has to be kept in the fridge— but, if you look at magnesium sulphate, it is dirt cheap. There is no provision in terms of care and how you manage that and it just bewilders me why provisions for that are so problematic. People who have spent much more time overseas will be able to answer those questions, but that should not be a major difficulty. The last point that you made I think is incredibly important, which is quality assurance and having some audit on what is going on. Nowadays we need to get into the situation where, whatever interventions we do, whether they are training or whatever, there is an audit trail on those so that we have evidence of good practice. Nynke, I am sure, will talk about some of the courses that we have delivered overseas in terms of training people.

Dr van den Broek: That is right and I think I agree with the previous evidence that you need to have a functioning, good health system to be able to have equitably distributed maternal health services. I am encouraged that there is increased advocacy for this because that is needed. MDG 4 and 5 have not been highlighted. Malaria, HIV and TB have been much more prominent. Perhaps it may be easier to solve them. It is quite clear that there are insufficient good quality services available worldwide for women who are about to deliver or who have complications of pregnancy delivery. You cannot really develop one without the other. If you can use the development of a good system and that is management, governance, finance, all the things that we know you need in a health system, the infrastructure, the drugs but also the governance and focus on making sure that at least a minimum number of health services are available for maternal health, then you can see how one influences the other. You will make a real difference and there is evidence for that. It is very clear that the two key health services, if you like, that are needed are skilled birth attendants and essential or emergency obstetric care and they are very well defined. That is what I would go for and unfortunately that is more complicated than saying "we are only going for drugs". You need to address the spectrum.

[5] Skilled Birth Attendants (SBAs)

Q97 Chairman: I kind of expected you would say that. It is really trying to see how these things fit together from your point of view as professionals.

Dr Islam: We discussed this morning whether DFID should provide budget funding or vertical funding. It would be good to provide budget funding but with some indicators to ensure this funding is being utilised for priority activities. There has to be a monitoring system because if you are providing only the budget funding without any indicators or control then the money can go anywhere. How then will you ensure that money is going to be spent on the health system? The maternal mortality rate is one of the indicators for a functioning health system. I would like to see improvement of maternal health become an indicator to assess how countries are using the funds. If you add those indicators, then budget funding would be a good thing. To give an example, when DFID funded a project in Nepal on maternal health, they had improved the system making surgical procedures and blood transfusions available. This improved system not only helped maternal health but also other programmes. In road accidents blood transfusion is necessary, surgical expertise is necessary, the system could be used. The health workers with surgical training were there to provide services in those cases. So I would suggest incorporating some indicators in budget funding. Then, also some vertical funding needs to be available. Last week I was in Zimbabwe and I visited one of the midwifery training schools. The school did not have the necessary books. They have only one midwifery book and 120 students are using the same book. One book costs nowadays $29 million Zimbabwean which is nearly $29 US. It is now $950,000 Zimbabwean for $1 US. We changed in one day from $800,000 to $950,000 Zimbabwean for $1 US. You can understand what is really happening. The books are not there. The number of faculty members has gone down. There are supposed to be seven or eight faculty members in that training school. They have only three. They do not have the right number of trainers. They do not have books or dummies and the charts are old because the funds are not there. I was so surprised to see that the students are really willing to learn and to contribute to the nation, but those necessary supplies are not there. We need to look at how we can improve the training facilities and providing the training. Then look at part of the supply side of it, particularly in maternal health. Oxytocin, magnesium sulphate and antibiotics are the most needed supplies. These are a few things which are necessary for maternal health. More importantly, DFID and particularly the parliamentarian group can also look at investment issues in developing countries like Malawi, Zimbabwe or Chad. The developing countries should not only be looking at what money they are getting from DFID but need to look at what they themselves are investing to improve maternal health. The countries need to also look at how the national budget is being allocated. What are the priority areas? This year with the UK Parliamentarians in Westminster, we got the parliamentarians from 15 developing countries and discussed how parliamentarians can raise that issue in their own parliament to increase their investment on maternal health and in other social sectors. That also needs to be there. The last issue that I would mention for DFID's support is the monitoring system because today if you ask the polio programme they will be able to tell you exactly where polio is coming from, where the outbreak has happened, but for maternal health the monitoring system is still very weak. We need to really invest more on the monitoring system and see how at the district level they can use the monitoring system data for planning, not only to send it to the national headquarters for a report to come out after four years and it has not been used. They can improve how districts use data for their own planning purposes. In those areas, I think DFID has done good work and DFID's support for maternal health is really tremendous. We need to look at all those things and decide how we can provide funding support.

Q98 Hugh Bayley: I just wonder what role there is for the private sector to make a contribution to reducing maternal deaths in developing countries?

Dr van den Broek: Many countries are addressing this issue because it is recognised that in a number of countries the private sector is, if you like, going up, which generally means that people with more money have better access to care. The report we compiled brings that out a little bit from people working in various countries, looking at different mechanisms with which you can make use of the skills and expertise, which are more available in the private sector, and distribute them more equitably. There are small scale projects where this is happening, where members of staff are doing both, some private and some more public orientated. There are bigger projects in districts where private hospitals adopt smaller hospitals and make a very close link. There are also other problems with the private sector in that they might not be helping. I think they should be regulated, especially with regard to for example Caesarean section rates or quality of care that is being given, so not perhaps for evidence based care but for financial incentives. There needs to be better international regulation of such institutes who will want to be highly accredited and seen to be doing the right thing. This has recently been approved for example in Sri Lanka, where at the moment less than 7 % of deliveries are happening in private facilities. They are looking for regulation but there is no international guideline either from the UN bodies or from us, so there are opportunities and I think the time is right to address this. It is too simple to give one simple answer but it is no longer okay to ignore that the private sector is growing, including for maternal health.

Dr Falconer: It is a very interesting question and an analogy with our own system. There is an inherent conflict here. If you look at where medical personnel are in many of these under-resourced countries, they will be in the major conurbations and they will be doing some private sector work. You cannot maintain these staff in the rural locations. One of those conflicts is that they get paid so poorly in their

basic hospital salary that they have to do private practice. Certainly my experience of visiting many of these people is that they have to work in the evenings and through the night to make their money. In terms of what impact that makes in the totality of health care, I would think it is probably relatively small in those countries.

Q99 Chairman: It does not have a political fall-out? Some of the statistics we have seen are that in quite a lot of these developing countries what you might call the elite, the better off, do not suffer all these dreadful maternal deaths and problems so they do not perhaps see the need to fight for those who do.
Dr Falconer: This is again going back to the training issue in terms of who should you train. If you train people who do a Caesarean section who are not doctors, then they will not be attracted because they cannot charge that fee. Again, in terms of where you put your resource, you may be better not to train people like me.
Dr Islam: We need to also look at the issues of the private sector. Of course the private sector has to play a bigger role but there are issues coming out that we need to look at while considering the private sector. Because out of pocket expenditure is high and going up why not invest in the private sector? Then we need to look at the out of pocket expenditure. A poor man: is he buying health or remedies? If somebody has had a cough, a poor man, he does not go to check whether he has TB but he goes to buy a cough mixture, just for the remedy. If this poor man has got a high temperature, he does not go and check whether he has malaria or pneumonia. He goes for Paracetamol. They are buying, spending their own money, just for temporary remedies but they are not buying health. This is out of pocket expenditure. Looking at only the amount of out of pocket expenditure and then saying, "Okay, out of pocket expenditure is so high, like in India 60 % of total health expenditure is out of pocket expenditure, therefore we should go to a private sector." That should not be the argument. We need to look at the private sector which needs to play its role but at the same time we should not be avoiding investing in the public sector. The public sector has provided support for a long time and we need to look at why the quality of services is going down. Private sector salaries and NGO sector salaries are higher than public sector salaries. So we need to look at the other issues, at why the public sector is not functioning before we say forget about the public sector.

Q100 Sir Robert Smith: On the scale of the human resources issue, in previous evidence we were told about the need for 2.4 million health workers, including 700,000 midwives. Dr Songane emphasised that mid-level providers like midwives, nurses and medical officers can be as effective as specialists in providing emergency care. What aspects of emergency obstetric care can be carried out by a specially trained nurse without requiring a doctor's intervention?
Dr Falconer: It depends on the level to which she is trained and how astute she is but if you look at the real life threats in terms of eclampsia, in terms of haemorrhage, there are first aid things that you can do and I think that is in that evidence in terms of putting up magnesium sulphate if you deal with an eclamptic patient. That is quite within the roles of all midwives and, if you can, transferring the patient to a safe place for confinement but again, if you do not have that, just that intervention by itself will probably save that patient's life until they deliver. Haemorrhage is a more complex issue because massive haemorrhage requires supplementation, or may require supplementation, with blood and that obviously is not available. Doing a Caesarean section again is a variable thing particularly in many of the African countries. The majority of Caesarean sections are not performed by medical people at all and the data is very encouraging. Also, it is much— can I say this word here?— cheaper. There is good evidence.

Q101 Sir Robert Smith: The outcomes are successful?
Dr Falconer: Yes. The quality of the research is difficult to evaluate but certainly in pure numbers it looks as though Caesarean sections done by medically qualified doctors and those done by what they call, I think, clinical officers, are very similar. In terms of what responsibility we have this end, we still come back to base. We have a major training issue responsibility and you have always got to have leaders. You have to have people who can train people out there and essentially you will never get away from that. There is a need for a core of medically qualified people in any of these countries. Historically, that was a responsibility enjoyed by this country. Sadly, at the moment, the door has been slightly shut because International Medical Graduates are not able to come to the United Kingdom. That may open up again because the number of British graduates has gone up so high, but in our discipline we still rely hugely on people coming from overseas. What we need are structures so that people can come temporarily to get the training access to the qualities that we enjoy and then they have to go back. That is the difference.
Dr van den Broek: Without a doubt there are eight clear single functions of emergency or essential obstetric care. All those eight functions— i.e., putting up IV[6] or anti-convulsants or oxytosis, the manner of removal of the placenta, assisted delivery, vacuum aspiration for incomplete miscarriage or abortion, Caesarean section and blood transfusion— they can all be performed, the first seven, by nurse midwives and are in practice performed by nurse midwives, if they are there. Very often they are not necessarily legally covered to carry out some of these skills and they have very little training in these skills. Tony alluded to it earlier. There is a need to build the capacity and the skills of this cadre of health staff, apart from increasing the numbers, because I think I fully agree there are

[6] Intravenous (IV)

insufficient, but to encourage them and to improve the quality of care they are delivering. Caesarean sections: again, you do not need an obstetrician or gynaecologist to do a Caesarean section. You might want them occasionally to look at the quality and training of doing a Caesarean section and worldwide of course most women are not getting Caesarean sections in time and there are insufficient people and resources to provide them. There is a huge human resource issue there but skills upgrading is being discussed in many countries and there are various models for doing this but I would say it needs a lot more attention and close monitoring of what happens if you improve people's skills, the effectiveness of delivering the care, the quality of care and whether the numbers of people coming to the institution for delivery and for emergency complications go up because they know when they go there they will get good quality, effective care.

Dr Islam: We also need to look at all those initiatives that are good. We need to have human resource planning. Sometimes the countries are deciding because they want to do something "in the meantime", what they need to do, but are not looking at the long term issues: their legal issue, their employment issue, their retention issue, their career issues. There are a lot of issues they need to look at. Whenever the countries are thinking of creating a cadre for certain work, we need to really look at all those issues and develop a long term human resource plan. The countries need support for this. Bangladesh now are giving training for community midwives. It was decided by the previous government. Another government might come and disrupt it completely, it has happened before. There is an instance like that, so we also need to look at human resource planning which is long term so that there are no disruptions and you don't lose more money and time rather than gaining anything.

Q102 Hugh Bayley: Could I look at the tier of health workers below that, the community based people, traditional birth attendants? What should they usefully be doing and how can their training be supplemented to ensure that they provide high quality care? Do they need equipment kits?

Dr van den Broek: This is a big, international debate which is probably why you are asking the question as well. The current strategy— and there is good evidence for that strategy— is that we need a skilled birth attendant at the time of delivery because that is when most of the maternal deaths and therefore the neonatal deaths occur. There is international agreement about the definition of what is a skilled birth attendant. It is a professionally trained person and then you can agree to deal with at least the basic social care. The traditional birth attendant— there are various names and various cadres— is generally not able to provide that. Even with a certain degree of training, they almost need a minimum of 18 months' training and then they become a sort of public health midwife like in Sri Lanka, as opposed to traditional birth attendants. The role of the birth attendant is probably— many countries are thinking about this both in Asia and, I believe, in sub-Saharan Africa— more of one in the community to help with emergency preparedness and to help so that the woman is able to prepare for her delivery and then seek skilled birth attendants, most usually at the facility. There is definitely a role for the TBA.[7] Different countries have different strategies for what that should be.

Dr Islam: I can give an experience of mine working in a village health complex in Bangladesh. A woman came after three days of labour with hand prolapsed. I examined that woman. The vulva was swollen, smelling like anything. She had a high temperature. The hand was hanging outside and the skin came off of the hand of the baby because for three days they were pulling the baby by the hand. That is what we are talking about: delivery by mother and mother-in-law or TBAs. If we look at the causes of maternal death, number one is the haemorrhage, what would a TBA be able to do at home if somebody is bleeding? Next one is the eclampsia which is a fit. What can a TBA do? The next one is sepsis. Sepsis is happening. Pregnancy and childbirth is a normal, physiological phenomenon. If you do not do anything, 80 % of the delivery will happen normally, but 20 % will need some support, just to give you an example. Today, in many countries where there are no skilled birth attendants or midwives, the complication rate is 40 or 50 % because we are introducing complications because we have no trained people. Untrained people are making our burden higher. When you are talking about the normal delivery at home, you need trained persons with many more skills. When deliveries happen at the facility we have a lot of other people who can provide additional support. But when you are delivering at home, even in the UK when you are talking about home delivery, you need many more trained persons, much more access to other accommodations, transport and other things. The TBAs, according to all the metanalysis done so far, really did not improve maternal health or maternal mortality. They did not. What we are looking at is a collaboration with the TBA? Yes. Investment? Maybe not. We should be investing in the right strategy. In 1987 the same issue came up: TBA or not TBA? Then there were forceful arguments: "skilled birth attendants take time, in the meantime we need to do something" and in the last 20 years we did not really invest in the right strategy; we invested in TBAs. We need to look at the long term issue. We need to invest in the right strategy. Yes, TBA can do some collaboration, some support, psycho-social support and also support of the baby, but delivery and childbirth is a complex issue and particularly at home. It is a much more sophisticated issue which cannot be done by TBAs.

Q103 Hugh Bayley: What proportion of births in Bangladesh perhaps or in rural Africa are attended by a skilled birth attendant?

[7] Traditional Birth Attendant (TBA)

Dr van den Broek: In sub-Saharan Africa skilled birth attendance is between 40 and 60 %. Each country has its own data. In Malawi, it is 45 %. I recently looked. Kenya I think is slightly higher but within Kenya or within Malawi you have non-equitable distribution so you might have areas where it is very low, where there are very few—

Q104 Hugh Bayley: My prejudice would say you are talking about urban Africa, are you not?
Dr van den Broek: No. That is the average figure. In urban Africa it might be much higher.

Q105 Hugh Bayley: Exactly. That is what I am saying. If it is 40 % coverage, then most children in urban areas would have a skilled birth attendant and few mothers in rural areas would have.
Dr van den Broek: In urban areas it is more than 50 % generally, yes. Bangladesh I do not know about.
Dr Islam: I think you are pointing in the right direction. We need to look at the urban area. In most of the countries, the rich people will reach MDGs, not the poor people. Why should we be providing poor options for poor people and all the higher options for rich people? The politicians in the country need to decide the right strategy. Every woman should have the right to the best care during pregnancy and childbirth and the best care would be a skilled birth attendant and access to emergency obstetric health care. What are we trying to say? The government and the politicians have to take the decision. Yes, it will take time but the decision has to be made today.

Q106 Ann McKechin: Can I follow on with the issue of geographical spread of medical experts and the problem of trying to incentivise the doctors and skilled employees to work in rural areas? I wonder if you could give me some indication of what actions you think have worked in trying to incentivise that? What are the key components? Is it issues of salary? I think you mentioned, Dr Islam, that also there would be an issue of the general conditions in which people are living and also the back-up they receive. I just wonder whether or not you can point to any good examples which you think DFID should be supporting.
Dr van den Broek: Generally health care providers the world over are the same. If you can provide them with good housing— in many countries, the government provides an increased housing allowance if you live in a rural area or the government builds houses in rural areas— then it becomes more attractive. Also, nearby education or extra salary to deal with having to send your children further away for education, for example. There is a number of incentives that can be used. I would have to ask our human resource expert. I have not recently read the report on which countries have the best and the most successful initiatives. I only know anecdotal evidence from the various countries. The one we most recently discussed is the one in South Africa where young doctors are made to work in district hospitals. I was talking to one of my colleagues from South Africa in the last month and that sounds like a very good idea. I always thought it was a good idea, but if the working conditions are not adequate, if the supervision is not adequate, they actually find it very difficult to function to the extent that they would like to function, just having come out of medical school. They become very demoralised and I understand there is quite a high suicide rate and depression amongst these people. Again, there is not a very straightforward solution. In north Nigeria, where we visited, it was quite clear that doctors said, "We need extra salary if we are to work out in that particular state because it is two hours away" and a certain amount of commuting was being done which was making it difficult to ensure 24/7 coverage with maternal health services. That seemed to be an incentive that was working relatively well, so different strategies I think.
Dr Islam: I go back again to 1979 when I had finished my medical education and I was posted to a village health complex. I went and I joined at the complex but some of my friends, because they had higher connections, managed to change their assignments. Why am I saying this? Because this is a question of good governance. If the doctors know that they will be in a village complex for a certain period and will not be rotting there for a long, long time they will go there. So it is not only the salary; it is other incentives. If you go and work, you have to work in a village three years or four years after graduation. If you do that you have access to higher education. You will be able to apply your higher education. That would be an incentive. Talking about accommodation and other things, that is also an issue. In India, in Himalchal Pradesh, where in the winter there is snow, nobody can go out. What the Chief Minister decided was that any doctors going there, working in the winter season, would get one year's salary more as an incentive. Their children will have the education facilities. There are a lot of other incentives you can provide. Salary increases will not be easy to provide because there is a public service issue. But there are other ways of providing the incentives. Mostly, we need to have a fair system so that individual doctors and nurses understand that even if they have a protest they will have it fairly because everybody is doing their duties. But it is not really happening because of an absence good governance.
Dr Falconer: The brain drain is what you are alluding to. If you talk to doctors in the United Kingdom on whom our health service has relied, as you know, 40 % of the infrastructure is made up by people who trained overseas. If you look at countries like Mozambique, I think Mozambique has 750 doctors now in the whole country. My hospital in Plymouth I think has more doctors than the whole of Mozambique, just to put it in perspective. If you ask these doctors from overseas, "Why do you come to the United Kingdom?" you can imagine. You get free health care. You get good schooling. You have political stability and you can externalise money back to your roots. Many of these doctors are externalising large amounts of their salary, so they are far more effective in terms of their infrastructure responsibilities and they are different to us. I have to

be very careful in what I am about to say because I think many people have gone into medicine for totally altruistic reasons or certainly they used to, and now it is a business for many of these people.

Q107 Ann McKechin: I think that is a distinction. Perhaps in some countries you mentioned there was compulsion. In somewhere like China, Nicaragua or the Communist regimes, people were compulsorily sent out or in the past people went out based on religious motivations. It seems it is trying to get the right mix of finance and other support.

Dr Falconer: I am slightly naïve on this and what DFID can and cannot achieve but whether you can develop contracts for certain of these countries overseas to say, "Yes, we will take you for a short time, a two year block. We will train you and you can acquire these quality standards that you want to take back" and they have to go back. There are models for that sponsorship scheme but it may be that that should be developed further and you could top slice a certain number of training opportunities in the United Kingdom and, say, fill those with people from the countries that we want to develop and then send them back.

Dr van den Broek: I also wonder whether personally I can add to that, having visited most of these countries. I realise that we in positions of leadership and maybe power do not pay enough attention to these rural areas. It is much more difficult to get there, to go and see what is happening. I am not sure that these people always feel valued or part of the system and that is partly to do with us and how important we make services in the periphery. It is very easy to concentrate on the urban assessment, the urban needs and so on.

Chairman: We saw evidence of that when we were in Malawi. We visited a rural hospital which was desperately poorly staffed and equipped with a huge number of patients and you could see that.

Q108 John Battle: You have opened up the whole question of the global economics of it. It is interesting that you helpfully open it by raising the question: is health care a business because, if private hospitals or care homes in Britain are recruiting nurses, I met a midwife in a care home looking after older people precisely because she could send more money home as remittances to her village. She believed that was doing more good than working in her village as a health care midwife. We have heard in a previous session about— I think it was 2.4 million overall total shortage of health workers, absolute shortage, and included in that figure are 700,000 midwives. I just wondered where the debate would go in terms of: you cannot just have a fair system in one country, can you? Global economics, whether it is telephones or whatever, as the jobs fill around the world, what more could we do perhaps to encourage not just sponsorship but exchanges? Do you think in the wider world of medical care that, if I dare said the ethics of exchange or the idealism of it, is still there and would work where trained people here also went there and vice versa— could that be opened up in a new way?

Dr Falconer: Nynke is the expert on ethics. I am not good on ethics but I will talk about the exchanges a little bit because historically that was the very pattern that used to happen. I am an example. I worked in Zambia and in South Africa. Very many did. That model needs to be developed. If the opportunities can come for people to come to the United Kingdom, many of our trainees' whole lives would be transformed by working in the developing world. You ask which countries do we have an association with? I am just talking now of the RCOG. All our roots are with the old Commonwealth, rightly or wrongly. They are beginning to change a tiny bit but if you look at India we have a massive presence of people there. If you look in South Africa, we have a big presence there. In east Africa we have a much smaller presence but those are the countries, so inevitably, because we have little infrastructures there, that is where we would look to.

Dr van den Broek: I did not know I was an expert on ethics, but we are very concerned about this issue of brain drain. I am not a global economist but I did some Economics at O level. I thought if you had enough nurse midwives the world over then you would not have this issue of us having to poach and America having to poach. We really must put more emphasis on training a higher total number of people. Yes, there need to be incentives for them to stay, maybe bonding, quick employment, proper salary, proper status, but I suppose legally and ethically you cannot stop people moving around. Perhaps we do not want to stop people moving around but the bottom line, as I understand it, is there are insufficient health care providers, particularly midwives. Maybe we should strive for that primarily.

Dr Islam: There were some interesting discussions in 2005 on brain draining where all the ministers were there and discussing the issue. Some countries from Africa were asking for compensation but the Philippines were saying, "No, do not stop our brain drain because that is our foreign currency". So we cannot stop people moving and everybody has the right to move around. There is no one solution to this issue. What I was talking about in Zimbabwe— the training issue. Can we think about improving the faculty and training schools so that they can have enough people trained there which they can have and also fulfil the demand of in the USA, the UK and everywhere where there is high demand for this cadre of people. In the UK or the USA nobody is very willing to go for midwifery and other training. If you have freedom of movement, you will not be able to say you cannot move, so we need to look at where is the best way. The country really needs more investment on training at the country level and good quality training.

Dr van den Broek: There is good evidence coming out of Malawi, where DFID has said, together with other donors, that there are ways to improve training in country by exchanges of tutors but also strengthening our midwifery schools and all cadres of staff in addition to supplementing of incomes which you will know has been done in Malawi. I was

just reading that report. It is available to read. It discusses the issue of the whole structure and support of human resources once they are trained, so they need to be available to be trained. There needs to be a minimum of education so you can have the right quality people to go into training. Once they are trained they need to be immediately deployed, not having to wait for two years for a contract from the Ministry of Health. They need to have in-service training. There is a whole model by which this can be implemented, which I understand has been evaluated as part of the general evaluation of sector wide approach in Malawi by DFID.

Q109 John Bercow: You mention Malawi and of course the Malawi Emergency Human Resources Programme running over a period of six years is one means by which DFID is seeking to address the problem of low human resources capacity and brain drain. You refer to improving the rate in Malawi and that prompts the question— or at least you give the impression of being open minded about it— what evidence exists to support the use of emergency schemes of this kind and what dangers, if any, do they carry?

Dr van den Broek: We have talked to the human resource experts, because this is not really my particular area of expertise. I understand that the jury is still out whether the £52 million from DFID and then another £50 or so million from the Global Fund, over a period that I think started in 2004 and is meant to go on to 2010, has had an effect. The bottom line is it is quite difficult apparently to monitor what happens to such monies, a 52 % increase in 11 cadres of staff in health provision as opposed to the rest of the public health sector, because of the way the monies were administered. They were either part of basic salary or part of allowances. I understand it is easier to monitor if they are part of allowances. There is a desperate need, now that this has happened in Malawi— I think it was meant to be a test case— still to commission a separate report just to look at that issue, to come up with lessons learned because the jury is out and the answer is not that simple. It seems to have done some good and some not so good.

Q110 John Bercow: It raises the associated question of whether, even if there is a benefit from such a targeted initiative, there might not also be a displacement effect. This of course is very much a feature of the political system in a great many countries. It is a feature of democratic policy in a sense that the people who lose out might well be disparate and in a number of different locations and not even be aware of the fact of their losing out and therefore disinclined or unable to protest about the fact that they have lost out; whereas the beneficiaries of the targeted intervention are likely to say, "Three cheers".

Dr van den Broek: That is true. Two of the immediate criticisms, if you like, of the way it was handled in Malawi: one, it was not immediately transparent to all the cadres of health care workers how and when this was going to happen; two, it would seem— but you should really get a proper report from the human resource people evaluating it— that the people at the top got 800 % on places and the people at the bottom got 150 or something. Please do not quote me on the figures. It is not that simple to just pour £52 million into a government and say, "Go ahead" along with other things like finance. There is this huge issue as to the capacity of ministries to monitor a huge amount of money and there is insufficient accounting probably.

Chairman: We had one anecdote from a nurse in Malawi who said that she got a 52 % uplift in her salary which was quite helpful but, on the other hand, the government had made education free and the standards had fallen so low that she was now having to pay school fees which were more than the pay increase, which I think is John's point about unintended consequences and their subsequent effects.

Q111 Hugh Bayley: First of all, on Dr van den Broek's comment about training in relation to the brain drain, I am all for improving the volume of the numbers of people training in developing countries but surely, if you really want to deal with the brain drain, you should be substantially increasing the number of doctors, nurses and sub-degree level nurses who train in this country. Leaving aside the intellectual exchange in training issues, which we want to retain, the immigration rules say you can only appoint a Philippino nurse if you cannot find a British nurse.

Dr van den Broek: I absolutely agree. There need to be enough midwives worldwide to look after women who are pregnant and need to deliver.

Q112 Hugh Bayley: Maybe one of our recommendations should be that UK training of health personnel should be a manpower/person power plan that affects our training?

Dr van den Broek: Yes. Maybe use that experience. Also, maternal deaths are happening in resource poor countries on the whole. I agree entirely but can we use that experience then to also help resource poor countries improve their training and their numbers so that we are sharing.

Dr Falconer: The only plea I would make is that we are British personalities and we should be leaders in many aspects of health care, as we are in many other things. If you are going to influence countries, you have to maintain an opportunity for those people to come over and work and be influenced by us, whether they are midwives, nurses, doctors or whatever. I support entirely your philosophy. If, as it should be, you provide for our own needs within the United Kingdom, you have no need for external people. We still need to maintain a two way dialogue and flow. One of the dangers of where we are currently going that I am a bit scared about is that that two way dialogue may stop because we just have to protect our own people, and literally I do mean protection because you may have medical unemployment for the first time ever in the United Kingdom in the very near future. I maybe wrong.

Ann McKechin: That would encourage them to go elsewhere.

Q113 Hugh Bayley: I agree in principle although I do know that, even if you take somebody for a one or two year training programme with the expectation that they will go back, they may well find they are better trained and more marketable in some third country rather than going back.

Dr Falconer: I accept that. I am talking institutionally now. The advantage that we have is that, when they go back, they are always part of our organisation and the quality standards— we have not talked about this at all today— that we produce are not just applicable to British women. They are applicable internationally and when you travel overseas and you talk to doctors who are members of our institution what is the one thing they really like? It is that they can go on a computer if they have access to it and get the clinical standards. We talked a little bit about eclampsia earlier. We have very good guidelines and those can be translated everywhere.

Q114 Hugh Bayley: Why is it so important to have good statistical data on maternal deaths? You have said in your evidence it would be good to adopt a look alike to the UK confidential inquiries approach. What would that look alike look like stripped down to its bare essentials in a developing country and why is that different from what is available now?

Dr Falconer: 1952 was the first production of the confidential inquiry into maternal death. That is still today used as the hallmark in many countries of the world as the paragon of audit. That does not answer your question specifically to overseas but that is what it starts from.

Dr van den Broek: Your first question is why statistics, because I have heard numbers talk probably more than not having numbers. It is very difficult to collect maternal health or maternal death numbers, as you have heard already. In some ways it might be a better effort to look at why mothers are what these audits are all about. There is good evidence especially from South Africa where they have really started on a very good national confidential inquiry system. From that they have identified exactly what the problems are and have used that to focus intervention and focus budgets to address those issues that are still not in place, which is why mothers die. Sri Lanka has also a very good maternal death audit system but it is in the field, so there is a self-evaluation of every maternal death by health care staff involved or community staff. At the district level, that brings up all the issues that need to be addressed to stop this, hopefully, happening next time. The problem in Sri Lanka is they have not reached the national level and they are not producing beautiful reports, but they are doing it. Then there are countries like Tunisia, if you like, where everything is there but birth registration, death registration. The private facilities are somehow outside of the system but the majority is there. Again, if they had a little bit more effort and understood the importance of this, they could produce these statistics almost or at least why are these women dying in our countries still. That would help to address the problem.

Dr Islam: We have issues if you look globally. Only 35 or 40 % of countries have got death and birth registration and causes of death reporting, so the other people are not reporting. I always like to give an example. When I was getting married in Holland, they wanted my date of birth registration certificate and I gave my school certificate. That was my date of birth certificate. They said, "No, we want something from your birth registration in Bangladesh", so I had to call my mother. "Can you please give me my date of birth registration?" Then the person in the register called me. "Can you tell me when is your date of birth?" so I had to tell her what was in my school certificate. There was no registration. That is the situation we are talking about. Why statistics really? It is necessary. A demographic and health survey has been carried out in 78 countries and they publish very good documents. It is being used at a national level but what we are doing now is some secondary analysis of those data like in Zimbabwe, like in Zambia, like in Chad. What we are doing now is to see the difference between urban and rural births, access to skilled birth attendants, Caesarean section and other things. What is the difference between different districts? Are all the districts performing the same or not? What is the difference between rich and poor? If we do the secondary analysis, then we can say where we really need to put our attention. That is where the statistics are necessary to really plan where we should be putting more emphasis. Is it universal coverage for everybody or do urban slum areas we need more attention or do rural areas we need more attention? The data will provide you with that and the data also provide you with support for advocacy purpose at the national level and at the global level.

Q115 Hugh Bayley: Who should take the lead— should it be the World Health Organisation— to ensure that a reasonably competent minimum set of data is collected in each country? You have cited a couple of examples, Sri Lanka and South Africa. Rather than British donors using the Royal College's model in a few hospitals where they work and a different system being used in a different region, somebody has to look at it strategically, have they not? Which should be the agency that leads this globally?

Dr Islam: There is a global initiative which has been supported by different donors and also by DFID, the Health Metrics Network. The Network is looking at how they can improve the statistical data collection and analysis that are used at the national level. The Network is housed in the WHO. The partnership for maternal and child health is also housed in the WHO. We realise the monitoring system is not really working. That is why we are trying to improve that system at the country level. From our side and from our department, we are trying to develop the country level, as well as the district level, monitoring and evaluation system.

Q116 Chairman: There is just one final issue, thinking of our own experiences in the countries we visit. Rural areas are very rural. The roads are very rough so many, many people are living not only a long way from any existing infrastructure but one suspects quite a long way from any potential infrastructure. The question you have is: in reality, is the only option for those people that they have skilled birth attendants in their community and an expectation of home births and possibly some process of identifying risks that you can identify prior to delivery but not obviously being able to transfer at the point of delivery very far. What is the priority? Is it to get women to be where they can actually get full clinical intervention or is it to try and give them the best you can in home delivery circumstances, knowing that that is still going to leave some of them at a risk that is not able to be addressed?

Dr van den Broek: It is an interesting point that is put to us quite often. Where we have done surveys of districts or regions to see what facilities are there, generally there are quite a large number of facilities, structures, some degree of staff, but none of them are fully functioning. Often, there are a lot of different facilities; none is properly functioning. It needs to be rationalised in line with at least a minimum agreed by the UN bodies of full basic emergency obstetric care and one comprehensive for half a million people. That can be done, maybe not with the minimum, but it is a focused approach. That can be mapped out and carried out, together with making sure that women of course can access these facilities because, yes, there are issues of roads. There are very imaginative ways of dealing with emergency transport, motor cycle ambulances, stretchers. My experience is mainly in sub-Saharan Africa so areas like Afghanistan and the mountains of Nepal are a different case, yes, but in sub-Saharan Africa where a lot of maternal deaths are happening there are good examples of combining equitable distribution of especially the basic facilities, where at least the basics can be done by the nurse midwife and then transfer to a hospital which might take a little bit longer, plus transporting the patient.

Q117 Chairman: You are implying it would be a big mistake to try and trade one against the other. You really have to try and make sure they are both pursued together?

Dr van den Broek: I think so and that has been the struggle because people always want to hear it is this one, single thing.

Q118 Chairman: No. We want to know what you think.

Dr van den Broek: Our experience tells us that that is what we have to aim for.

Dr Islam: If you look at Africa where most women, 80 % or more, will come for antenatal care one time, two times or three times, walking all the way, but they do not come for delivery. Why? Because the quality of care they receive at the facility is abysmal. Sometimes supplies are not there. If you have seen that film on *Panorama*, *Dead Mums Don't Cry,* drugs and supplies are not there, so the woman does not want to come. The options we are giving women are either you die at home or you die at the facility, so they decide to die around their family. That is the issue we need to look at, the quality of care. The other issue is what Nynke said, a different type of transport. What we have done before is build a maternity waiting room, to have a facility near the main facility where women can come one month or 15 days before and they rest and do some type of work and, when due, they go to the main facility to deliver. There are different ways of looking at it. There is no single way we can reduce maternal mortality. If our goal is to reduce maternal mortality there is no other way but to provide skilled care and emergency obstetric care.

Q119 Sir Robert Smith: How quickly, once you provide the skill, would the message get back to communities that they can now trust the services provided?

Dr van den Broek: Very quickly. A month, I would say, but it is true that enough care and enough quality care.

Dr Islam: If you look at Botswana, that got independence in the 1960s, at that time Botswana had a low percentage of delivery by skilled birth attendants or at the facility. Today, 98 %. If you look at the local tradition, they managed to change because they are providing reliable, quality care. That is why women are coming there. It was nice to work for ten years in Botswana because of the quality of care they are providing, so it is possible.

Chairman: Thank you. That is extremely helpful to our inquiry. You have really taken us through those issues with a great degree of clarity as well as your own expertise both as professionals but also with real experience in dealing with the countries that we are most concerned about. I really want to thank all three of you very much indeed. It has been a really helpful session.

Thursday 22 November 2007

Members present:

Malcolm Bruce, in the Chair

John Battle
John Bercow
Mr Stephen Crabb
James Duddridge
Ann McKechin
Jim Sheridan
Sir Robert Smith

Witnesses: **Mr Richard Horton,** Editor, *The Lancet*, and **Ms Brigid McConville,** White Ribbon Alliance, gave evidence.

Q120 Chairman: Can I bid you good afternoon and thank you for coming in on this inquiry into maternal health that the Committee is carrying out. We have had a considerable amount of evidence. We have already taken some formal evidence, and I would not say the Committee is yet expert, but we are beginning to get to grips with the issues of what is an extremely demanding international ambition which we are falling a long way short of achieving. I wonder if, for the record, you could briefly introduce yourselves and then we can perhaps proceed with some questions.

Ms McConville: I am Brigid McConville. I am a journalist. I was elected to the Board of the White Ribbon Alliance for Safe Motherhood in 2005. The White Ribbon Alliance is a unique international grass roots advocacy organisation based in developing countries. We have got 14 country alliances; we have got members in 91 countries. Our basic approach is that this is a social and political issue and that advocacy is the key to moving the whole issue forward, and the main problems are rooted in the low status of women and that the voices of the poor, especially poor women, are not being heard.

Mr Horton: My name is Richard Horton. A long time ago I used to be a practising doctor, but no longer. I edit a medical journal, *The Lancet*. We have a particular interest in international health issues, very broadly, and what we have tried to do over the last three years or so is bring together teams of international scientists to focus on neglected issues, of which maternal health and sexual reproductive health are two very important domains, to try and generate new evidence to inform the global and country debate around solutions to these challenges.

Q121 Chairman: Thank you very much for that. One of the things that have been said to us is that the ideal solution to the problems of maternal mortality is an established health service infrastructure on the ground that women can access, but that is a long way from where many developing countries are. There seems to be a debate about whether the emphasis should be on providing the services or actually helping with what their rights are and supporting their demand for the services. I wondered if you could comment on whether you think that the DFID approach has got that balance right or whether there is a need for reassessment of where the emphasis should lie and whether or not you accept what we have been advised, that DFID's record on this is, generally speaking, good, but feel free to make any comments that you think appropriate about your judgment of DFID?

Ms McConville: We feel that DFID has done an excellent job in many ways, especially in funding governments, and also DFID has supported the White Ribbon Alliances to some extent. Our point of view would be that, unless there is demand for services in communities, women will not have access to them. For instance, I do not know if you have heard the expression "the three delays"; that is one way of describing the difficulties that a women will face. For instance, if she goes into labour in Burkina Faso and she starts bleeding, that is a medical emergency, but there will be a great delay for her seeking help because she will perhaps think, for a start, that it is a matter of witchcraft, and after that, when they finally get round to moving her to a health facility, it could be a 30, 40 kilometre journey to the health facility. If she does not have any money to pay for the care that she will need when she is there, she will not be able to go. If she does not have her husband's permission, or in some countries her mother-in-law's permission, all those delays will prevent a woman in the community from seeking care and, unless we address those delays, even if the best services are there, she is not going to get to them. So, one is no good without the other would be our view.

Mr Horton: I think you point out actually a dilemma that has in many ways split the maternal health community in an extremely damaging way, because it has caused confusion about advocacy. Should one take the line, as many would say is the ideal solution, of a facility-based intrapartum care solution or (but maybe it is an and) have community based solutions? In terms of DFID's role, when you look across the array of donors out there, I would say that DFID has played an outstanding role in trying to get the balance right between those. It is a very hard balance, because you always end up upsetting one group or other, and they do, unfortunately, divide into groups rather clearly. The DFID approach, as far as I see it, has been to support very strongly the policy of facility-based intrapartum care but also to support very valuable research based in the United Kingdom into the efficacy, the impact, of community-based solutions; and over the last three

[1] Department for International Development (DFID)

years there has been a gradually accumulating evidence-base to show that women's groups in communities can be extraordinarily powerful in reducing maternal mortality, newborn mortality where you do not actually require facility-based intrapartum care.

Q122 Chairman: Is that by providing support in the community for the mother?
Mr Horton: Exactly right. It is about building up knowledge and social capital awareness and a demand from women in communities for maternal health services and local knowledge about very simple things related to hygiene. DFID has pursued this dual approach to try and accumulate knowledge, on the one hand, about community-based solutions that pursue a more political target of a policy of intrapartum care.

Q123 Chairman: So you say that DFID is good at identifying and, indeed, even encouraging the local communities and the women in the communities especially to express themselves. I do not know if that is Brigid's area, but that is the real key. You have kind of sat on the fence and said they do it, but I just wondered: are they proactively doing it?
Mr Horton: There is a divide between DFID's role in countries and DFID's role at the centre. I am talking about DFID's role at the centre in supporting the creation of a strong and robust evidence-base that can then lead advocacy for community-based solutions.
Ms McConville: I would say that DFID has supported some excellent projects. This is one that I received from DFID. It is a short participatory film project. I will give you copies later.[2] You will see here there is a community of mothers and midwives making their own film. This film was then shown in the communities outside the local hospitals. That raised the profile of the issue and of the women involved in those communities. It then went to the capital, Dar es Salaam, where it was shown in the Parliament building. The Minister of Health was there; all the leading figures were there. That raised its profile again. It then became a film that was shown on TV. The White Ribbon Alliance rang around all of the parliamentarians and said, "Watch this film and ask questions of the Minister tomorrow", and they did that in Parliament and that was a tremendous amount of pressure to improve human resources for maternal health. That is an example of a very successful project, but it has not been sustained. I think the other point I would like to make is that DFID is funding governments, which we welcome. However, governments do not hold themselves to account. Who is going to hold those governments to account? As MPs, you know how that works. You do need civil society to ask the questions. I can tell you that White Ribbon Alliance members in many countries are going out to the facilities and finding out who is there, and they might find that the Government has said there should be two or three midwives and, in fact, there is only a caretaker. They are bringing back the statistics and raising the pressure on governments to fulfil their duties and they are also then working with governments on policies and plans for the future. So I would like DFID to support that.

Q124 Chairman: Do you think that it could do more on that front?
Mr Horton: It could do more on supporting civil society, yes.

Q125 Jim Sheridan: Just on the community-based service facilities or, indeed, qualified staff, particularly in rural areas, and I have extremely limited experience: it is extremely difficult to get facilities or services or, indeed, qualified staff to move out of the city centres, if we can call them that, into the rural areas because most of the qualified people either want to emigrate to some other country or they want to stay where they are. The main reason for that, particularly if they have a family, is there are no education facilities for their children, and that is the reason why they do not move to the rural area. Is there anything that DFID can do to incentivise qualified people to move from the urban areas to the rural areas in order to deliver maternal services?
Ms McConville: You are absolutely right that that is a major barrier. Of course people who have qualified and worked very hard to get there are then reluctant to go off into remote and possibly insecure districts. I think that DFID can certainly help civil society and lobby government for perhaps better salaries and better incentives to work in those rural areas. Certainly in Tanzania they have been very successful. There has been a five-year advocacy campaign to persuade the Government to employ and deploy more skilled birth attendants to the rural areas, and I can provide you with those figures, if you would like.[3] They are quite stunning. That steady pressure has been very successful and, in some health facilities where no women were going to give birth, there are now 30 in a short space of time, and in places where there were two healthcare workers there are now four or six. So that steady pressure on government, if DFID can back civil society to help bring that pressure to bear on governments, I think is the way forward.

Q126 Chairman: That is a slight difficulty for DFID— I do not mean it is one that they cannot take on board— as to what extent are you responding to community needs or stirring them up or trying to manage them. In terms of the practicalities, how can DFID do that in a way that is ensuring that they are genuinely getting the response of the community rather than, even if unintentionally, manipulating or directing it?
Ms McConville: I was part of the Women Deliver team planning the conference that was on recently; there were some advocacy people in New York saying, "We need to start a global movement." There is a global movement. All over the developing

[2] Ev

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world there are people who are the people with the ideas, with the experience, with the energy. They are the people who know the problems. They are the people who know the solutions. They are the social entrepreneurs of their generation. They are often midwives who have had the tragedy of working with women who have died in childbirth, and that never leaves you. They are already working very, very hard, and this has not started with DFID, it started in those countries with those local people. In India, where the White Ribbon Alliance has been tremendously successful, for instance, there was a march to the Taj Mahal, I think in 2000 or 2002, and thousands of people attended that march. It grew and grew— parliamentarians, media and film stars were involved. That made such a big impact on government that they then invited the White Ribbon Alliance to work with them on planning and policy changes, and there was a tremendous shift there in that the staff, and even the auxiliary nurse midwives who were previously not allowed to perform certain life-saving skills, were then licensed to do so; that work is continuing and the White Ribbon Alliance is now working with government in six states. There are six state alliances as well as the national one. So, I would say that is not a matter of DFID stirring things up; there is already a tremendous amount of energy and activity that needs to be supported.

Mr Horton: Yes, I think that is right. I will try and place it in a broader context, because there is a danger of having a series of vertical programmes here. One of the things that DFID is doing very well and is being encouraged to do even more is to help persuade governments to support the health system more generally. It is not just about maternal health here. There is a whole series of issues for which the health system has to be strong in financing human resources stewardship in order to cover, including maternal health but also many other areas, so I would be careful about singling out one exclusively. If you go to a health facility in Northern Ghana, there will be a doctor there who is trying to cover surgery, paediatrics, maternal health, a whole range of things— just one person covering a huge area. It is that broad-based general budget support for the health system that has to be the focus, and that is, indeed, what DFID has been pushing strongly.

Q127 Sir Robert Smith: You have already touched on the balance between facility-based and community intervention. In September 2006 you carried an article by Anthony Costello and others that in the long run the ideal solution is the facilities based but in the short run medium term community interventions can make a difference. I think you said in an earlier answer that DFID were already funding research that was showing that community interventions could make a difference.

Mr Horton: They funded Anthony Costello's work.

Q128 Sir Robert Smith: Is this the only research, or is there other research that you could point us to that shows, in the short term, that having that community-based intervention would make a difference?

Mr Horton: This is one of the problems. There has been a lack of evidence about the community-based support. There are vitamin A trials going on, community-based interventions, women's group interventions; there are something like four clinical trials that are currently in progress in Asia and Africa, some of which are being done by Anthony Costello, many of which are being supported by DFID. So we are accumulating knowledge right now as we are meeting to try and answer this question, but to my mind this dichotomy that is being created is a false dichotomy. You need dual approaches. You are not going to solve this by a purely top-down building clinics and facilities. You have got to mobilise the grass-root support in villages if you are really going to tackle this as well, and I think that that policy message has not been strong enough out of UN agencies. I think there is a real problem in UN agencies over this. We have a UN system that, frankly, does not work very well. There is no single technical agency that leads on maternal health; it is divided amongst many. There is a paralysed partnership on maternal, new born and child health right now, and so we have a problem there in terms of global leadership, and I think DFID can play a vital role, an increasing role, in trying to mobilise that global leadership which is absent right now.

Q129 Sir Robert Smith: In mobilising the community to demand so that there is better delivery, is there an ethical dilemma in maybe raising the expectation of the community that that is what they need and, in a sense, creating a demand so far ahead of any supply that you are actually----. Is there an ethical dilemma there?

Mr Horton: I think if you go to villages and you just sit with village elders, with women and talk about the predicament they face, those kinds of dichotomies I personally have not seen; maybe others have. What you see is just a desire to take control of decisions about their health, to get access to services to which they do not have access and to find the best way to do the best they can for their families, their children and their community. These nuances that we talk about are really not very strongly evident in the villages that I have visited, which is why I think we need to be ruthlessly pragmatic about what we can do and not let ourselves fall into what are sometimes ideological traps: we must only follow this course because that is the ideal, that is the rights-based approach that says you must have this and nothing less will do. We need to be a little more, as I say, pragmatic about solutions.

Ms McConville: I would back Richard up on that. What comes to mind for me is that, when you go to villages and you listen and talk with the people about what is going on, you will get a sense of how incredibly hard people will try to save mothers' lives, how difficult it is, the dangers and the perils that they face— long journeys through the night, down rough roads where there are security problems, sometimes carrying women on wheelbarrows or on stretchers, sometimes for days on end, a woman who is in

agony, who is bleeding and dying. Often men get blamed for not giving enough support, but the number of husbands who have contributed to our Stories of Mothers' Lost exhibition and talked about their terrible grief at losing wives, fathers who have lost daughters. It is a whole community thing, and I think really that we have to all work together to support the people in communities, who are very intelligent and determined people, who are tremendously resourceful up against barriers that we can hardly imagine and they will do anything that they can to save the lives of their mothers, and we are letting them down, frankly, by not providing the health system that they need to make that possible. Why is it that there is no road for them? Why is it that there is no form of transport? Why is it that there no magnesium sulphate in the first health centre that they get to? It is as cheap as table salt. In an age where we have had astronauts on the moon for decades, it is a disgrace. We need to work together to make sure that we back the energy of those communities with an equal commitment to make sure that those lives can be saved.

Q130 Sir Robert Smith: Magnesium sulphate came up last time we took evidence. No-one could quite understand why something so basic—. It is not particularly rocket science.
Mr Horton: No.
Ms McConville: I can give you a view on that. It is that women are not valued around the world. A woman's life is of very little consequence, unfortunately, in many, many cultures, and that is the bottom line of all this and this is why this is a political issue. For a very long time it has been seen primarily as a health and a technical issue, and of course that is true, and we do need the health solutions, we do need the health systems, but the key to this is the advocacy to make that link, to convince the people who have power in communities (and that is usually men) and in governments to value the girl child, to value women. Girls do not get fed in the same way that the boys get fed around the world. Girls do not survive. They do not get educated. They do not get employment. They do not get health services. That is the level, and we can take the lead on that, I think, internationally.

Q131 Ann McKechin: Brigid, you spoke about a network of groups within developing countries who are advocating for change, but on the other hand Richard was speaking about the failures of, for example, the UN system at a global level. What do you consider should be the priority of advocacy currently for maternal health? Should it be based on developing governments or should it be focused at a global level? How much priority do you give to each?
Ms McConville: I think we have had quite a lot of international advocacy over the years. There are many UN departments with their own communications people who have run campaigns and so on. What we have not had is sustained and long-term support for the advocacy needs of developing countries, and that, I think, is where we need to focus now. For instance, White Ribbon Alliance has an alliance in Orissa, in India, one of the poorest states. I heard recently that they had managed to gather a petition of 35,000 people: many of those will have been thumbprints. That is a massive petition by any standards. I said, "Have you got a photograph of that so we can use it on the website and publicise it?" They did not have a camera. They were asking us, "Please can you help us with our advocacy needs?" Here we are: "A 1999 World Bank survey asked 60,000 people living on less than a dollar a day to identify the biggest hurdles to their advancement. It was not food, shelter or healthcare, it was access to a voice." People are always asking us, there is a great demand, for more and more alliances all the time. Advocacy is what we see as the key, and this is what will unlock the process in moving forward. So, yes, we would ask DFID to focus more on civil society organisations.

Q132 Ann McKechin: Richard, where do you think the priorities should be based?
Mr Horton: I am not going to disagree with Brigid, of course there needs to be a civil society approach, but there is a huge space that needs to be filled on the global side. We must not pitch one programme against another programme— it is very important not to do that, so do not get what I am about to say wrong. It is about increasing the envelope of funding, but if you look at the attention that is given to HIV/AIDS in the world today through incredibly successful advocacy and then you look at the place of women and maternal health, there is a disparity. I am not arguing against HIV/AIDS, but I am saying that we have to get the balance slightly different to where it is right now.

Q133 Ann McKechin: This would seem to follow on from Brigid's argument about the position of women and the lack of power that they have.
Mr Horton: Right, but if you had the G8 focusing on women in Japan next year---. The Foreign Minister of Japan is making a speech on Sunday at a conference where he is going to start laying out his strategy in the run up to G8 next year. Japan is desperate to engage the world to help it shape its position for G8 next year, particularly on health, and you have got the Foreign Minister talking about health, so there is an opportunity for DFID to help shape the G8 agenda and get women as a much higher priority.
Ms McConville: You are all parliamentarians. You all know how important it is when the NHS comes up at election time when there is something wrong with your local hospital or there is something wrong with the ambulance service. As far as I know, there has never been an African election in which health is a major issue. That is a telling point, is it not?

Q134 Ann McKechin: I think that shows in the share of the budget that is sometimes allocated. Can I ask you briefly about the Women Deliver Conference in October 2007 and whether or not you think it was effective in responding to the issues raised by women

and health professionals in developing countries, including midwives, about the priorities that need to be set over the next few years?

Ms McConville: I would welcome the approach of the Women Deliver Conference. It framed the issue in terms of a political meeting. I think that was a very wise and a very good move. From our point of view, it would have been better if more voices from developing countries were involved in the planning and perhaps there could have been better listening to those voices during the meeting itself. There was a sense that it was rather the same old same old, but lets move on in a positive way.

Mr Horton: I think Women Deliver was an opportunity for the maternal health community to regroup. It was a very important moment. Twenty years of Safe Motherhood had not worked, and the whole issue had to be reframed, and the beauty of Women Deliver, in the very title Women Deliver, it was about reframing the whole question of maternal health in the context of women, not motherhood, and that opens up so many more opportunities for progress on advocacy and technical solutions and so on. It gives you an entry into the women's movement which, if you just focus on Safe Motherhood, there was dissociation between the two. It allows you to think of women as political and economic citizens, not just about people who produce babies. I think Women Deliver gave us an opportunity to create a different frame of reference for maternal health which now is our responsibility to work from. It did not come up with a magic solution, but it was a very important step-change in our thinking.

Q135 John Bercow: What role should scientists and scientific journals play in advocacy for maternal health? I am possibly playing devil's advocate and possibly not. Is there any possible conflict of interest, in a sense, with primacy of scientific principles of independence and impartiality?

Ms McConville: I would say that as the White Ribbon Alliance we are a coalition, so we welcome what everybody has to bring to the table from whatever sector they come, whether it be faith-based, individual, media, government, UN agency or academics and scientists. Over to you.

Mr Horton: Science is political. How a democracy chooses to spend its money and which areas it chooses to spend its money on are political decisions, not just scientific decisions. So the idea that science is somehow immune from politics would be a fundamental mistake, I think. The responsibility, therefore, is on scientists to try and select what areas they are going to study and journals to do the same, to look for gaps in the evidence, to look at what the priorities might be, should be, in the world and bring those scientists together to focus on generating the best evidence so that it can be used as a platform for advocacy. Advocacy, without some kind of reliable, robust knowledge-base underpinning it, is empty advocacy. I see our role, one of many thousands of journals, as trying to bring those scientists together to create that foundation of knowledge on which advocacy can be built. I would say the one additional thing is that if you sit down with these scientists who have dedicated their careers to this, they are fantastic advocates but they do not see themselves as advocates particularly, but you get some of these people out on the stage talking with ministers— I have sat in rooms where you have the Minister of Health from Mozambique or Nigeria sitting right next to a scientist who has done work in their country—that interplay is fantastic. You can see how ministers will imbibe the science. They demand the science, they need the science to formulate strong policies; so it is a question of bringing them together, and I think what journals can do is to help create the climate for those kinds of interchanges to be made. I think science has been far too removed from the policy process before. It is part of democratic accountability.

Q136 John Bercow: To what extent then is policy, in practice, either of developing countries or, indeed, of our own, genuinely evidence-based? Can I pick up on the metaphor that you used as you viewed, I think you meant in developing countries, ministers imbibing the science, so to speak, the informed outpourings of the scientists? To what extent, having undertaken their imbibing, has that influenced their future choice of menus when implementing policy? In other words, do they actually take note? It is one thing to be inspired there and then, but do they take note to such an extent as to change policy?

Mr Horton: I can give you one set of examples related to maternal health but focused on child survival. A few years ago we were involved in producing a similar series to the one that we sent you on child and newborn survival. There is no question that bringing that knowledge-base together helps inform ministries of health in continents like Africa. The problem is that ministries of health on their own are quite weak, of course; so we cannot do it all. What you are trying to do is provide the ministries of health with that knowledge but then also trying to influence presidents and prime ministers. Building that social, that political movement you have to include both groups, and I think conferences like Women Deliver can be valuable because it brings the finance ministers, ministers of interior, presidents and prime ministers together with ministries of health to change their culture. On our own, of course we cannot do it.

Q137 John Bercow: Thank you for that, Mr Horton. May I follow up on one of the initial observations that Brigid made when this question began or in response to earlier questions, namely the importance or lack of importance attached to women within society, particularly in the developing world? I do not know whether you think, because some reference was made to welcoming evidence from scientists and contributions from a whole variety of actors on the stage, including faith groups, that the presence in a room, or the delivery of a very effective scientific paper by an expert scientist to a minister in a developing country government can in any way match or counteract the sort of cultural or even religious influences under which that minister would

normally act. To put it very simply, if there is a natural lack of interest in these matters or, dare I say it, even an attachment to what we would consider very outdated ideas of women's importance or lack of it, can that attitude be atoned for when distinguished science is presented?

Ms McConville: I think distinguished science can form the foundation, the bedrock, for the work that will follow. I think those maternal mortality figures, in particular, the data is very important. We hear over and over again, a woman has been buried in the garden and not even counted, and that has been one of the problems when work has begun on so-called Safe Motherhood. One of the first things that happens is the counting starts and then the figures look bad, they look work worse, and it does not look like a good return on the investment, but once those figures are in place, things can move. Jeremy Shiffman, who has done some leading work on advocacy, has worked out some of the key issues in how advocacy has changed issues around the world. For instance, in Guatemala a reproductive age mortality survey was one of the major factors in moving things forward in that country, so I think data can be tremendously important. I will give you a slightly different perspective. One of our leading advocates in Africa, working within her own country, a senior figure in the government said to her, "What is all this fuss about? Here we have one woman crying. A few women are dying and one woman is making a fuss." That is the response she got at her own government level. Women are up against that all the time. I have worked as a journalist in developing countries. It is very hard sometimes to find a space in which women can make themselves heard. You find yourselves crowded out by men, very often. Women face a lot of barriers and they may not feel safe to express themselves. If you have a leading figure in a movement like the White Ribbon Alliance who is seen on TV, as our co-ordinator from India, Aparajita Gogoi— she was on the stage at the Clinton Global Initiative— that is an amazing role model for other women in India. I think there is a matter of solidarity there and a matter of leadership that can inspire and give courage to other women, but we need these things together. It is not either/or.

Mr Horton: May I be allowed to add one very brief codicil. I want to be very clear what we mean by science. By science I do not mean stuff that goes on in the lab or even clinical trials. Monitoring and evaluation of what governments are doing, creating league tables. Are governments investing in health? Are they meeting the Abuja Declaration? What are the financial flows? How are they using that? That is the sort of science I mean.

Q138 John Bercow: It is output driven.

Mr Horton: Yes, and that is the kind of accountability mechanism that the scientific community can provide. There is nothing more worrying to a minister than being held up as not meeting some international norm. I do not say it is about shaming, but it is about naming, and in a very public sense, and that can make a difference.

Q139 Chairman: Is *The Lancet* a campaigning scientific journal?

Mr Horton: I jolly well hope so. It was founded in 1823 by somebody who was a campaigning doctor at the time and he became a Member of Parliament in the end and fought for the coroners' courts in the UK and for public health and sanitation law. I think what *The Lancet* is trying to do now is reinvent itself in a global setting.

Q140 Jim Sheridan: I am delighted that the scientific profession are acting in the pragmatic way in which you are suggesting, but picking up the point that Mr Bercow made about faith groups and various religions, is there the same potential conflict there amongst faith or religious groups, particularly when we talk about birth control and maternal services?

Mr Horton: That is a really tough one, is it not? The Catholic Church, for example, provides a huge amount of the care services for people living with HIV in Africa, and if you took a completely negative view of faith-based care services, you would pull the rug out from the care of millions of people on the continent, so one has to be very careful about how one frames this point. My experience is that we sometimes put faith groups in little boxes and stereotype them. I know a lot of people who are from faith communities, who work in science, for example, who might have a personal view about abortion but will be part of a movement that will argue very strongly for harm reduction, which means providing safe abortion services; so I would be quite cautious about accepting any stereotypes. I find, again, that when it come to issues like this people are actually very pragmatic.

Chairman: There is an interesting poll in today's papers, *Catholics For Free Choice*, which is identifying that the Catholic Church is rather divided on that issue.

Q141 Mr Crabb: Mr Horton, in your *Healthy Motherhood* piece as part of the maternal survival series last year you issued a call for the professionalisation of maternity care to be made an absolute priority. To whom were you laying down that challenge? Who was the relevant audience?

Mr Horton: Policy-makers. There is no question about that. I think one of the problems within the medical community---. First of all, I think the medical community can be an extremely damaging obstruction to some of these issues, because we as doctors sometimes think that it is only doctors who can provide solutions, and it is not, there is a whole set of community health workers out there who are much more likely to be offering solutions than doctors are, but the professionalisation, the improvement in skills, that message still has not been more forcefully made to policy-makers and I think the medical community can be an extraordinarily important lever in making that message heard more loudly. The medical community is an advocacy community in its own right, and I think it can mobilise itself more effectively to make those messages.

Q142 Mr Crabb: Can you give us some thoughts on why professional attendance at birth has remained so stagnant in Sub-Saharan Africa and South Asia over the last 15 years?

Mr Horton: I think that comes down to Brigid's point again about the failure of advocacy. You do not need more research to prove this, these are messages that are well known, but we have not been able to make the case strongly enough that professionalisation of care, skilled birth attendants, emergency obstetric care, facility-based care, is an absolute priority.

Ms McConville: I think that is somewhere that we can really show that we have been very successful in working with communities. For instance, in countries like Tanzania only just over half of women give birth with any kind of skilled attendant, and that mirrors the figure for the whole world. It is just extraordinary in this day and age. Fifty per cent of women all around the world are still giving birth, probably at home, alone or with a mother-in-law or a neighbour, with no skilled person at all to help her if she gets into difficulties; but the journey from there to skilled care is a long and social one. The roots of her getting from A to B lie in the community, in her own empowerment, in her own education, in the amount of information she has, in the power she has to make decisions for herself about her own healthcare. Those are social issues and it is only community mobilisation that can bridge that gap up to the health centre. There has been this debate for many years about traditional birth attendants versus skilled birth care, and the evidence is overwhelming that skilled birth attendants are the answer to this issue. However, we can work with traditional birth attendants to encourage them to come with women to the health facility. It is not a question of excluding the community, excluding and blaming those people who do not have those skills. We can work with them to bring women to health facilities.

Mr Horton: It is making connections outside of the health sector. This is not just a health solution we are looking at. Work done in Bangladesh, for example, shows that reductions in maternal mortality are tightly linked to improving educational status for women. In the educational sector, MDG 2, on education, there are vital links that are made. Again, we must not pigeon-hole health, we must look across the multiple sectors.

Q143 James Duddridge: What is the most effective contribution civil society and grass roots organisations can have for advocacy on maternal health? You mentioned a number, but what are the most effective levers?

Ms McConville: The most effective levers in terms of?

Q144 James Duddridge: In terms of their advocacy work. Who are the most effective people to target and with what methods? Rather than simply talking about advocacy overall, who do they target and how?

Ms McConville: I think there are various levels and, as Richard is saying, we cannot have one against the other. We cannot divide them up; we have to look at the issue in the whole. We have to have community-based advocacy; we have to work very closely with families. We have to have men on board; we have to have husbands and mothers in law. One of the things that we do in India, for instance, is Safe Motherhood classes for young couples and, at the end of it, the husband, if he graduates, will tie a white ribbon in the hair of his new bride to show so he has made that pledge to care for her in the future. We can also then have representatives on local health committees; so that district level is often very, very important; that is where a lot of decisions are made about healthcare. So we have White Ribbon Alliance members represented and asking questions on those committees, and then, at national level as well, we need to be pursuing the policy-makers in government. By the way, health ministers often welcome that pressure, because they need to advocate within their own governments for more funds for maternal health. In Burkina Faso, for instance, the White Ribbon Alliance there persuaded the Government to hand over a further 10 % of the health budget to maternal health, which was then spent on facilities, training, community awareness raising and sensitisation, and so on. I would not prioritise one against the other; I think we have to work right across the spectrum.

Q145 James Duddridge: Presumably with a limited budget, White Ribbon individually, or globally with a limited budget for advocacy or maternal health services, choices have to be made. Perhaps another way of expressing the question is: of the White Ribbon budget, the advocacy budget, where do you spend that? What of it is the grass roots? For example these classes for fathers and families: what percentage, broadly speaking, is for the advocacy at an international level and at a country level?

Ms McConville: When you talk about the White Ribbon Alliance budget, a lot of our people are actually volunteers. Many of our co-ordinators are not paid. We often work within other organisations, we are given a home within another organisation, and then we survive on projects, but many of our co-ordinators knock on doors for several years before they get any pay at all. The other point to make, I think, is that different countries and even different regions within countries will have very different priorities, so our alliances will decide within those countries what they should work on in an autonomous way. In India, for instance, I have told you about the new laws that were steered through to enable nurse midwives to perform. In Tanzania the priority was human resources. There was a tremendous shortage of skilled birth attendants. There was also an unemployment issue in Tanzania, so the focus there was on persuading the Government to hire staff immediately. The step forward has been made in that the Government now immediately employs graduates from the medical and midwifery schools, so they go straight to work, whereas before they were waiting around for

interviews and then disappearing. So that was their target. In Indonesia the issue was to alert villages. Communities raised awareness so that families would know the danger signs in pregnancy and plan ahead, and they would have some funds ready for transport. A similar thing happened in Malawi, where White Ribbon Alliance members joined forces with the police service. The roads there are often atrocious and there is very little transport, so you would often find women giving birth on the road or walking to a facility many, many kilometres. They worked together with the police to set up a small fund so they could use the police transport to get to a health facility and beyond. For us it really depends on what the issue is in that particular country and the decisions that are made within that country.

Q146 James Duddridge: Earlier you gave quite a powerful example of being asked by some Indian ladies (there was a petition of 35,000) for a camera, something as basic as being able to capture the moment. How are local groups best supported by international organisations such as yours, or is it really, as you are saying, driven on a country by country demand-led basis? Is there a model perhaps for what other international networks can be doing to assist local groups?
Ms McConville: I think we are a unique organisation in that we have got going within the last nine years and we have absolutely mushroomed, and the demand for the Alliance is growing all the time. We do not have any sustained or core funding, except for a small team that runs a kind of hub, a secretariat. If you like we are almost the inverse of a UN organisation where we are very, very big and extensive at grass roots but we do not have any sustained or steady funding sources, and certainly that is where we could do with some help.
James Duddridge: Message received!
Chairman: A straight answer to a straight question.

Q147 John Battle: I rather liked Richard's broader definition of science. I am interested in what might be in your term "the science of civil society"? I think we have massive questions to ask, not only developing countries but also here, about representation, role and voice, not least to ensure that the poor are heard rather than spoken for. I wonder if I could ask you: how do we turn positive anecdotes, personal community stories, into analytical evidence that can be used to drive the argument and the advocacy forward? Bridgid, you gave us some examples: I think a film that was taken in Tanzania, Burkina Faso, the health budget; you mentioned Indonesia and Malaysia; but can those success stories of community mobilisation be turned into a source of analytical evidence to push the arguments further forward? Where would we go to get them and who could put them together?
Ms McConville: Jeremy Shiffman. I have got a summary of a piece that he did in *Insight Magazine*. He is a leading researcher from the USA and he is saying that advocacy is the key, and he has done an awful lot of work on this, and he says that the degree to which political leaders actively pay attention and allocate resources to this issue varies according to the amount of pressure that is put upon them within developing countries by advocates, and he has got chapter and verse about how that works. He says, "National advocates have achieved varying degrees of success in promoting the cause and they were most successful when they" (and he has given one example) "organised focusing events such as national forums to promote the cause, including a march to the Taj Mahal in 2000 organised by the White Ribbon Alliance of India", and a couple of other examples there, and he is saying, "Advocates must develop political not just technical strategies".[4] So the research is there. There is also Wim Van Lerberghe at the WHO[5] has published papers about how that worked in Europe. We have got where we have got because of sustained political pressure and advocacy over the years.

Q148 John Battle: I am tempted to say that, in terms of poverty in the UK, Europe and America, we are not there yet.
Ms McConville: No, I think there is a very important point there, which is that in every society there is a marginalised group and it is those groups that we need to reach, and we have that same problem. The maternal mortality rate in America is shockingly high. Those are usually the black and Hispanic communities. It is the same pattern.

Q149 John Battle: I think in my neighbourhood in the inner city I kind of jib at the notion of the hard to reach people because they are there all right, it is that others talk about them as the hard to reach; but what I am saying about that, Brigid, is to push this idea. Can we get the analysis from the local to the centre? Can we really tune in? Let me ask a particular example. DFID is funding, I think, research in Nepal, for example. Can we get from that research, just in the same way—I do not know the two people you have referred to, and that is very helpful, but the Alinsky Institute, for example, in Chicago and all the work they did on community campaigning to push civil society in the west, has that research in Nepal given us the kind of evidence to say that community mobilisation has brought tangible improvements in maternal health and we can document it, list it and tabulate it so that we are in Richard's domain of science, not to play that off against you, and the science is fused with the advocacy to become an unstoppable argument in terms of demanding justice for the poor, not least women, who pay the highest price of all everywhere?
Mr Horton: The answer is absolutely, unequivocally, yes, and DFID has funded this research. It is back to Anthony Costello again. Let me just give you an example of his work. What has he done? He has done a randomised trial to show that women's groups can reduce maternal mortality, newborn mortality. He goes on to show that that is a cost-effective intervention being afforded by the

[4] Jeremy Shiffman, Generating political priority to reduce maternal mortality, *id21 insights*, vol 11 (2007), p 5
[5] World Helath Organization (WHO)

health system, and then he has done, effectively, anthropology, looking at the care-seeking behaviour of women, reporting that in a very conventional, rather boring way in a boring medical journal like *The Lancet* that can be used by Brigid and her colleagues as the mechanism for advocacy, doing exactly what you say. That is science for civil society, so that it can be recognised as robust evidence at a ministerial level but it has that texture, that quality, that means something and is not just numbers in an abstract sense.

Ms McConville: The whole function of an Alliance is to bring everybody together with those complementary perspectives that we can build on and move forward together.

Q150 John Battle: And build the commonsense for change.

Ms McConville: Exactly.

Q151 Chairman: Thank you for that. You have already mentioned, Brigid, your Stories of Mothers Lost. You made reference to it and gave one or two points from it. First of all, is that still on its travels?

Ms McConville: Yes, indeed.

Q152 Chairman: What are the sort of key points? In a sense one can judge what it is, but can you just tell us a little bit more about what is in it and how it is focused to get these results?

Ms McConville: Yes, by all means. In fact I have brought you all a folder that you can take away with you.[6] The exhibition is a collection of fabric panels. We put the word out to our members in all our countries and asked them each to submit a number of stories from those communities, the story of a mother who has died in pregnancy or birth, and the result was absolutely stunning. We expected 50. We had some funding from the UNFPA[7] for that. We got over 120 in the space of a few months. I am glad to be able to say that our partner in the UK has been the Royal College of Obstetricians and Gynaecologists International Office, and they very generously lent us their premises for setting up the exhibition. We launched that— you were all invited actually— in October and we had a tremendous audience, over 250 people, and this is where we can do things differently in the Alliance. We had not only the medical and health community and the development community, but we had media people, theatre people, music people, ordinary citizens— the whole spectrum came to that event. We had asked Mrs Sarah Brown if she would open that event for us, and she said that she could not do that but instead she would invite us to a reception at Number 10 Downing Street. So, two days later, we took 20 of the panels, the stories, into Number 10 and we invited, again, a very broad range of people, and our advocates included such women as Judi Dench and Diana Quick and we had some top media people as well, executive editors of our national papers, we had some top music people and some people from the business and corporate communities. We also had Douglas Alexander, and we had our singer Stara Thomas, the pop star. I think what was wonderful about that was that we were able to bring stories of women who have died. Normally those stories are never heard— that woman has gone— her story is not heard. The community told her story. These are the poorest of the poor. Those stories were brought right into that hub of power and influence and I am tremendously proud of that, and most of our co-ordinators from Africa and India, many of them, were there, and I think that was a tremendous accolade and a tremendous boost to their morale. We are following up all of those leads and all those connections that we made at that time. We also are very pleased to announce that we now have funding from the Bill & Melinda Gates Foundation to take the Stories of Mothers Lost on an international tour. So that is going to be the focus of an international advocacy campaign. Our next port of call is Washington DC in April, which is the World Bank and IMF[8] meeting, so we want to influence policy-makers there, after that we go to Japan for the G8, and we hope again to make sure those voices are heard in the highest places, and after that we go to South Africa, which I believe is the World Economic Forum. So we have got three major political meetings to which we will be taking the panels as evidence.

Q153 John Battle: Just a suggestion, as well as the excellent work there. In this room we saw the Panorama film which was in the early sessions of our inquiry. I showed that film in my own neighbourhood and Sure Start Group in an area which has some of the worst records of maternal health in Britain. The response was fantastic. I would like to suggest, if it was possible, for the international exhibition as well as aiming at the world economic fund, the policy makers, also to be used to build support on the ground floor level to push the policy makers from solidarity from the base as well.

Ms McConville: Absolutely. Obviously we cannot take the panels to every place but we are making a film about the exhibition. Some of the footage was taken by the communities as they put their pieces together and I should tell you also that there was a tremendous amount of advocacy in the putting together of those panels. For instance, in some communities in Pakistan, young people got together in the making of the panels and pledged a commitment to Safe Motherhood and signed pledges. In one other area there were 25 media articles alone around one particular story. In Uganda there was a TV programme. Parents were filmed by the graveside of their daughter, talking about her death and that film was on television, so already those panels have had a tremendous advocacy effect in the communities. The panels, by the way, will go back to those communities at the end of their job. To build that connection in the UK we are also very keen to do that.

[6] Ev

[7] United Nations Population Fund (UNFPA)

[8] International Monetary Fund (IMF)

Q154 John Battle: Perhaps the department that is in charge of the Sure Start programme should be alerted to your campaign and push it through Sure Start.
Ms McConville: That would be wonderful.

Q155 Chairman: Thank you very much. When we embarked on this inquiry, obviously the first thing we did was to get a briefing on the context. The context is appalling. It is the most off track MDG. The figures are variable but there are more than half a million women dying in childbirth and many, many more millions of people are affected by the consequences of that and the very poor progress towards dealing with that. That is part of the reason we are doing the inquiry to see whether or not we can focus on this. Your evidence has been extremely helpful. You have given us some very powerful evidence in terms of what you feel works and what you feel is the right approach. It is a very subjective thing but how optimistic are you? It is not a question of physically doing it. Both of you say of course we can do it. We can mobilise world opinion and the people who need to make those decisions including in the developing countries. We need to do it. How optimistic are you?
Ms McConville: My view would be that this is a really important time in history. We have had 20 years of the Safe Motherhood initiative with shamefully little progress. However, at the moment there is a tremendous amount of pressure from the governments of the UK and Norway. There is also a building global movement at grass roots level. We are getting closer to the target date of the Millennium Development Goal. If we can bring those together now, if we can bring top and bottom levels together, we have a tremendous opportunity, but we can only do that if we really respect and listen to the voices of the people in the countries where those issues are problematic.
Mr Horton: I am extremely optimistic. In the past five years we have scaled up advocacy, resources and political commitment to child survival. I think we can do the same over the next five years for maternal health more broadly. We have a lot of the knowledge in place. We have a lot of the leadership in place. It is a question of making connections between those two, between the politics and the knowledge. If we get that equation right, we can make incredible progress at country level.
Chairman: That is a very positive note on which to end your evidence. Thank you very much indeed. It has all been very clear and helpful.

Witnesses: **Ms Aasha Pai,** Acting Regional Director, Africa and Latin America, Marie Stopes International, and **Mr Giorgio Cometto,** Health Adviser, Save the Children UK, gave evidence.

Q156 Chairman: Thank you both very much for coming to give evidence to us. You obviously have heard the evidence we have just had. You are particularly focusing on conflict situations in fragile states but I wonder, for the record, if you could please introduce yourselves?
Ms Pai: I am Aasha Pai. I am Acting Regional Director for Africa and Latin America for Marie Stopes International. MSI is one of the leading sexual and reproductive health organisations working globally in 38 countries. Last year we served five million clients and particularly in terms of humanitarian work we have an initiative working with Columbia University called RAISE[9] which is really looking at trying to be a catalyst to change the way that reproductive health is seen in crisis situations. This goes from a very practical level in terms of integrating reproductive health with the work of health care NGOs[10] and other humanitarian NGOs, also to making a more enabling environment for funding and for policy change on the issue.
Mr Cometto: My name is Giorgio Cometto. I am a physician. I have worked in the last few years in east Africa and the whole of Africa in managerial, policy and advisory positions with international NGOs, a bilateral donor in the World Health Organisation and very recently I joined Save the Children UK as a health advisor based here in London. Save the Children UK, as you might know, is a leading global NGO working for the protection of the rights of children and their carers and it has operations in over 30 countries, in Latin America, Africa, Europe and Asia.

Q157 Chairman: Last year the Committee did a report on conflict and post-conflict reconstruction. We are not expert on anything in this Committee but we do try to inform ourselves and focus on certain issues. Obviously we have seen some of the devastating effects that conflict has in general terms on women and children in particular. I wonder if you could give us a little bit more insight into why, in that situation, maternal health is particularly badly affected by conflict as opposed to the destruction of a health service or the lack of it or inability to get about. It means that all health issues are a problem but why and in what ways is maternal health particularly badly affected by conflict and post-conflict situations?
Ms Pai: Very particularly in conflict situations you have quite a lot of gender based violence so we are looking at rape being used as a weapon of war. We are also looking at domestic violence. Refugees may be coming from areas where you have high levels anyway but in those high stress situations we see an increase of domestic violence. You have these situations where women are being raped, being raped systematically, being raped simply when they want to walk to get water, to get fire wood for their survival needs; but also an increased level of violence in their own relationships coupled with being forced to sell sex in many situations in order to just get their

[9] Reproductive Health Access, Information and Services in Emergencies (RAISE)
[10] Non-governmental Organizations (NGOs)

basic needs met. In these ways you see that the reproductive health needs you have anyway are far more acute in terms of the depth but also in terms of the scale because, in many refugee and displaced people camps, the majority of the people who are there are women and children. When you have maternal mortality and maternal morbidity, you see that affecting straight away most of the people that you have there in the population and children being affected when their mothers are dying or suffering from disabilities as a consequence of poor maternal health.

Q158 Chairman: I would just comment in passing on our conflict report. In reality, we saw in the Panzi Hospital in the eastern Congo the victims of systematic and abusive rape. We have seen in the camps in northern Uganda the whole issue of poor support. Just having come back from Afghanistan, we were told that 80 % of women are subject to domestic violence within their relationships. So there are just three examples of countries which the Committee has visited which have come out of conflict where those facts have been brought to our attention. It does reinforce what you have said.

Mr Cometto: That is the case also in other settings. In Liberia for instance it has been estimated that between 60 and 75 % of women of child bearing age have been forced into sex at some time or other during the period of conflict. Gender based violence is a big part of the reasons. It should be emphasised that conflict and immediate post-conflict situations usually are characterised by a near total collapse of health systems. Maternal mortality relates very directly to the status of health systems and the capacity of women to access health services. This relates both to the supply side and the demand side. In many cases access can be constrained by security problems. A generally intimidating climate can suppress demand from the women so there are multiple dimensions in conflict that directly pose an increase in maternal mortality. Considering the groups of fragile states and other low income countries with a more stable political environment, the maternal mortality ratio is up to 2.5 times higher in fragile states or else it is equal, so there are really significant elements that determine higher maternal mortality in fragile states.

Q159 Sir Robert Smith: Given that challenge, what do you think donors such as DFID can do to ensure that issues like maternal health, reproductive health and gender issues are dealt with systematically at that time of conflict affecting countries and these fragile states? Is there any specific strategy?

Ms Pai: DFID has been a leading donor in terms of humanitarian issues. DFID has also been a leading donor in terms of gender and reproductive health but where I think more can be done is to bring those two together. When you look at a crisis situation from the outset, you should be looking at the needs of reproductive health and consider them to be as essential as any other health issue. If you look at all of the things we just talked about in terms of maternal mortality and morbidity from the onset of the emergency we have to put the systems in place so that you have basic emergency obstetric care, for example, so that you can deal with these situations from the beginning. Also, we need to look at the complexity of programming that is required. If you are talking about different groups of people from different places, you have a lot of socio-cultural issues as well and if you are talking about places like Afghanistan, as you would have seen on your visit, it is so important for example to have women doctors providing care for women, for them to access service. All these things are incredibly sensitive and require slow funding that trickles over time, that is constant over a long term. You need to have a concerted effort over time to be able to transform situations and make a difference. At the programming level DFID could do more to bring that together also through specific mechanisms, such as through CHASE.[11] Now there is language that has been added to include reproductive health and to encourage NGOs to apply for funding through that mechanism, but more could be done to make sure that their programming does include reproductive health and that there are some tracking mechanisms to see that the money that is being allocated for these NGOs is increasing over time.

Mr Cometto: I would like to emphasise that post-conflict reconstruction programmes are long term endeavours. It is quite frequent to witness a pattern in terms of aid disbursement into post-conflict settings. In the immediate post-conflict period, there is a gap between the time emergency funding is scaled down before recovery and development mechanisms pick up. This has been documented in several countries all over the world. DFID acknowledges this. For instance in a country like South Sudan, they set up a basic services fund, acting as a bridging gap measure for this period. This, in my opinion, is best practice that other donors should look at. What specific strategies and answers are to be put in place? It probably depends from country to country. What can be realised is that these are long term endeavours. The answer lies in strengthening health systems as a whole and also recognising the important role that civil society has to play in particular in settings like fragile states and in an area like maternal health and reproductive health. We broadly concur with the strategy of prioritising the strengthening of government structures and the adoption of government mechanisms for disbursement and for building up health systems. Having said that, it should be acknowledged that in certain countries government structures are not in place and governments may not be able or, sometimes, willing to provide what is needed. In these cases, probably civil society has a role to play also in terms of service delivery. Even when that is not the case, even when a government is effective in providing service, there is anyway a residual role for civil society in terms of advocacy, capacity building and piloting different approaches that can fit into the general policy at country level.

[11] Conflict, Humanitarian and Security Department (CHASE)

Q160 Sir Robert Smith: In the emergency funding phase, how are things at the moment?
Mr Cometto: You refer specifically to the case of southern Sudan?

Q161 Sir Robert Smith: No. In the emergency funding phase post-conflict, how does maternal health cope at the moment?
Mr Cometto: My experience, which is limited to two or three countries post-conflict, I would say that it is quite fragmented. Multiple partners intervene sometimes with overlapping mandates. A lot of the funding is still structured according to vertical lines in vertical structures. It is something that usually comes during the recovery and development stage, but typically the emergency relief phase is characterised by severe inefficiencies.

Q162 John Battle: I wonder whether funding, a trickle over time, to develop a health system is not irreconcilable with a fragile state. There seems to be a complete incompatibility. Do you think you could identify at what point in a post-conflict situation donor attention should move from emergency support to strengthening health systems. Sierra Leone was one of the places I visited with the Committee.
Mr Cometto: We would recommend pursuing a twin track approach. It is very difficult to recommend a specific point in time, whether country specific or when emergency funding should be scaled down. Something that has happened a number of times and has been documented for instance in Liberia or in the mountain region of Sudan is a severe contraction of service delivery right after the conclusion of the hostilities. Probably the wisest approach in my opinion would be to scale down emergency relief once something else is available. That usually takes a minimum of two or three years before something is put in place.

Q163 John Battle: To follow the scientific approach of the previous conversation, are there types of information or data that can be collected to inform policy makers and monitor progress in that context so that you maybe cannot identify a moment on 26 April at 4.30 but rather can we identify some key indicators and data that we can work from to say to donors, "Look, there is an area here now where we could give more support to health systems and move away from emergency funding as a result of a crisis or conflict"?
Mr Cometto: I believe that a lot of information has been published, in particular from countries that have shown better results than others. For instance, Afghanistan features quite prominently in the literature in the light of its faster than usual results in delivering improvements in outcomes. I am not familiar with a particular person or a particular set of publications that looks specifically at these points. Usually, a lot of the evidence is published at country level and rarely does it fit into global debates, but there are units, for instance the World Health Organisation, and other departments that look specifically at conflict or post-conflict situations. Another example is the London School of Hygiene and Tropical Medicine. They are an important source of information and they are a leading global partner in determining, publishing and assimilating evidence on this.

Q164 John Battle: I was incredibly encouraged by the positive responses to the Chairman's questions about the hope for the future in the last session. I wonder if we could look at health care in a positive way. I once went to Kosovo right at the end of the conflict. I observed and was part of a deal where an Albanian and a Serb started to work together as two electrical engineers repairing a power station. They were discussing politics and theology when they did it but it got it up and running. It was a moment when repairing a power station was a catalyst for peace in the neighbourhood. Could provision of basic health services act as a tool or a catalyst for promoting peace and stability in fragile states? Could we look at it in that context?
Mr Cometto: I suppose it is possible to look at it that way. As a matter of fact, the association between the provision of social services and peace and stability or conflict on the other side has been made in several settings. Establishing a causal link between the two might be harder than a general type of association but it is probably an area which further research and better evidence could help.
Ms Pai: Any kind of investment to any social services could very potentially have that effect. You also see that in fragile states, if you can focus on working with NGOs, that is one thing. Maybe you are going to have a stop gap service that can be provided. Going back to what was said before about also working on the capacity building and advocacy issues at the same time, it is an investment not just around immediate needs but around avoiding potential conflicts in future because you are addressing the needs that people have. Again, it is about not putting health in a particular box but looking at overall development.

Q165 Chairman: Is it not extraordinary in the situation with DRC?[12] Everybody happily—I say "happily" using a very ironic term—talks of it being the worst conflict worldwide since the Second World War in terms of the numbers of deaths. A figure of four million was quoted, but when you ask how did these people die most of them were not killed in conflict. They died of disease and lack of access to health care and so on. From your engagement in other conflict states, is there something wrong with the international community that it does not understand that what is needed in a post-conflict situation is prioritising the delivery of those kinds of services? The specific issue we had as a Committee was engaging with ECHO,[13] who were proposing at the time to withdraw funding from the Panzi Hospital on the grounds that the conflict was over. The Panzi Hospital was full of people who were

[12] The Democratic Republic of Congo (DRC)
[13] The European Commission's Humanitarian Aid department (ECHO)

coming in every week, women who had been mutilated and savaged and yet somehow the international community said, "Well, there is no conflict so there is no need for further funding." The point I am making is, from your perspective, should the international community respond better and to what extent do you argue that case?

Ms Pai: Absolutely. If you look at reproductive health specifically and ask the questions about how or why is it different in emergency situations, of course we have a lot of evidence to show that. The point is that reproductive health is a fundamental right anyway, whether you are in a crisis situation or not and of course the needs are more acute when you are in crisis situations. We make a lot of unhelpful distinctions around what is conflict, what is post-conflict, what is development, what is not, what is crisis and what is not when in fact these are basic human needs and basic rights that we as an international community are ignoring, whether it is a crisis situation or whether it is not. We need approaches where we can look at working with NGOs and funding NGOs, look at making the work of NGOs less fragmented by funding larger NGOs and funding smaller NGOs who can come together and have more of an impact at the same time that we fund governments and civil society to influence policy change. We simply have to work on all fronts. I just do not see it any other way.

Q166 James Duddridge: This Committee recently returned from Afghanistan and you have touched on Afghanistan and the need for women doctors in particular in Afghanistan. That might be one of the challenges but what are the other challenges particularly in Afghanistan in relation to maternal health? From both your organisations' perspectives, how well are DFID doing in addressing some of the challenges and what more should they be doing going forward?

Ms Pai: In Afghanistan particularly, apart from the women health care providers, you have the same kind of security issues that you have anywhere else. The cost of being able to provide services and at the same time have security for your staff is incredibly high. Then you have all the other issues that you have already when you have damaged infrastructure and poverty. The costs are incredibly high and donors are not always willing to go as far as they need to go in order to address all the issues. DFID can play a really strong role in terms of influencing other donors as well. The interesting thing about Afghanistan, I understand, is that if you look district by district, because you are having to work through NGOs as well as doing some work through government, you can see big differences district to district, depending on the donor who is there and depending on donor policy. For example, where you have USAID working, you do not have the same attention to reproductive health issues and you can see the gaps in services. Where you have other donors, you see that there is that influence. With DFID's influence in terms of reproductive health, not just in Afghanistan but in other places, it can show what can be done if you put that attention onto the issue, funding NGOs, getting the money in but also influencing other donors in order to do the same thing so that you do not end up having these very fragmented situations where you are not addressing the issue.

Q167 James Duddridge: In provinces in Afghanistan where the Americans control, will they provide cover and allow people to come in from international organisations looking at reproductive health? Will the American military facilitate that?

Ms Pai: I am not sure about that actual access issue in terms of those districts but what I do understand is that, whatever is happening, the result is that you do not have the services. It may just be a question of funding and not access. The way I understand it is that certain donors are funding certain districts, so it could just be that there are not other donors present and that is why you do not have that reflected.

Mr Cometto: I was one of the NGOs that were subcontracted out to run health care services in one of the provinces in Afghanistan. I do not know if you are familiar with the aid architecture in health in Afghanistan but basically it was decided that a basic package of health services would be subcontracted according to geographical regions. The three main financiers would be the World Bank, USAID and the EC.[14] The Save the Children province was in USAID and to a certain extent it is correct that the different donors have placed different emphasis on certain components. The issue of reproductive health being less of a priority for USAID as compared to other donors is a factor, although there was an attempt at national level from the point of view of the Ministry of Health to achieve a standardisation of the service that would apply across all the regions. As far as I know, there is not a problem of access to areas that are directly controlled by the Americans.

Q168 Sir Robert Smith: We visited a hospital in Lashkagar in Helmand where British money had built an accommodation block for trainee midwives to live in while they were being trained. Because they thought USAID were going to provide money to train the midwives, the block was empty while we were there because at the time USAID had run out of money. Because the block was there it looked like USAID were going to deliver the money. Presumably, that highlights the coordination. There are a lot of players there and maybe greater coordination is needed.

Mr Cometto: To be fair, in the hospital that Save the Children UK managed, which was funded by USAID, we did not do training of midwives so perhaps that was a localised problem.

Ms Pai: Undoubtedly where you have that better coordination you have much better results. Now that you have some moves for example with the WHO to be a coordinator amongst humanitarian organisations in terms of health, the key there is

[14] the European Commission (EC)

making sure that what you see is part of the basic package of health services with reproductive health, particularly emergency obstetrics.

Q169 Ann McKechin: I wonder if I could ask for your comments about how effective you think the UN cluster system has been. The Committee visited Pakistan last year where we obviously had a chance to talk to people about the cluster approach after the earthquake. I wonder how you think DFID could best support humanitarian actors, especially in an emergency, and whether the cluster system has any benefits.

Ms Pai: I certainly think it has benefits because in so many other places what you have is a complete lack of coordination. In the UN agencies you have lots of different NGOs, everybody doing their own thing to the extent of carving up districts and doing very different things in different places. Absolutely from a principle point of view that would make sense. Further to that, DFID again could use influence there to stress the needs of maternal health and reproductive health in those situations and even beyond having a health cluster that is coordinated, but specifically within that have something that is for reproductive health which is also a coordinated mechanism.

Mr Cometto: I agree with this perspective. In many ways DFID is to be commended for its commitment and for putting in place policies that most technical people would largely agree with. If something can be suggested to do more, it would be to strengthen the role that DFID plays at country level. Sometimes there is a sort of hands off approach operating mainly from multilateral agencies or NGOs, whereas perhaps DFID could play a stronger role in terms of leadership and engagement with other partners.

Q170 Ann McKechin: I wonder if either of you or both of you perhaps could give us some examples of success stories in providing effective health services. You have talked about best practice. What do you think are the key factors in that success?

Mr Cometto: If we talk about fragile states in particular, in my experience the list of success stories is not very long unfortunately. Afghanistan usually comes up as one of the best examples of quick improvement in health outcomes. To a certain extent, this can be ascribed to a bold decision that was taken by the Ministry of Health early in the reconstruction process of sticking to a more limited role in terms of coordination and oversight of the health system but subcontracting the provision of health services to non-state providers. This translated into massive improvement in terms of health service utilisation indicators and child mortality saw a dramatic improvement. It was reduced from 257 per 1,000 to a little more than 190 per 1,000 in the space of five years. Likewise, there has been an improvement in skilled birth attendants and antenatal care attendants. In terms of maternal mortality it has not yet been possible to document such a dramatic improvement. Whether this is an example that can be adopted successfully in other countries in other contexts remains to be seen. Despite the obvious appeal of the approach, there are also setbacks that have been identified, such as a hypothetical lack of sustainability with such a strategy and, to a certain extent, conflicts of dynamics between non-state providers and the government itself, especially at provincial level. A similar approach has been adopted for instance in southern Sudan as well with still to be documented results, but in other countries that have successfully moved from a conflict situation to a more stable type of environment the time frame typically has been much, much longer. For instance, in Mozambique, it took 10 years before significant improvements could be documented. It should probably be acknowledged that these processes take time. Sustained effort, sustained commitment and prioritisation of maternal reproductive health can achieve results.

Ms Pai: I agree with the point about when you go to an emergency at the beginning and the way that you view what is considered to be an essential or a basic health package, how important that is. If you say that from the beginning emergency obstetrics, post abortion care and family planning are all fundamental parts of that package, then you can go a long way with that. In terms of more specific examples of success stories, in northern Uganda where we have been working for many years we have seen great success in terms of the demand and supply side when it comes to these reproductive health issues. We are working in a few clinics in the areas where we have a whole lot of displaced people's camps and we are doing a lot of outreach. There are many organisations working there. Part of this RAISE initiative is to work with these other organisations that were not ever doing reproductive health. We are training them in reproductive health areas so that their health providers can do counselling and also provide services in these areas. We have seen thousands of clients coming in and demanding family planning which has been quite an amazing thing to see. Even in these conflict situations, often people say that women have perhaps lost children so they are not interested in using family planning because they are quite desperate to have more children. Of course, that is going to be true for some women but for a lot of people they are in situations in displaced people's camps in northern Uganda for years and years. That becomes their life. They also see that having too many children too close together results in all kinds of problems as well, so there is a very high demand not just for limiting the number of children but also spacing births. We have seen through our outreach people coming and also changing people's ideas. This is where the advocacy comes in. DFID has been funding through the Civil Society Challenge Fund for us to work with the police and the local military and work at the district level, so that at the same time while you work at a national level and you try to make sure that the policies are there— often the policies are already written there— it is about getting people to put money behind those policies and get that to happen at a district level. We also work

through committees whereby our staff will go to the district health meetings and say, "We understand that there has been an allocation for reproductive health. We do not see it here in your district. Where is it? Why is it not here? Why is it, when I go to my local public facility, there is nobody there providing the service?" We are trying to work to help that through this advocacy but also by providing services in the meantime, taking our teams and going to work in the public facilities. This is where I think it is really important to look at the public/private initiatives of NGOs working together with government and the demonstration effect that has. We have our own clinics. That is fine and good but they are only in certain areas. If we can go and work where there are already government facilities, perhaps not well staffed, without supplies etc., if we can bring our teams there, we can work with the one nurse who is there, who is completely demotivated and does not have anything to work with. That is also building up her skills and that is providing many more points of service delivery for people.

Q171 Chairman: You have partly answered the question I was going to ask. If you look at the European experience in the Second World War, it tells you that people do tend to postpone children at a time of crisis. This is why we had a low birth rate during the war followed by a boom afterwards. The first question which you partly answered was the role of family planning, not least because in the wider context of maternal health it has been pointed out that if women are under pressure they do not necessarily want to have children but do not have an option and if there is difficulty feeding the family they have so they are underfed and under-nourished, vulnerable and not easily accessible to services, how important is family planning? That seems to be a classic case where you need to be alongside women and say, "I want it." Somebody has to be there to fight for it. I was interested in what you said about Uganda because, having been twice to northern Uganda last year—it may be my fault or the view that we took—what disappointed me about the camps was the total lack of any visible facilities for almost anything. You said you were working there successfully, so how are you delivering those services when there does not seem to be much in the way of clinics or any other kind of facilities, in spite of the fact that sometimes tens of thousands of people were living in a camp and you would have thought it would be easy.

Ms Pai: Absolutely. Our particular model has been an outreach model. We have clinics that are located just outside of where the camps are. Our medical teams use those as a basis and move in and out of the camps. We have to work with the other NGOs that are there. This is a good collaboration with other NGOs who are there, who are not particularly providing reproductive health, also going to the public facilities which are already there. In some cases they are in an absolutely shoddy condition and it does not look like a place where you would want to provide any services. This is how we work in other countries as well. If you bring in a medical team and you can provide a sterile environment, it can just be a small room and you can provide family planning; you can provide post-abortion care for women who are suffering from the consequences of unsafe abortion. There is a whole lot of things you can do. Going back to your question about family planning, it is absolutely critical but again in emergencies it is always seen as something that is second or third tier because the immediate benefits are intangible. There are a lot of studies that show, if you spend one pound on family planning, you will lose so many problems; you will save £10 on other services. Apart from the fact that women want to limit births, also looking at what happens when women do not have access to family planning and they are faced with unwanted pregnancies, we know that women all over the world, in conflict situations or not, do extraordinary things to end an unwanted pregnancy. The consequences of that in terms of maternal mortality are staggering. If it is 25 or 30 % outside of crisis situations, the stats go up to 50 % if you are talking about emergency situations. You also have to look at emergency contraception, at post-abortion care for when women take matters into their own hands and at safe abortion, where it is legal and you are able to provide it.

Q172 Chairman: How do you coordinate? Marie Stopes is almost a world leader in this and people would know what your sphere is but Save the Children has a broader remit. Your own survey said that coordination was not right and the skills were not always there. What should be done to try and ensure that in these conflict situations NGOs can cooperate and the sexual reproductive health element can be built into that? Does it require an agreement to give some leadership to certain ones? How does it work? Otherwise, if you are all doing your own thing in your own boxes, you could get in each other's way.

Mr Cometto: In my opinion, the issue of positive reconstructive leadership is key. The government plays a very important role in these issues and therefore it is important to exercise sufficient advocacy at a higher level in government to ensure that reproductive health and maternal health becomes a political priority for the country; that comes before the coordination of operational activities at country level. That is something that in many countries, in my experience, is lacking, the perception of the needs at political level and the perception that these represent a priority for the population. As other speakers have said, in certain areas advocacy is really key to the development of successful solutions to problems at the local level. In terms of coordination of activities, again the role of government is essential. It is only the government that has sufficient clout and political weight to mandate how coordination should work. One reason why Afghanistan is considered in international aid circles a successful example in terms of health is that the government gave very strong directions and indications, demanding that the contracting of health services for instance happened on a geographical basis. An organisation

now for instance is responsible for a whole area and that means at the hospital level, the primary health care facility level, the community level, everything; whereas in many other contexts you have multiple actors operating, frequently stepping on each other's toes in the same area and that obviously leads to duplication and inefficiency.

Q173 Chairman: What do you think DFID could usefully do in terms of relating to NGOs in helping to deliver better priority towards sexual and reproductive health generally but obviously in post-conflict situations? Do either of you feel there is more they could do, whether in terms of their country programmes, resource or overall policy or whatever you think is appropriate? What do you think DFID could do differently or better that might help deliver your objectives in this field?
Mr Cometto: Building on what I was saying before, we do believe that NGOs have a strong role to play in this area of maternal health, in particular in conflict or post-conflict settings. This relates not only to service delivery but also to other areas, advocacy, capacity building etc. That requires resources and to a certain extent sometimes the balance which is struck between strengthening government structures and keeping a lively civil society sector to exercise a watchdog function or to fill some of the gaps that the government is unable to fill, in terms of resource allocation, is in our opinion struck too much to the side of the government. That is something that could be considered.

Q174 Chairman: To acknowledge your role, in other words, a little bit more?
Mr Cometto: Definitely. If you want NGOs to do something, you also have to back that up.
Ms Pai: I absolutely agree with that. Again, I really think it should not be seen as an either/or. If you fund NGOs, it does not mean you cannot fund government and *vice versa*. Also, to look at the ways where NGOs work with government, where NGOs are able to enter into agreements where we work in public facilities and help bring up the skills of providers there, where we are able to build the capacity of government providers through more formal training. Also, through advocacy. That is absolutely key. Where DFID has in certain countries—whether in crisis situations or not—decided that reproductive health is a priority, it becomes a priority at every level. I also think that what has been great to see with the Civil Society Challenge Fund is the recognition that it is not just advocacy that should be funded but also the service delivery. This speaks to the question that was raised earlier: are you creating demand where there are no services? Is that not fair and unethical to do that, to work only on that front? I would say to continue that funding, becoming more of a leader in terms of combining. DFID is a leader on one side and on the other but to bring together humanitarian funding and the reproductive health funding is most critical.

Q175 Chairman: Does it matter to you whether they do it as a partnership with the government of a country? In other words, saying let us bring in these NGOs as part of your service delivery programme, or would you prefer DFID to say, "That is providing support but we will provide direct support." Does it matter to you which way it is done?
Ms Pai: Certainly, practically, the direct support to NGOs makes a big difference. If you say the money is going to go to direct budget support, we say that some of that should go to NGOs and there should be encouragement or policy around work with NGOs and government, the mechanisms are of course very difficult. If it comes down to the government saying, "Fine, okay, we will subcontract NGOs to do various things", if all your money is going through there, at the end of the day, not all your money is going to come out the other direction for the NGOs. NGOs are going to spend a lot of time just trying to get paid for the services that they are providing and that they are willing to provide. I think that as much as DFID wants to support sector wide approaches, direct budget support and all of that, you have to work at the same time on both fronts and at the interface between NGOs and government.

Q176 John Bercow: It may be that I am being quite obtuse about it but just for purposes of clarification, when you say that if and where DFID decides that reproductive health care shall become a priority it does, do you mean that that is so because of DFID's stated expenditure intentions or because it is able to exert some other influence?
Ms Pai: I think it is both. The two go hand in hand. Other donors will look to DFID. Because DFID is spending the levels of funding that it is spending on humanitarian issues but also reproductive health separately, if in a particular country DFID says, "In this emergency situation, we see that reproductive health is essential and we are going to fund it through all the means we just talked about in terms of capacity building, advocacy, service delivery, both governmental and non-governmental", then it does have an impact. There is influence that can be used with other donors and governments also change their policies.
Chairman: Thank you both very much indeed. It has been an interesting afternoon for us in what is a really challenging environment. Both you and the previous witnesses have given us something positive as well as a challenge. We will take some more evidence. At some point we have to put this all together and come up with some recommendations. This goes for our previous witnesses as well: if anything occurs to you on reflection, after this evidence session, that you feel you want to stress or bring to our attention, I hope you feel completely free to contact our Committee staff and feed that in because we are anxious to get the most up to date and the most relevant input. Thank you very much.

Wednesday 5 December 2007

Members present:

Malcolm Bruce, in the Chair

Hugh Bayley	Ann McKechin
John Bercow	Jim Sheridan
Richard Burden	Sir Robert Smith
James Duddridge	

Witnesses: **Professor Peter Godfrey-Faussett,** Chair, Technical Review Panel, Global Fund to Fight AIDS, TB and Malaria, **Professor Charlotte Watts,** London School of Hygiene and Tropical Medicine and **Ms Catharine Taylor,** Lead Specialist for Maternal Health, HLSP, gave evidence.

Q177 Chairman: Good morning, ladies and gentlemen. Before we go into the session I would just like to say that we have as a committee each year marked World AIDS Day by taking some particular evidence. This is obviously part of our inquiry into maternal health but focuses particularly on the impact of HIV/AIDS in that area. The Committee was not actually here on 1 December; this is the closest date to it. The point that I feel sure this will bring out is that, clearly in those countries where HIV is prevalent, the impact of that on maternal health is pretty closely linked. One or two figures which have been highlighted are that HIV positive women are four times more likely to die in pregnancy or childbirth than women without HIV; HIV positive women face a higher risk of infectious diseases, such as TB and malaria, and yet less than 10 % of pregnant women with HIV are estimated to be receiving any anti-retroviral therapy; and in 2005 more than half a million children were newly infected with HIV through mother to child transmission. So pulling these things together is clearly significant. I think the point we have already identified in this inquiry is that too often maternal health is one thing, malaria is something else and HIV/AIDS is something else and yet pulling them all together is clearly logical; so what we are looking at is how DFID[1] and the Global Fund can actually help in that process as well as the other issues such as gender inequality and sexual violence, which aggravate the problem. It is just to put those issues in context and connect it specifically to the Committee's annual commitment to acknowledge World AIDS Day and make a contribution to that. With that preamble, I wonder if the panel, for the record, would perhaps introduce themselves and then we can go into the more specific questions related to the inquiry.

Professor Watts: Shall I start? Good morning. My name is Charlotte Watts. I am from the London School of Hygiene and Tropical Medicine. I am not an expert in maternal health but I have been working for many years on HIV, in particular gender issues around HIV, and I head a research centre working on gender-based violence and health.

Ms Taylor: Good morning. My name is Catherine Taylor. I work for HLSP, which is a consulting firm that specialises in health system strengthening in low and middle income countries and I am the lead specialist in maternal health. My background in maternal health is that I worked in the NHS for 14 years as a midwife and as a midwifery tutor and then overseas for 15 years on a number of long-term projects working in maternal health, reproductive health and, more recently, HIV/AIDS. I have just taken over the Programme Manager post in South Africa for the DFID funded multi-sectoral programme for HIV/AIDS.

Professor Godfrey-Fausett: Good morning. My name is Peter Godfrey-Faussett. I am a professor of international health also at the London School of Hygiene and Tropical Medicine, but I am here really standing in for the Global Fund to Fight AIDS, TB and Malaria. I serve as the Chair of the Technical Review Panel for the Global Fund, which is the body that recommends to the Board of the Global Fund which projects should and should not be funded. I am glad to say that to date the Board has always accepted our recommendations. Our role on the Technical Review Panel is independent of the Global Fund and, when the Global Fund were asked to come and give evidence to the Committee, they, unfortunately, were not able to send one of their technical people and so they asked if I could come and speak to the issues. They pointed out to me that I was entitled to speak, as I do for the Technical Review Panel, as an independent witness rather than formally representing the views of the Global Fund, but I know the processes of the Global Fund very well because I have been deciding what to recommend for funding over the past four years.

Q178 Chairman: Thank you very much for that. On the general review that this Committee has done on the progress towards the targets on HIV, the concern has been that the target was set for 2010, not interim targets, and to the extent that there are interim figures available, they do not look like being on a line that would achieve those targets. There has been some increase, apparently, in those receiving treatment from anti-retroviral therapy. It has gone up from 7 % in 2003 to 12 % at the end of 2004 to 20 % at the end of 2005, but that still leaves about 4.7 million people in Africa who need anti-retroviral therapy who are not receiving it, and, as I said in my opening remarks, less than 10 % of pregnant women living with HIV/AIDS are receiving necessary treatment, even though it is demonstrated that if

[1] Department for International Development (DFID)

they do their survival rates are much higher. Very specifically in the context of the Department for International Development, what can DFID do to improve access to anti-retroviral therapy that they are not doing already specifically to ensure that pregnant women who have HIV can get access to the drugs that they need, given the evidence is quite clear that, if they do, it greatly increases their survival rate, so it not only reaches the HIV/AIDS target, it also delivers on one of the Millennium Development Goals which is most off track?

Professor Godfrey-Fausett: Shall I kick off. I think that the environment around care for HIV changed hugely, of course, with the arrival of anti-retroviral drugs, and we have seen a massive scaling up of treatment for people living with HIV with anti-retroviral drugs in poor parts of the world, so the numbers have gone up a lot. I think that the emphasis on providing treatment for people living with HIV has, to some extent, distracted attention from what was happening before those big treatment programmes started going. In particular, the early programmes on prevention of mother to child transmission started usually with the assistance of UNICEF,[2] who led the first pilot programmes, and they have not continued to scale up. I think that is because people's attention has been more focused on getting treatment out to adults who need it.

Q179 Chairman: You think it is that. In other words, you reach the easiest people first and it is harder, without the infrastructure, to reach more or actually the will has diminished?

Professor Godfrey-Fausett: No, I think it is a matter of focus. It may be a matter of the resources available in ministries of health and other relevant ministries to provide, but if you take, for instance, the example of Zambia, where I have worked and lived for many years and which I visit regularly, the number of adults now receiving anti-retroviral drugs is more than 120,000, so they have dramatically scaled up over the past five years; and it is not that those people are easy to reach, those are big, difficult programmes, often supported by PEPFAR,[3] the Global Fund and the Ministry of Health in Zambia, but, at the same time, women who come to a regular antenatal clinic are not always offered an HIV test, do not always receive anything to prevent infection of their infant; in fact the rates of services to prevent mother to child transmission for those women is still unacceptably low. My own perception is that that has been because there has been a focus issue, and I think that focus is now shifting back a bit. I think people are accepting the importance of prevention, which perhaps we had lost a little bit in the push to get people on to treatment, and I think perhaps we are becoming a bit more balanced, not least because, as more people are treated, many of those people have been treated through programmes that have been established in order to treat people and they are based within the health service; they, nonetheless, have their own reporting and recording systems often. There is a degree of disease-specific focus around that, and the obstacle to continuing to expand those programmes is the weak health infrastructure, and the weak health infrastructure in turn relates to why women may not want to go to the health service in the first place; it relates to the inefficiencies in the health service in delivering what should be a much more straightforward intervention. If one talks about the medical side of it, and I think it is very important that we move beyond just thinking of the medical part of preventing mother to child transmission, but if we think of the medical side alone, it is a much more straightforward intervention than the idea of starting someone on treatment and then keeping them on treatment for the rest of their lives because it is a time-limited intervention that is just for the period in the run up to labour, in labour and thereafter. It should be much more straightforward. So, I do not believe that it is because it is more difficult, I believe that it is because of the attention that has been placed upon it.

Q180 Chairman: Can I ask the other witnesses. Is there anything specifically you think DFID could be doing to help address this shortfall?

Ms Taylor: In fact, I would just like to go one step back before answering that question, if I may. My fellow witness here has alluded to this fact. Often HIV/AIDS, TB and malaria are seen as disease specific and activities involved in actually addressing those diseases are not integrated into their health system and so they often run as parallel systems, and I think that that is historical in that HIV/AIDS was almost taken out of reproductive health and placed over here and so we have actually had fragmentation of the issues. I think that that is playing out in the fact that often maternal health services and health systems in low income countries are poorly resourced, both financially and in terms of human resources, in relation to HIV programmes. So that is the context. In relation to what DFID could be doing, I think from the work it has been doing recently it is going in the right direction. It is working at a global and regional level with policy-makers to address this lack of integration and is highlighting the need for reproductive health services and family planning services as part of PMTCT[4] activities as well as looking at continuing care throughout pregnancy and after. For example, it recently funded the maternal and newborn health programme in Zimbabwe which actually linked very closely with the HIV/AIDS programme, and it was specifically designed to do that; so that they are, for example, at a policy level, talking with the major agencies and funding and then, at a country level, they are actually leading by example and funding programmes where there is linkage between maternal health and HIV/AIDS. What more could DFID do? I think definitely more of the same. There is a lot of lobbying and the new International Health Partnership that they introduced in the autumn, I

2 The United Nations Children's Fund (UNICEF)

3 The United States President's Emergency Plan for AIDS Relief (PEPFAR)

4 Prevention of Mother to Child Transmission (PMTCT)

think, is a very good step in that direction, looking much more at health as an integrated approach rather than in silos, as they are called. As I said, more of the same, lobbying at an international level, but also at a country level. We know that there has been a shift over the last few years towards budget support, and I believe that that has a lot of advantages in many areas, but when you are giving budget support there is also a need for very good technical knowledge at a country level so that you can enter into negotiations at a country level and be seen as credible in those negotiations with government, so that you can actually influence policy at a country level, so that the budget support is well spent, but also keeping up technical support for countries that do have budget support. In the more neglected or marginalised areas, such as youth, for example— I use youth as a marginalised area— we often think of neglected or marginalised groups in terms of commercial sex workers or males having sex with males, but youth are quite neglected and marginalised areas and often governments are quite reluctant to deal with those areas.

Q181 Chairman: The Committee addressed that in our report on AIDS last year, but it is still relevant.
Ms Taylor: I think there is still a need for a varied basket of aid instruments at a country level. Yes, budget support, because that has many advantages, but also not forgetting that there are other areas that are neglected which sometimes require integrated programmes to perhaps kick-start or help governments develop evidence in their own country which then they can act upon.

Q182 Chairman: Professor Watts, the evidence we have had so far on the general issue of maternal health has been that the cost of accessing health services, particularly if they are of poor quality and a long way away, is high, and also women may not be able to get transport or even have their own money. Is this the same problem— that access to anti-retroviral drugs or even the knowledge that you have a problem is exacerbated by the fact that there is no infrastructure? Does it bring us all back to that same problem?
Professor Watts: I agree, there are large issues around infrastructure, accessibility, weak health systems. I agree completely with my colleagues. The point that they have not touched on which I think is also important to consider is the gender issues about the barriers that women face in terms of actually getting HIV tested. You might have a woman coming to a facility but being too scared to find out her HIV status because the implications of knowing her status are very scary for her. She might fear violence if she does find out that she is HIV positive, and what we see from prevalence surveys in low and middle income countries are figures like one in three women are experiencing physical or sexual violence by their partner. This is a very common reality and, even if a woman is not in a violent relationship, that fear of violence is often very much there. Thinking about how we can strengthen health systems, a component is to try and think about how we can support health workers to start talking about these issues with women. There are some research studies talking about increased experiences of violence for women who test positive. Often this is a continuation of previous violence that is happening in their relationship. How can the health sector be involved in engaging with women around these issues?

Q183 James Duddridge: Of the women that do go along to get tested, what percentage manage to do so without their partner or close community actually knowing?
Professor Watts: I do not know the figures on that, but my sense (and my colleagues can correct me if I am wrong) is that if you are thinking about antenatal settings, women are getting tested on their own, they are not there with their partners, so there is quite an important opportunity there, and health workers are being trained in counselling around HIV; they could also be receiving training around gender, around violence, how to respond if a woman fears violence, what are the issues around how to disclose and think about the procedures around disclosing in a safe way to their family, to the community? In terms of how many women succeed in doing that, I do not think we have figures on that.
Professor Godfrey-Fausett: No, but I think the point is well made. I think one of the advances, perhaps, that has been made in the HIV testing field is to encourage more family-based and couple-based counselling where both husband and wife might know their result together, because it allows one to negotiate and to think about it. The danger for a woman who finds out she is HIV positive, if she discloses that to her husband or to her sexual partner, is that he will often assume that she brought it into the relationship, whereas, of course, who knows what the real story is and how it came about. I would certainly agree with Charlotte that many women do not disclose their status. I think increasingly, to come back a little bit to the question— I am sorry, I cannot remember which of you posed it— of whether it is the difficulty in getting to the health centre, certainly that is part of the issue, but the fact is that technological advance has meant that the technology of HIV testing is extraordinarily straightforward now. You can have HIV tests that do not need to be stored in a fridge, that are accurate, reliable, work in 15 minutes on a spot of blood that is put on the filter paper, on the stick, and give a reliable test. So many women are passing into antenatal care— though by no means all— and of course we should be pushing rates of antenatal attendants and skilled attendants up, but many more women are having a skilled attendant in attendance at some stage during their pregnancy and yet many of those same women are not being offered an HIV test, which could dramatically reduce the chance of their infant being infected with HIV. HIV in children virtually does not exist in this country now. Children are not becoming infected because of a policy of routine screening of all women, whether they are thought to be at risk or not, and they will all have an HIV test, routinely, unless they specifically say,

"You must not test me for HIV." The same policy is gradually being rolled out across most other countries, a provider initiated HIV test. Again, the traditional approach to HIV testing has been much more softly, softly, has been based very much on being really sure you want to know your HIV status because there are risks associated with that; whereas I think the system is changing now so that in many antenatal clinics the aim is that women should routinely be offered an HIV test unless they say they do not want to have an HIV test, and then, depending on the results of that test, a number of other actions follow. Can I add one extra thing that came out of this: the role of men. We talk about the prevention of mother to child transmission; in our Technical Review Panel at the Global Fund we like to try and think about parent to child transmission, because this business of involving the father or the sexual partner is extremely important in the whole process. The first aim, of course, is to prevent the mother from becoming infected with HIV, which also has a lot to do with the partner's behaviour. Specifically there are examples where sexual intercourse during pregnancy is seen as taboo or is not permissible in many cultures and, as a result, there is some pressure on the man to seek other sexual partners during pregnancy, and, of course, that puts the man at risk of acquiring HIV infection and we know that the period shortly after acquisition of HIV infection is the most infectious period. So a man who goes and acquires HIV infection because his wife is pregnant is particularly likely to infect her when they do have intercourse, and, if she is recently infected, similarly, studies show that she is particularly likely to pass it on to her infant, because she has a high viral load around the time of infection. One can see a sort of scenario where cultural norms enhance the possibility of transmitting HIV to both the mother and to her infant, and, therefore, we do need to be involving men in the situation. I am sure many of you have visited health centres or antenatal centres in developing countries. They are not at all male friendly. Men are very much kept out of maternity suites and so on because many women are in labour side by side, or whatever, and it is often not seen as appropriate for men to be there. Managing to create a more male-friendly environment is very important, I think.

Q184 Hugh Bayley: You have begun to answer my question without prompting. Clearly the health environment is one of the factors that increases rates of mother to child transmission, but even when the woman knows her HIV status there are a number of simple, cheap, easy to use in developing countries, clinical interventions that can dramatically reduce the risk of transmission at birth. Why has the spread of that knowledge, the use of that knowledge, in developing countries been so slow and what can be done by DFID to speed it up?

Ms Taylor: May I just make a quick point on another question before I answer yours. I think we sometimes fall into the trap of thinking about PMTCT as only the third of the four prongs. PMTCT is not just about pregnancy and HIV testing in pregnancy and the use of anti-retrovirals, et cetera. PMTCT starts in actually ensuring that women do not become HIV positive whether they are pregnant or not. That is the first issue. It also involves women making reproductive health choices: "Do I want to get pregnant? If I do not, how do I ensure that I have access to services so I can get contraceptives for dual protection purposes: both from pregnancy and from HIV?" Then we come to the question, as you mentioned, of services during pregnancy, but after that there are also services for making sure that the woman who is HIV positive remains healthy, and often women fall off the cliff, as it were, in the postnatal period when they then do not have access to anti-retrovirals, and of course the likelihood that she will die and then her child will die is increased. I just want to mention that when I talk about PMTCT I am not just talking about in pregnancy. To go to your question around PMTCT in low income countries, many low income countries have increased their services for PMTCT during pregnancy and they have introduced antenatal care testing facilities. Somewhere like South Africa, for example, I think probably about 90 % of their primary health care clinics would put their hands up and say, "We provide PMTCT services", but as my colleague said—

Q185 Hugh Bayley: But doing it in South Africa is hugely easier than doing it in Malawi or Zambia. It ought to be, it is a much richer country with a much stronger health infrastructure, more trained personnel, and so on.

Ms Taylor: Yes, but still the rates there vary very dramatically. If you look at Cape Town, for example, over 70 % of the women who need it will have it. If you look at some rural areas, you are looking at an uptake of PMTCT as low as 24 %. Offering the service is one thing, but during that period there are a lot of things that can go wrong; so the service may be there but then the woman has to actually go to antenatal care, and over recent years— and I am making a link with maternal health here— the focus has gone away from antenatal care, because in maternal health we were thinking that really lives are saved at delivery and after, which is true, and then there was less focus put on antenatal care, I believe, for a number of years. So, you have a situation where the services for antenatal care are perhaps not as good as they should be because there has been lack of resources and there is not the quality, and then you are asking them to add another service, which is PMTCT. The woman has to agree to actually go to antenatal care (and this is an access issue), then she has to agree to have a test, then she has to have the results and there are rapid tests where she could have the results that day, but often services do not provide that, so she may have the test and then not go back.

Q186 Hugh Bayley: By all means explain what the difficulties are, but the question is what can be done by DFID or other agencies to help to improve the state of provision?

Ms Taylor: I think perhaps, if I may go back to this, the fact is that we always think about PMTCT as a point of contact, say, in the antenatal clinic or a VCT[5] testing centre. Perhaps one of the things that we could be doing is to look at how we can really expand opportunities for people to actually know their status for HIV. So, rather than thinking of it purely along the lines of those areas, examples would be family planning clinics: make sure they have VCT testing, make sure that ordinary primary healthcare clinics have the facilities for VCT testing and that they do not just have it in one room where people have to actually go to a room but that it is part of the general service. I think it has been a problem that often it is not seen as being an integral part of the health service but something separate. I would say increase opportunities for people to understand their status but at the same time, I think when we are looking at health services, as my colleague said, we forget the community aspects of that, and I think civil society and community groups have a huge role to play in reducing stigma and discrimination against people who are HIV and I think often that is a neglected area. So, it is funding health services to increase access but at the same time ensuring that resources are going to civil society and community groups to reduce stigma and discrimination.

Q187 Hugh Bayley: Could I ask further about the balance between prevention and treatment? Are any of you able to give the Committee a ball park figure of the cost per HIV infection avoided for, on the one hand, prevention for women of child bearing age and, on the other, prevention of a mother to child transmission? Which is the more cost-effective?
Professor Godfrey-Fausett: I thought they were both same.

Q188 Hugh Bayley: Prevention of infection for a woman of child bearing age as against prevention of mother to child transmission at birth.
Professor Godfrey-Fausett: I can give a ball park figure for the first.

Q189 Hugh Bayley: Perhaps a general cost—
Professor Godfrey-Fausett: Charlotte has done some work around this. Around 250 dollars per HIV infection averted.

Q190 Hugh Bayley: ---of general health education.
Professor Godfrey-Fausett: There are a number of approaches, but somewhere around that sort of value. That was the value that came out of one of the trials.

Q191 Hugh Bayley: The cost of preventing mother to child transmission. I understand it is not just giving anti-retrovirals at birth, it is providing a whole package.
Professor Godfrey-Fausett: I am afraid I have not brought the data with me. Elliot Marseille has done work on this.

[5] Voluntary Counselling and Testing (VCT)

Q192 Hugh Bayley: Behind the question is this. If I was a policy-maker, have we got the balance right between prevention and treatment of an HIV positive pregnant woman and her baby?
Professor Watts: I find the comparison a bit hard. You are saying is it better, is it cheaper, is it more cost-effective to prevent an infection of a woman—

Q193 Hugh Bayley: These are always hard choices.
Professor Watts: I know. ---or the subsequent transmission to her child, but if we prevent the infection of that woman we also prevent the subsequent transmission to her child. If we are talking about $250 to avert an infection amongst women, then we are actually averting two infections potentially, if she is likely to become pregnant over that period.

Q194 Hugh Bayley: Or perhaps, given the birth rates in Africa, more than two?
Professor Watts: Maybe that. We have a one in three transmission probability.

Q195 Hugh Bayley: The question is: have we got the balance right between prevention and clinical interventions to deal with people who are HIV positive, but rather than just talking in general terms, we have to do as much as we can for both? Given resources is a huge constraint in sub-Saharan Africa, it would be helpful to know how many lives are saved or how many lives avoid infection by one emphasis over the other.
Professor Godfrey-Fausett: I entirely appreciate Catharine's comments about not focusing just on the medical side, but I want just to focus on—

Q196 Hugh Bayley: I think it is very important.
Professor Godfrey-Fausett: Nonetheless, since you raised the question of treating them, there is no doubt that finding that a mother is HIV positive and giving her and her infant a short course treatment with anti-retrovirals is certainly a very cost-effective way of ensuring that that infant is not infected. If we look at the Global Fund's programmes, for instance, I think that currently 130,000 HIV positive mothers have received such treatment through Global Fund programmes up-to-date, but I think it comes back to your earlier question about what DFID can do and how it is doing it, and it comes to the question of a country's own priorities. When one puts in budget support, then to a large extent the country is deciding what are its priorities, and there are many political pressures on that priority setting process in-country as well and it is not always clear, but the budget is often not supported to the extent that everything they would want to do is being done. Unfortunately, ministries of health and, indeed, ministries of education often get less out of the budget than might be anticipated and, as a result, it is not only that you find that peripheral clinics do not necessarily have the facilities to do HIV testing and offer a cheap way of preventing mother to child transmission, they often do not have antibiotics in the cupboard, they often do not have this or that, and that relates to procurement systems, it relates to

delivery systems, it relates to the quality of the roads, it relates to the quality of the staff, it relates to development in fact. So, of course, as one wants to develop, one has to work out how to encourage countries to develop and then they will be much better at that. The alternative is to take a more targeted approach where you say that we think that this particular problem should not be allowed to go on but we can do something very concrete about it, and that tends to lead to more specific interventions around maternal and child health or around tuberculosis or around the delivery of anti-retroviral care. You ask: why are things different? The reason things are different for anti-retroviral care is that the international community made a very strong push and pushed, through the World Health Organisation, perhaps through its Three by Five initiative, and through PEPFAR, which is a very big programme from the American Government for putting large numbers of people on treatment. They were very focused on targets and they said, "This is what we want to achieve"; whereas the targets that were set up at UNGASS[6] to achieve 80% reductions, and so on, they did not have an action plan to follow. They were aspirational targets and very different from, if you like, a PEPFAR target to say, "We are going to treat this many people with anti-retroviral drugs and prevent this many new infections and this is how we are going to do it." I think I would echo what you said, Catharine, but perhaps I am slightly further on one side than that. You mentioned in your comments the need for multi-modes of funding. My own view is that if you put all the money into budget support, many of these programmes simply will not happen, they will not work. We know that things are extremely difficult in the poorest countries of the world and that those governments have many competing priorities of which ensuring there is a rural clinic where the people do not have much political clout, ensuring that the women there have adequate care, maybe quite low on the political agenda and may not be something that is easily funded out of budgetary support. It is, of course (and I am arguing from the Global Fund standpoint), a good reason for support through a mechanism like the Global Fund that takes internationally recognised priority areas of HIV, TB and malaria, including reproductive health within the HIV focus, and says, "We are going to give money for what the country chooses." It is a demand driven process. The country has to say, "These are the things that we want to do." The Global Fund provides money, if they seem technically appropriate, but also ensures that they are doing what they said they were going to do. So, I strongly support this view that you cannot simply give budget support and say, "We have done our bit and we can encourage the country to go down that way." I think more targeted interventions are much more likely to have an impact on specific disease levels.

[6] The UN General Assembly's 26th Special Session (UNGASS), meeting in 2001, issued a Declaration of Commitment on HIV/AIDS

Chairman: Can I give a time warning here, because we have quite a lot of questions and we are going to run out of time. Can I say to both sides, shorter questions and shorter answers and we will get through them.

Q197 Hugh Bayley: How important is it to have a skilled birth attendant at the time of birth to reduce mother to child transmissions, which is extremely important, and do you think sufficient emphasis is given to training staff, paying whatever incentives you need to get them into rural areas, as against some of the other priorities of the Global Fund? I understand the political pressures from the West for universal medication. It is the sort of thing you have just been criticising me for, for looking at interventions and thinking that that alone will solve the problem, but the cost of a life-year gained through anti-retroviral drugs is usually higher than the cost of a life-year gained through preventing, avoiding mother to child transmission. Is it important to divert some of the Global Fund's resources into training of more qualified birth attendants and midwives?
Ms Taylor: Yes.

Q198 Hugh Bayley: Perhaps we should ask the Global Fund to comment.
Professor Godfrey-Fausett: I would also say yes, but I would follow that by saying, and you may think that I am dodging the question, that the Global Fund is a financing mechanism. The Global Fund does not decide what countries should ask for. I would say that the Global Fund, certainly at our Technical Review Panel, are frustrated in the area of mother to child transmission in its broadest sense, that countries themselves frequently focus precisely on testing and giving Nevirapine. We cannot do anything about that, because our job is to recommend to the Board, yes, or, no, on the technical merits of a programme. The Global Fund does not tell countries, "That is what you should do." That is the role, if you like, of the technical partners, of the international NGOs, the people who work with the countries to encourage them as to what they should apply for.

Q199 Hugh Bayley: Let me ask you this question. If you had a free hand, knowing what you know having been Chair of this Technical Panel for some time, would you say we ought to be giving advice about the shape of a cost-effective health intervention, a mother and child strategy for a developing country? You cannot control the whole thing, but do you think more emphasis should be placed on this?
Professor Godfrey-Fausett: I think that we should be engaging countries in a conversation about what they see as their priorities. I think we should be working hard to build the public health capacity of the countries themselves so the countries do not feel that they are being, if you like, dictated to. It should be that they can enter that conversation in a less asymmetric way than they do at the moment. The more we can build up the ability within countries to

have that conversation the better. I would be careful. I would not want to say we should say this is how it should look; one size will certainly not fit all in different situations. Certainly we should be laying out, "These are the possible benefits of things", and letting countries come and say, "Yes, that is what we want to do."

Q200 Sir Robert Smith: We have been talking about integration. You have got a targeted fund at the Global Fund looking at specific diseases and then, obviously, the clear links with sexual and reproductive health. From what you are saying though, does the Fund actually take any practical steps to encourage that integration of maternal, sexual and reproductive health into the programme that it funds or are you very much reacting to what is coming in?
Professor Godfrey-Fausett: We are a demand driven process. It does not encourage specific things, it says, "This is the area", but it catalyses discussion on those areas mainly through its technical partners. For instance, there was a recent meeting that the WHO (World Health Organisation) organised in conjunction with the Global Fund to which it invited countries and experts to discuss the ways in which countries could apply for money to strengthen their health systems. The Global Fund has always made it very clear that strengthening health systems in order to have some impact on HIV, TB and malaria is an entirely legitimate use of the Fund's money, but to date countries have not availed themselves of that resource as much as they might, maybe because they misinterpret, they say, "HIV, TB and malaria— that is what it is for", whereas actually I think the Fund would welcome a broader base to what countries ask for. In answer to your basic question, the Fund is not a technical agency. The Fund does not tell people, "This is what you should be doing." It says, "Apply to us with what you want to do and, providing it is in line with international best practice, then we will fund it." So I think it is more up to DFID, WHO, more technical agencies, to be encouraging countries with what they could apply for.

Q201 Sir Robert Smith: Do you have any examples though of applications that have shown good integration that maybe you could give us? Perhaps not now.
Professor Godfrey-Fausett: Yes, there is a number of different ways of integration of different parts. There are certainly programmes. In Malawi there has been a programme that is about healthcare workers at perhaps a more peripheral level; so precisely the point we were talking about earlier of having a more rural-based cadre, resurrecting a lower cadre of healthcare workers with support from the Global Fund to allow the reach of the health system to go further. There are numerous projects that aim to embed within reproductive health services at clinic level the ability to encourage prevention of HIV at that level and prevention of mother to child transmission. I have mentioned that about 130,000 women so far have been treated in such ways, and those are within a large number of programmes across all the regions. I can list a few of them if you would like me to.

Q202 Sir Robert Smith: Perhaps you could send them to us?
Professor Godfrey-Fausett: Yes.

Q203 Sir Robert Smith: DFID is giving £359 million through to 2008 to the Fund?
Professor Godfrey-Fausett: Yes.

Q204 Sir Robert Smith: But your advice is if DFID wish to see that money go to more integrated delivery it has got to actually speak to the applicants?
Professor Godfrey-Fausett: Yes, DFID is in a strong position because it has country programme staff as well, it has people who are engaging with ministries of health, ministries of finance and the technical people on the ground, and if it encourages those people to realise what they can apply for, then the money is sitting there and is largely available. I think that the Global Fund is happy to receive things. This is not a carte blanche. The Fund was set up to make an impact on HIV, TB and malaria, but I think it is very easy to make the argument that investing in improving integration of reproductive health services and HIV, investing in reproductive health services, is very likely to make a difference to HIV and tuberculosis, as we heard at the beginning, and, indeed, malaria. I think all of these, in fact, relate to maternal health in a big way. I think that the argument is very easily made and, providing that argument is made in the proposal and it is not seen that this is simply investing without the link, if the link is made I think it is entirely appropriate.

Q205 Jim Sheridan: Can I perhaps address my question to Professor Watts. There is a clear inter-relation between sexual violence against women and HIV/AIDS. Is there any practical example that you can tell us about where you have intervened to try and perhaps stop this from happening?
Professor Watts: A recent and quite high profile success was an intervention study that I was involved in in rural South Africa, and that was very much primary prevention. It was in part funded by DFID, where we basically empowered women, both economically and socially. It was working with a very strong micro-finance group and adding on to that micro-finance participatory activities around gender, violence and HIV. What we saw over two years, over a short pragmatic time-frame, was a 50 % reduction in women's experiences of partner violence. It has been a very exciting study and it illustrates the potential. I think looking at development opportunities— in that case we were looking at micro-finance— but adding on issues around gender, around power, and we saw a very synergistic effect that very much resulted in changed relationships, much stronger improved communication and reductions in HIV risk behaviours amongst participants and reductions in violence.

Q206 Jim Sheridan: A 50 % reduction. Have you any plans to reduce that even further, or how best could you extend it into other areas?
Professor Watts: It is a very good question. I was pretty pleased with a 50 % reduction. For that project it was a small scale thing, and what we are doing now is the micro-finance group is scaling up across the region and we are doing work with them to say, "How do we scale up the gender elements?", but also trying to learn from that about what are the implications for other development initiatives. Are there ways that we can take some of that learning and apply it in other settings? It is not something that is done very much though. There are these promising initiatives, and I would be very much encouraging DFID to be trying to learn from that in terms of their broader activities.

Q207 Jim Sheridan: You said DFID part-funded it.
Professor Watts: Yes.

Q208 Jim Sheridan: Who else funded it?
Professor Watts: Ford,[7] CEDAW,[8] a range of the more progressive donors essentially.

Q209 John Bercow: Apologies, Chairman, to you and our witnesses for arriving late. Professor Watts, I am very interested in this field and, in particular, in the reference to the survey that you have just made. On the assumption that predominantly gender-based violence is inflicted by the existing male partner rather than by somebody else in the household or in the village or neighbouring area, was it the working assumption of that study that both partners should be involved so that the men, who are after all the culprits, have some purchase on the training, the therapy, the advice, the exhortation, whatever misogyny or different tactics are involved?
Professor Watts: A good question. In that particular study we very much focused on women, but it was very context specific; so in this setting it was very much that men are quite migrant, they are going to Johannesburg to work in the mines and coming back. We started off wanting to work with both men and women, but men are much less accessible and so when we were talking to women, they were saying, "No, work with us and then we will take issues to the community." As part of that work there was a very strong emphasis on social mobilisation and part of the lower group activities, part of the micro-finance activities, led to those groups taking issues to local leaders, going out and talking to youth, to boys, and so it was working through women to reach men. There are other examples of programmes that focus exclusively on men that are also very promising in terms of promoting alternative models of masculinity, really engaging on: what does it mean to be a man? To me it is a challenging issue, but actually fundamentally it gets at what we need to be looking at around being a good father, about not coercing sex, about issues of HIV prevention, and where you do see evaluations of those projects they are quite promising and they lead to multiple benefits.

Q210 John Bercow: Of course, from our visits to several different countries in Africa, we are well familiar with the phenomenon of substantial periods of separation between male and female partners, with the man typically going to work in one or other of the big cities a substantial way away. It would be of interest to me, and it may seem academic, but I think it would nevertheless be potentially relevant to know, whether the incidence of gender-based violence is that much greater, and therefore the problem is that much more acute, in those households where there are long periods of separation and, to put it very bluntly, Professor Watts, the male partner, the husband, comes back and then, if I can, as I say, put it very explicitly, thinks, "Well, I have got to make up on lost time." However intolerable culturally that is to us, it is a reality, is it not? Does that tend to have an impact?
Professor Watts: It is a good question and one we have not looked at. When we looked at the level of violence in those populations, they were pretty similar to other areas in South Africa that have less mobility, but in a way you think it could be lower because the men are not around that much. I cannot say yes or no.

Q211 John Bercow: On the whole question of the cultural norms which tend to influence behaviour, do you or others in programmes of this kind tend to accept male resistance to condom use as a given and feel you have just got to work round it or are you, where it is, frankly, prevalent, trying, at the risk of being accused of cultural imperialism, to say that this really will not do and there is a better way?
Professor Watts: I think in the end, in terms of this project, if I think about this project, the focus has been on everything, so you want to reduce risk behaviour, you want to try and challenge the acceptability of men having multiple sexual partners, extra-marital relationships, you want to improve communication in the household, you want to empower women to be able to more openly discuss condom use or other health needs and you also need to be investing in alternative technologies. I think you need to be pushing on all fronts but recognising that those underlying issues around concepts of masculinity, around violence are something that you have to be quite explicit about and we have to engage with in a meaningful way. When you look at HIV messaging, my frustration is that there is this sort of implicit assumption that most sex is consensual, or that sex is consensual within loving relationships. That has become very distant from the reality of many people's lives and we have to start thinking about how do we deal programmatically with those uncomfortable realities that you are referring to.

Q212 Richard Burden: John has covered many of the areas I was going to explore with you. Perhaps I could focus a little bit more on DFID's role both in

[7] The Ford Foundation
[8] The United Nations Committee on the Elimination of Discrimination against Women (CEDAW)

relation to the South African project that you have been talking about and also some of the projects that have been done in relation to gender-based violence in Nepal. What lessons have you learnt from those in terms of how DFID itself could make a greater contribution, could scale up and apply any lessons elsewhere?

Professor Watts: I think there is a number of different levels where DFID could be making an important contribution. At an international level, for example, in the recent UNAIDS[9] costing of resource needs for HIV, for the first time they included responses to gender-based violence and $2.2 billion was included in those projections. I think DFID has an important role at that international level pushing for there to be investment in that, and when you translate that into a national level, those resources are going in, explicitly addressing some of those links between violence and HIV. One of the main challenges in terms of what do we do is the limited evidence-base, and what I see is a number of very promising interventions that do show we can have quite large impacts over short periods of time but I can count the evaluation studies on one hand, and so we do need to build an evidence-base about what are the approaches that work with men, with women, what is the role of the economic components versus addressing issues around alcohol, fundamental attitudinal issues around the acceptability of violence. From the projects that we do know, where there is success, I think the core elements are that there is a meaningful engagement with communities, with men, with women, over time, and so in terms of programming, I think it is looking at what are opportunities of, say, working within the development sector or even within the health system; where an agency is having an on-going relationship with the community or interaction with men and women in that community, to say how can we explicitly bring issues around gender and HIV and violence into those programmes.

Q213 James Duddridge: A few questions for Catharine Taylor. The first one is around the interaction between sexually transmitted diseases and HIV. In particular what can donors do to integrate the diagnosis and provision of treating the two conditions together, because that seems to be the thrust of what you were saying: a more integrated health system?

Ms Taylor: Yes, as you were saying, there is a lot of evidence about the interrelationship between HIV and sexually transmitted diseases. I think, again, look at reproductive health in its broader sense. For example, you often find that STI[10] diagnosis and treatment is actually very poorly implemented at a clinic level and often is not really seen as part of the package. Again, from personal experience here, often in countries you go to the dermatologist if you think you have got one of those diseases, as it were, and so often health services are not fully equipped to deal with the diagnosis and treatment of STIs. So I think ensure that it is part of the package within the health service.

Q214 James Duddridge: The donors' funding money in that direction though: is the message getting through to donors?

Ms Taylor: Yes, I think the message is getting through to donors but I think often there is a disconnect between what the donors are saying at a policy level and the implementation of that on the ground. I think there needs to be not only a lot of emphasis on policy but also looking at integrating and implementing good services on the ground. I think there is still that disconnect. If you talked to anybody in the Ministry of Health they would agree with you that STI diagnosis and treatment is a very important aspect of care, but if you go to any clinic it is not happening. So it is really to ensure that the implementation is there as well as the policy.

Q215 James Duddridge: Have we seen any benefits yet of the integration within the DFID team of the HIV/AIDS policy group and the reproductive and child health policy group, or is it too early to see the benefits?

Ms Taylor: It has only happened quite recently and I think it is possibly too early to see a lot of the benefits, but I do see in my discourse with advisers, et cetera, a lot more discussion around the integration of reproductive health and HIV, certainly. The fact that the maternal health adviser is not in that group but, I think, in a separate group perhaps needs to be addressed so that she has the opportunities to interact with that group as often as possible.

Q216 James Duddridge: Was that issue raised when the integration was talked about? I had not appreciated that the maternal health side still sat outside that group. That seems to be an anomaly.

Ms Taylor: It is my understanding that that is the situation. I cannot say what the discussions were when the decisions were made. If I understand correctly, I think that she is in the Scaling up Services Team, so she is very much within the health systems aspect of it, but I think a lot of linkages need to be maintained.

Q217 James Duddridge: We will make sure we go away and check the facts.

Ms Taylor: Yes.

James Duddridge: You said you are unsure, so we will go away and check. Thank you very much.

Chairman: Thank you very much. The general theme of the evidence we have taken so far is a rather big one, which is that you can only tackle these problems if you have an integrated health service. We have enough trouble with the Health Service in this country. I am not going to ask you to answer the question now, but if you have any thoughts at the intermediate level, how you get from having a proper health service when there is none to ensuring that, nevertheless, there is practical access to essential services. That it what we are struggling

[9] The Joint United Nations Programme on HIV/AIDS

[10] Sexually Transmitted Infection (STI)

with, because we are not getting anywhere near the MDG[11] on maternal health. It has been suggested to us that a lot of that is cultural, attitudinal and gender-based, in other words women's low status— I guess one is trying to fight for that— but if you pull it together and say it is all part of the general health of people of both sexes and all ages, you actually start to get it into a situation where it does not get that degree of discrimination. If you have any thoughts, having exchanged this evidence with us, that would help us in that direction to make some constructive recommendations, because we have got this big vision and a huge gap in practical terms in relation to which, certainly for me and other members of the committee as well, we are struggling to find something useful and constructive that can take us from where we are. May I thank all three of you.

Q218 Hugh Bayley: Can I ask for one further bit of information after the event. To go back to the question about the relative cost of preventing mother to child transmission, you gave a figure for prevention, but if you could come back, if you could find a figure for mother to child transmission and also find a comparative figure of the cost per life-year gained through anti-retroviral therapy, I think it would be a very useful indicator of relative costs of interventions for the Committee.

Professor Godfrey-Fausett: I would be happy to, and I will certainly try and find those costs, but I would like to preface that with a comment to be cautious in the interpretation of these data. I think we possibly met in Zambia on one occasion some time back. I lived in Zambia at the time before the anti-retroviral drugs became available; I have been visiting Zambia continuously. I lived there from 1992 to 1998 and have been visiting two or three times a year ever since. I have seen the emergence of what has happened. There is no doubt that the provision of anti-retroviral drugs has a far greater impact than simply those people who are being kept alive. You can imagine that to work in a clinic where, of the people who come to that clinic, 50, 60 sometimes 70 % of the adults are dying of HIV. If you do that in an era before anti-retroviral drugs, your morale is zero. You have nothing to offer people except the home-based care. You then transform the situation by saying: "Actually now this is how we can do something about it", and you can see the change in the way clinics are performing in Zambia now, not just in delivery of ARVs[12] but in terms of a feeling that actually we are delivering healthcare. For the healthcare workers' morale, esteem, situation in the community, it leads to cleaner clinics, so I think it is much more transformative and I think it can be dangerous only to consider the costs and immediate, medical benefits. Because anti-retroviral care is widely available now, in all districts in Zambia, for instance, and this would be true in many other countries— there is some access, people know about it— that in turn transforms attitudes to HIV itself. It means that people are much more able to name the beast because they think, "Actually I can get treated if it turns up." It alters things in ways that are every hard for an economist to put down on a sheet of paper and probably, although it is hard to prove, has a major impact indeed on prevention, because if, as a result of reducing stigmatisation around HIV because more treatment programmes are available, women feel more able to discuss it with their partner in a less frightening way, that may well have a beneficial impact. Whilst there are certainly figures out there, I would have considerable caution in using those to make policies. Of course they are part of the decision-making and the policy-setting agenda, but I do think they need to be taken quite carefully because there are many intangible benefits that are very hard to put down as a cost.

Chairman: If you feel able to attach a couple of practical case studies to the figures, that might help. Thank you very much indeed.

Witnesses: **Dr Gill Greer,** Director-General, International Planned Parenthood Federation (IPPF), gave evidence.

Q219 Chairman: Good morning, Dr Greer. Thank you very much for coming in for the second half of our session. Again, briefly for the record, would you introduce yourself?

Dr Greer: Thank you very much indeed. I am delighted to be here and thank you for your time and interest. I am Gill Greer. I am the Director-General of the International Planned Parenthood Federation. We have 152 Member Associations affiliated with us and we work in 180 countries in delivering comprehensive sexual reproductive health services, providing education and information, including sex education, and also in advocacy with civil society, with governments, with ministries. Thank you very much indeed for this opportunity. As you can tell, I am a New Zealander, so let me know if there are any problems with translation.

Q220 Chairman: Thank you very much. Those of us in Scotland will have no difficulty! The situation with MDG 5, the most off-track of the Millennium Development Goals, is that, as we move off track, we seem to increase the targets and we have actually added to it and embellished it and made it more difficult even though we are actually drifting away from it. DFID, I understand, has been involved in developing the new target in spite of the fact that we are not making progress on what the original target is. I think we have now incorporated into the target addressing the adolescent birth rate, antenatal care and the unmet need for family planning on top of the original targets. What do you think the barriers are both for achieving the original target and how much more difficult is that target going to be now we have

[11] Millennium Development Goal (MDG)

[12] Anti-retroviral Drug (ARV)

extended it and expanded it, and what is your organisation, the International Planned Parenthood Federation, recommending about how we can actually take on that challenge? Adding new targets when you are not achieving the first ones does not in itself seem to change the situation.

Dr Greer: Thank you very much indeed. It is our conviction that we will not achieve the first target or, indeed, MDG 5 or, indeed, any of the MDGs if we do not address the issues that are covered by the new target. We are very grateful, in fact, to the UK Government and DFID for supporting the call for this target. Originally, you may know, we called for a ninth Goal, because we believe that of all the important international meetings, declarations, conventions of the 1990s, the one that was left out when it came to the MDGs being finally framed, which is so essential for maternal health and for health and well-being generally in development, is that of universal access to reproductive health, which was the Cairo goal from 1994. I believe that if we really are to meet the goal and the targets (the target now has a contraceptive prevalence rate indicator), then we will make progress on the first, but, I agree, it does not seem to make logical sense when you first look at it.

Q221 Chairman: I am not deploring the targets, it is the practicality, and that is really the point you are trying to press. For example, if you take the new targets, how are they going to be measured? How are we going to determine that we are reaching them? Is the information that exists and the method of collecting facts and figures in developing countries adequate enough? When we were having our preliminary discussion, I was pointing out that the figure for the number of women who die in childbirth is very precisely stated in a number of publications. In spite of the fact that we have had evidence that nobody actually knows what the figure is because there is no satisfactory method. The question really is: once you set a target, how do you actually define what the situation is in individual countries and how do you then determine how they are progressing towards meeting that target? Have you got any constructive recommendations?

Dr Greer: I think there are some very interesting questions embedded in there. I do agree that trying to get really clear data is a major problem in itself. I am very interested in seeing in the IHP[13] Plus that there is going to be a component of data analysis at the very beginning. I think it is very important to try to build (and this is perhaps a role for DFID to consider) the in-country national competency in building statistical surveys and data collection so that it is sustainable. If it is always done by people coming in from the outside and, even though we do, as we can, encourage people to report against those MDG goals and other UN commitments, it is very difficult. I think, too, just from our own experience, we have recently put in place for all of our Member Associations reporting for a global indicator survey against 30 indicators, which include sexually transmitted infections, sexuality education, maternal health, HIV-SRH* integration, and so on. I know the difficulties that our Member Associations experience in trying to keep that data, but I am also seeing that it can be done. I launched a project in Kampala for HIV/AIDS and sex workers recently and, two months later, was able to get a very clear picture of the work that they are doing in broader primary care but also specifically related to maternal health and HIV. So I think there are some models there, and I know that the ideal is civil registration. When it comes particularly to maternal health, we are a long way from that in many places, but I think we can move towards it, and I know that there are some new models around too that the UN are considering as possible ways of measurement. I think it is difficult, particularly in areas to do with this area of health, because often it takes so long for the outcomes to become obvious. We can count inputs and outputs, but the outcome is much harder.

Q222 Chairman: When we were recently in the highlands of Vietnam we were in a village where the norm was for girls to get married as young as 13 or 14 and very quickly have families. That is obviously one of the new areas, which is that girls are getting married and having children younger, when they are not fully developed, and that is a contributory factor. How can you change that if you have got an embedded cultural situation? How do you actually get across that you are putting your community and your people at risk for your cultural reasons that are actually not healthy?

Dr Greer: I think encouraging governments to invest in girls' education and women's literacy is critical to that. We have enough data that shows the impact of that on later first birth, on child spacing, and so on. There have been some very interesting projects in Bangladesh and Nepal, where community groups work with parents to encourage parents to keep their girls at school. Also, when we look at the impact of free lunch schemes, which of course was one of Jeffrey Sachs' quick wins, we know that it actually works— the same with school uniforms— it encourages and motivates parents to keep their girls at school. We know that for every year that they are in school there is considerable impact on both the timing of their first child, and the number and the spacing of their children which will then impact, of course, on maternal health, plus their ability to understand nutrition, risks to themselves in pregnancy, have some sex education.

Q223 Chairman: It is a chicken and egg situation, because if the girls are at home having babies they are not in school getting the education to tell them that is what they should be doing?

Dr Greer: Indeed, one of the drivers of unsafe abortion is that in many countries a girl must leave school if she is pregnant, there is no way that she can continue her education, and in some cases that is

[13] International Health Partnership (IHP)

*Sexual and Reproductive Health (SRH).

likely to drive that issue, but I think there are laws and we need to encourage their implementation and enforcement. Nepal is an interesting example.

Chairman: We might come to that later in more detail.

Q224 Richard Burden: I would like to ask you one or two questions, if I may, about the unsafe abortion issue. It is obviously a very big question. One in eight of the 600,000 women who die from pregnancy-related complications somehow seem to have a link through to abortion-related complications. I want to ask you in a minute about the substance of that and maybe what we can learn from that and policy directions. But going back to the thing you were talking about before about the data itself, apparently the figures there have not particularly changed since 1990 and a question mark has been put to us particularly about the reliability of that data. Do you have anything to say about that and is there anything in relation to unsafe abortion where we can improve the evidence-base? Is it easier, is it more difficult or is there anything specific about the evidence-base there that we need to do to get more reliable information?

Dr Greer: If I could go back and say that, if we start by recognising the fact that 200 million women cannot access modern, effective contraception and, therefore, we have high numbers of unplanned pregnancy, some 86 million; there are 40 million abortions a year, of which 20 million will be unsafe, it is not surprising 70,000 die as a result. Yes, we will not have exact figures and, as long as it remains illegal in so many countries, we will continue not to have exact figures, I believe, because very often it will be laid down to either the immediate cause of death, whether it is haemorrhage, anaemia, whatever it may be. It is going to be very difficult. It is hard enough to get figures for maternal deaths as it is let alone for those deaths which occur as a result of unsafe illegal abortion. I think that is enormously difficult. What can we do? At the moment, for example, we have just developed a tool which we are sending out to all countries and we are working also with FIGO[14] to get them to analyse exactly what the law is. One of the problems is that in many counties the law does allow abortion under very certain restricted circumstances, but in fact neither the providers nor the women themselves often know to what extent it is available and allowed or how to access it; so we have to have really clear data in relation to that and I think then build on that to get the kind of data that gives us a clearer picture. We do know in some countries like Uruguay around 46 % of maternal deaths are caused through unsafe abortion.

Q225 Richard Burden: Obviously there is a real issue in countries where it is illegal, or near as damn it illegal, to get at that kind of data, and there are all sorts of issues around that, but are there any countries, even where it is illegal, where in terms of collecting data there is any best practice that could be applied, or pressure could be applied elsewhere?

Dr Greer: There is no doubt that through menstrual regulation (for example, manual vacuum aspiration), there is much more done than people are aware of, but providers in those countries where it is illegal and where there are harsh penalties of imprisonment, both for the woman and the provider, to a point where sometimes providers will not even address issues of a possible ectopic pregnancy because they are worried about being accused of carrying out an illegal abortion, are not going to record in any way that could be publicly disclosed what the numbers are because of the risk to themselves and their clients. That is why I say we have to work in every way we can to advocate for law change. I want to congratulate the United Kingdom and DFID for the Safe Abortion Action Fund, which we manage and distribute. Out of the first year, I would just like to say, we have distributed to 45 organisations and 32 countries for two-year projects, and they cover a range of projects, and it is that kind of funding which enables us to work as advocates, not us but, in fact, civil society, and even sometimes ministries, to work together on these issues.

Q226 Richard Burden: I think Jim will be asking in a minute specifically about the Fund. Could I perhaps ask more broadly as far as IPPF is concerned, as well as the use of that Fund, first of all, what are the areas that you are involved with in terms of reducing maternal deaths through unsafe abortion, and where do you think we should be going? Where should we be moving next on that? What are the kinds of things we need to be doing?

Dr Greer: We need to upscale family planning, for a start, as part of a comprehensive sexual and reproductive health continuum of services and information. We have already talked about the unmet need of 200 million and I have read one figure that would suggest that maternal mortality could be reduced by 20 % simply by meeting that need. Another is to encourage, for example, a focus particularly on the young. We know that girls between 15 and 19 are twice as likely to die as those above 20 from pregnancy-related complications, and we have the biggest population of young people that the world has ever seen in the world's poorest countries right now, so we must focus on that, and that is part of the work that we are trying to do, integrating sexual and reproductive health and HIV and AIDS and trying to make sure (and this is again something that your Government and DFID can do) that civil society is at the table when planning and budget decisions are discussed and that these issues, which have been neglected tragically for so long, are now included at a time when there are so many competing priorities. When, for example, the Global Fund is being considered— whether it is SWAps,[15] PRSPs,[16] budget support— we are

[14] the International Federation of Gynecology and Obstetrics (FIGO)

[15] Sector-Wide Approaches (SWAps)

[16] Poverty Reduction Strategy Programmes (PRSPs)

concerned, and every donor government I have spoken to so far continues to be concerned, that issues of sexual and reproductive health and maternal health will fall off the agenda if, indeed, to whatever extent they were on the agenda to start with. So, for us, advocacy with our Member Associations so they can convince others in the development community of why these issues are important to development as a whole and then, together, convince their governments so that they too, not just donor governments, play a part in recognising that they need to implement their commitments, they need to make sure that these are part of the discussions that they have with donors when, for example, they are developing national health plans, national AIDS and development plans, when they are developing infrastructure plans. This needs to be integrated into all of that. So, that is part of what we are doing, advocacy as well, and trying to get investment by local governments as well, but also working with sexuality education and trying to reach the poorest of the poor, the rural, the urban poor, the most marginalised— sex workers, men who have sex with men, young, gay, lesbian and bisexual people. If I can just comment, there was a question earlier about sexually transmitted infections. Can I say that that is a major part of our work, and I believe the stigma surrounding STIs is as great as that surrounding HIV/AIDS, and that impacts on maternal health and on HIV and AIDS obviously.

Q227 Jim Sheridan: Can I just probe you on the Safe Abortion Action Fund and thank you for your kind words about the funding from UK taxpayers through DFID. Experience tells me that is usually a code for: "Leave my fund alone and go and look somewhere else if you want to make cuts." Against that background, can you give us any tangible evidence that the Fund that the taxpayer is paying for is going to the people it should be going to and can you justify the amount of money you are receiving just now or, indeed, an increase in it, but, most importantly, can you tell us exactly how this money has been spent and has it been targeted at the people that it should be targeted at?
Dr Greer: To begin with, we were not sure how much the amount of the Fund would be because we had the original funding from the United Kingdom, who then worked (and we supported them) with other governments to encourage them to contribute. In terms of process, I think it has been rigorous. To begin with we advertised the Fund mostly through civil society networks, we did not go much beyond them. We had over 170 applications in that first round, and I think that sheer number in itself speaks for the fact that there is a real need for this. There was an extremely rigorous process of technical review to come up with those 45 final projects, and those were independent technical reviewers who did this on an entirely voluntary basis and then met and discussed this face to face. DFID itself and the other donor governments are represented on the panel and we believe that this helps to ensure good processes. Clear expectations are in place for monitoring and evaluation and, of course, we are only at the beginning of the projects now being implemented, but we are already noticing in terms of, for example, demand for supplies and other things coming through, that the progress is moving rapidly and we will get regular reports on that; but I have brought some further information on that for you as well.

Q228 Jim Sheridan: When will you be in a position to give us clear evidence that the number of women who are dying from unsafe abortion is decreasing?
Dr Greer: We will have the first reports back on the projects within a year after they started. To what extent that will demonstrate that, I cannot honestly say because, for example, if it is an advocacy campaign, that will have taken time to put into place, to implement, to see if there is any change in the law. If we think of Nepal, our association began advocating for law reform on abortion in 1971, and the law was finally changed in 2002, so outcomes are not as quick as you and I would want, but I am sure that these are good projects and I am sure that they will the give us results.

Q229 Jim Sheridan: Is there an audit trail to ensure that the money is getting to the actual people it is meant to go to?
Dr Greer: Absolutely; yes.

Q230 Jim Sheridan: Is it evaluated?
Dr Greer: There will be an audit trail. We do not allocate funds without a very clear audit trail on expenditure and very clear reporting dates and guidelines for that.

Q231 John Bercow: Dr Greer, forgive me if I am being abnormally slow on the uptake, but as of this moment it is not clear to me what is the balance of your work as between advocacy of safer abortion in countries where it is already legal but often unsafe and advocacy for legal abortion in countries where it remains illegal, the latter being of notable significance when one considers, as we are advised, that no fewer than 69 countries, representing just over a quarter of the world's population, currently ban abortion?
Dr Greer: Any organisation that is a member of IPPF works in five priority areas, and they are expected to do something in all of them and the objectives are laid down. These are HIV and AIDS, access, which includes in particular maternal health and wider access to a range of services, adolescents, abortion and the last is advocacy. In the case of the Safe Abortion Action Fund and, indeed, our own Member Associations, they are expected to report back annually as to what they do in abortion-related services and advocacy in relation to abortion. So there are two components in that which they report on. Given the figures you have just given, more work is done in relation to advocacy, in particular making sure— and this is the reason for the new tool that we are sending out— what the law is, are providers absolutely aware of the law, are women aware of the law and, even in countries where it is legal, how accessible is abortion because of transport costs,

service coverage, stigma, a whole range of issues, is a major part. We believe that there is not a country in the world, including this one, where our Member Associations cannot continue at least to work in advocacy. When it comes to services, many will give options counselling only, and it is because of that, of course, we do not receive US funding, as you will be aware. Many will refer and some will carry out abortions, either medical abortion or surgical abortion, depending on each country context and the capacity of the Member Association. So, it is hard to give an overall figure, but I can certainly send you the data for the percentages in terms of both service delivery and advocacy if that would be useful.

Q232 John Bercow: The prohibition on American funding is not of very long standing, is it? It depends what you regard as long standing, but, for the avoidance of doubt, that prohibition on American funding was applied under President Bush but did not apply, presumably, under President Clinton.
Dr Greer: No, it did not under President Clinton.

Q233 Chairman: It does not apply to the Gates Foundation, just to the American Government.
Dr Greer: No, American funding.

Q234 Chairman: Any American funding?
Dr Greer: Access to American Government funding, for example from USAID.

Q235 Ann McKechin: You mentioned recent legalisation of abortion in certain Asian countries such as Nepal and Bangladesh. I wondered to what extent you are gathering statistics about the incidence of female foeticide because of gender-based abortions and whether or not this is becoming an increasing issue?
Dr Greer: We are aware of the issue and of the concern about the issue. I suppose, for us, it is another sign of male preference and often of the invisibility of women which, I think, impacts on their lack of education, their lack of empowerment, the lack of maternal health. It is very difficult indeed to, again, get accurate figures. I must say that the expansion of medical abortion, which many would see as the greatest technological development in the area for many years, will make it even more difficult to be aware at the extent of this; if women really are eventually able to take absolute control of this with minimum input from health providers, although that might not necessarily be advisable, but that may be the way it is. There is no doubt that it will have an impact where you get a major imbalance, and I think China is recognising it, India is recognising it, but at the same time a woman who has been raped or has seven children is not necessarily going to want to have an eighth and the sex of that child will not be what is primarily in her mind, and I think we need to be aware of that and also aware of what it is that pressures a woman to undergo a sex-selective abortion. It is not a simple matter, and I think there is enormous pressure on women to do that, where that occurs. Again, I think it is very much about addressing issues to do in particular with male preference and instead valuing women in every aspect of life and making that value visible.

Q236 Ann McKechin: We visited Vietnam recently and someone said to me that this incidence actually increases as people become wealthier; so it is not necessarily directly related to poverty or lack of economic power but becomes a question of status. We obviously talk about the interventions of providing health facilities, trained attendants, contraception, but do we actually do that at the expense of addressing some of the more difficult social and cultural issues which underlie some of these problems and which, if you do not address them, are likely to become the dominant factor as countries develop?
Dr Greer: I have heard a similar statement. At the same time I have also seen presentations which have talked about rural peasant populations believing that it is only if they are buried by their sons that they can meet their ancestors. So I think we do see it at both ends of the social continuum. At the very core of our work is a Charter of Sexual Reproductive Rights which we developed 10 years ago which is translated into many languages, well over 30 anyway, and is used by all of our Member Associations, and we are currently updating that in a Bill of Sexual Rights, recognising that although sex precedes reproduction it is also often separate from reproduction and we need to be making sure that we are addressing that end of the continuum as well. Part of our work, whatever we do, is to make sure that services and information have a strong rights-based approach, that a gender equity perspective is in everything we do, and it includes addressing gender-based violence, domestic violence, violence during pregnancy, and that women's empowerment is seen not as the disempowerment of men but the opportunity for both to be equal, to strengthen families, to strengthen communities and be strong together, and so a lot of work with men, in particular, to help them recognise both the importance and the contribution of women and girls but, second, the impact of disempowerment and violence against women, and thirdly the importance of their own good health.

Q237 Sir Robert Smith: You have already mentioned in your evidence that if the unmet need for contraception was satisfied maternal mortality would be dramatically reduced. What sort of effect have the current pressures for funding for HIV services over the last decade had on the availability of funding for family planning and other reproductive healthcare?
Dr Greer: I think it is clear, if we look historically at funding levels, that funding for family planning has decreased in proportion as funding for HIV and AIDS has increased, but having said that, I do not see it as either/or. I can absolutely understand, when we see how relatively few still are able to be on ARVs, for example, that there is an absolute need, and the virus will mutate and it is always one step ahead of us. That is critical, but so is funding for

family planning. It is when we hear, for example (and figures were quoted earlier), that less than 16% of women who are pregnant have had voluntary counselling and testing for HIV. This is a major project of ours to push that out across the globe now. I am a woman. I walk into a clinic. I want to know how to manage my contraception. I want to space my children. I may also have an STI, unknowingly, and in many countries, as you and I know, the greatest risk of HIV is to be young and married for a woman. It is the greatest risk for HIV altogether. So I may also have HIV. I have to be treated as a whole person, and so, for example, we believe that the Global Fund needs to be far more proactive in ensuring that the broader continuum of sexual and reproductive health, including family planning, is included, and some of that is to do with the country mechanisms and what comes forward, of course, to the Global Fund, but we would like to see a greater proactive approach in that way.

Q238 Sir Robert Smith: You think the Fund should actually be asking---. You heard from the earlier evidence maybe that the Fund was saying, "We sit here. We have got the money. It is up to the applicants to recognise they can unlock that connection." Should DFID be doing more to encourage applicants?
Dr Greer: I absolutely believe that DFID should be doing everything it can to encourage the involvement of civil society and women's organisations, for example, at country level in the mechanisms that are related to any funding at all and, in particular, to make sure that sexual and reproductive health and HIV and AIDS are integrated. There are many women who will not go to an HIV and AIDS clinic in Vietnam— you have been there, some of you; you will understand that— for testing or to a sexual health clinic, but they have been for a long time to a family planning clinic or to a primary care provider. There is no stigma with going; it is acceptable to plan their family. They feel safe; they feel secure. They need to be able then to access voluntary counselling, testing, prevention of mother to child transmission, all of them, the full requirements.

Q239 Sir Robert Smith: One of the other barriers you also touched on to accessing family planning is pressures from society, male dominance, and so on. What more can be done to relieve those pressures, to actually enable women to access family planning?
Dr Greer: Again, I think, education, both of men and women, plays a major role. Once one generation of women is educated, then it becomes far more acceptable in the next generation of both boys and girls, men and women. Secondly, I think we have to invest more in outreach and outreach is expensive. We know, for example, from work that we are doing with displaced people, with refugees, we must reach out to those communities. There is no way they can ever find their way to a clinic— that is a static clinic. That is part of it. Secondly, we need to use the media more. We need to use interactive technologies. We have sitting in the room somebody who has done some fantastic work with our Ethiopian Member Association using film to demonstrate both safe birthing but also to help to build education around these issues. There is a whole range of ways in which we can move, we just need to scale them up, and we need to measure their effectiveness as we go.

Q240 Ann McKechin: You mentioned how it took over 30 years to legalise abortion in Nepal. How was it eventually achieved and to what extent did civic society play a role in that?
Dr Greer: As I said, they held their first workshop back in 1971. After Cairo in 1994, they held another series of workshops with parliamentarians, civil society and others and working with other partners. In 1997 they had the first draft Bill. In 1999, you may remember, there was a major outcry around the world about a 14-year old who was imprisoned after she had been raped by her uncle, reported by her father, and nothing happened to the uncle. There was a call by IPPF, together with donor governments, to have this life sentence reversed, and this was done. Not long after that it really gathered impetuous. She, in fact, now works for the Member Association which received, ironically, an award from the Government this year and they then worked again with a wide range of civil society and with people interested in the Government so that the draft Bill ws passed into law in 2002. There are 165 providers. Our organisation has 13 clinics and is hoping to build another six, and they are working very closely with the Government to address the issue, but there are still a number of unsafe abortions being carried out.

Q241 Ann McKechin: I was going to ask you that, because I noticed in your submission that you did not actually state what the actual reduction had been in maternal deaths?
Dr Greer: There is a reduction in maternal deaths and it is a dramatic reduction, and it has been basically halved. About 48 % is the reduction.

Q242 Ann McKechin: I have also noticed there has been a very dramatic reduction in the fertility rate over 10 years from 5.1 to 3.1. Is it because there now is open provision of family planning or are there any other issues, like marriage age, which have been altered?
Dr Greer: I think that has certainly contributed to it, and there is a law against child marriage, although it is inconsistently applied and the sanctions are not as rigorous as one might hope for: because, without a doubt, child marriage is a driving factor in increasing rates of maternal mortality and particularly maternal morbidity, and I think that is what we must not forget. For every one of those half million who die, another 30 women are disabled or injured or ill as a result, and in Nepal in particular, as a result of early marriage, of child marriage, we see a lot of pro-uterine prolapse, which it is very difficult to get funding to address. We have tried a couple of times unsuccessfully.

Q243 Ann McKechin: Which countries apart from Nepal have seen a drop in maternal deaths following legalisation of abortion? Has that been a universal consequence?
Dr Greer: I think, yes.

Q244 Ann McKechin: Are there other measures?
Dr Greer: If you take, for example, Eastern Europe, Romania, which is the classic example because it has been backwards and forwards now several times, yes, we have seen a real demonstrable drop in countries where abortion has been legalised.

Q245 Ann McKechin: Lastly, can I ask you how significant was DFID's role in reducing maternal mortality in Nepal? Was their particular intervention a catalyst for change and how easily could they actually replicate that approach in other countries in which they operate?
Dr Greer: I think it has been a major success. I understand that at the beginning perhaps there were queries about who was accessing and whether it was the neediest who were accessing, and that has been addressed and I think, with those lessons learned, it can certainly be built on and replicated as, indeed, DFID projects in terms of increasing the number of health workers, trained birth attendants in countries like Uganda, Malawi, but I am really critical, and I do think one of the things we need to think about is very much the role of volunteers, of lower level health workers in maternal health in particular and the impact too, if I can add very quickly, of micro-credit. I am thinking of a scheme, for example, in India where women purchased a taxi. They make money from the taxi but when anyone needs emergency care because of problems during labour, they use the taxi, and they have also managed to get cell-phones so that they have a method of contacting each other to get a woman to care in time.

Q246 Chairman: Can I ask you on this issue of family planning and abortion and maternal mortality how aggressive you feel you can be in promoting your case? These are sensitive issues, there are faith issues and there are moral issues. You put it starkly on the basis of the figure you gave before. What you are really saying is that more than 100,000 women a year are dying in childbirth because they have been denied access to contraception, yet you cannot get money from the United States and there are other organisations, churches and the like, who say we cannot do that. How aggressive do you feel you can be in saying, "Actually these organisations are condemning women to death by denying them access to these facilities?
Dr Greer: It is similar to saying that condoms are not effective against HIV and AIDS when they are 98% effective. It is denying people in that case information and a method to protect themselves. IPPF describes itself as a leading advocate on sexual and reproductive health and we believe that that is absolutely what we must do. We recognise that in those 152 Member Associations they are working in differing country contexts and there is no doubt that, unfortunately, morality and mortality become intertwined all too often, and so they need to choose their own strategy for working. Somebody said to me recently, they could understand that it was difficult for a particular association or particular country because it was a Muslim country, as was theirs, and I said, yes, as are most of the countries in which we work in in South Asia, many in South East Asia, many in Africa and, of course, in the Arab world, and those that are not will often have a very strong Roman Catholic tradition or sometimes a new fundamentalist tradition, but if we do not speak out and say that no-one should die as a result of sex, that pregnancy should be a cause for celebration and joy, not for despair, and that women should not die needlessly, if we are not brave enough to say that after 50 years, or 60 years, who is going to say it? So, we do expect our organisations to be brave and angry and effective and accountable. It is what Gloria Steinem used to call "intelligent rage". It is no good just getting in and shouting about it, although that has its part to play. It is about showing the data, telling the stories of those who die needlessly. I do not believe that anyone really wants to see women die. We have seen changes, and we can make change. It will take time, but we can do it, with support.

Q247 Chairman: Thank you very much for that. I am glad I asked you that question. Thank you for coming.
Dr Greer: Thank you very much.

Tuesday 18 December 2007

Members present:

Malcolm Bruce, in the Chair

John Battle	James Duddridge
Hugh Bayley	Ann McKechin
John Bercow	Jim Sheridan
Richard Burden	Sir Robert Smith

Witnesses: **Baroness Vadera,** a Member of the House of Lords, Parliamentary Under Secretary of State for International Development, **Dr Stewart Tyson,** Head of Profession for Health, Human Development Group and **Mr Andrew Rogerson,** Head of Human Development Group, Policy and Research Division, Department for International Development (DFID), gave evidence.

Q248 Chairman: Good morning, Minister, welcome to the International Development Committee and your first appearance in front of us, but not your last, as we have already got your second appearance booked in. Thank you for coming in. As you know, this is the last evidence session on our report on maternal health, which is the MDG[1] which is most off-track and one which we are particularly concerned about. For the record, I wonder, first of all, if you could introduce your team— I know you have a change, which we have been notified of— and then we can proceed.
Baroness Vadera: Yes, I am sorry, it is Christmas week. This is Dr Stewart Tyson, who is the Head of Profession for Health, and Andrew Rogerson, who is the Head of the Human Development Team.

Q249 Chairman: Thank you very much indeed. I re-read last night the Department's submission for this inquiry and I have to say it is extremely robust, both in terms of the language and the commitment— that is not in question. I think we accept that DFID, both in its own terms and internationally, is seen to be a major driver of maternal health issues and progress towards MDG 5, but the problem is progress is poor. I suppose that is the first question. If DFID is so strongly committed to it— and that is not in question, that is clear and comes through very definitively— and is providing a leadership role, why are we doing so badly and what, particularly, do you think are the things that are holding us back?
Baroness Vadera: I guess I would say the fact that there is no magic bullet here when it comes to maternal health. Maternal mortality is one of the trackers of health systems but you have to get a very comprehensive health system in place in order to ensure progress. There are some of the other MDGs where you can do certain things immediately, for example, with child mortality, and while health systems are very important you can get a great deal of immunisation coverage without. So it is the comprehensive nature of the solution, I guess, that is one of the main issues. The second is, obviously, the cultural and social issues, particularly around women's rights and the role of women in society and political leadership. I would say that political leadership is one of the big issues here which, in one sense, internationally, behoves us to do more but a lot of it has to come from the country. I think it is also a cross-sectoral issue because it links to girls' education, to access to treatment and poverty issues, in terms of remoteness and getting money to get to health care services, transport. So I think the fact that there is no silver bullet means that that attention is not as easy to get and the problem is more difficult to solve.

Q250 Chairman: If you think back a few years, for example, maybe 20 years, there was a huge, international world obsession with population growth and huge campaigns for family planning, and these kind of issues, which seem to have gone off the radar. If there is no silver bullet— we accept that and we have obviously been taking evidence from a variety of quarters— are there particular obstacles that you feel are standing in the way?
Baroness Vadera: I would say that health systems would be one of the first ones that we would like to see more focus on, and that is why DFID is focusing a lot more now on health systems, and on making sure that the health systems and the countries actually care about and track maternal health issues, whether that indicator is on maternal mortality or skilled attendants, or whatever it might be, and getting it universally available and getting it to remote areas. That would be one big area. The second would be around women's rights and girls' education because we do know there is quite a direct correlation here. Sometimes it is obviously very difficult for us to be advocating changes in legislation in-country, but when we do see a wedge we do try and go in there and work with the country to try and change the legislation and the rights, because, obviously, issues like access to safe abortion are very critical as well, as the third largest reason for maternal mortality. I would highlight those two.
Chairman: The evidence has thrown up a number of issues which we will explore during the course of the morning.

Q251 John Battle: In a sense, unlike dealing with malaria or HIV/AIDS, it is clearer where to go, but what has come across in this evidence is that it is quite a diffuse target, in a way. Therefore, there is a sense in my mind that sometimes people think, in all

[1] Millennium Development Goal (MDG)

the agencies and the donors, that: "We will do what we can and we hope that the country shares the funds out into transport, into the clinics, into peripatetic workers, and health workers and hope that it somehow hits the target". I was really encouraged by DFID's lead, our Government's lead, to make MDG 5 a key target. It is miles behind all the others and I wonder whether we could not just catch up but really push it and champion it. Just to give an anecdotal account, as part of our evidence we did see the film *Dead Mums Don't Cry,* a *Panorama* programme, and I showed that film in my neighbourhood in inner-city Leeds and invited people to discuss development from the SureStarts, the Mums and Tots and groups that never go anywhere near development. They were shocked and enlightened and encouraged that DFID had championed it so far, but then wanted to know what more could DFID do to get a grip on this MDG nationally and internationally. They were actually saying: "Can we raise money to help? It connects to our agendas here. It is a campaign-championing issue." What more could DFID do and where do you see DFID going? Not for DFID to do all the work but with that leadership and campaigning and championing to get MDG 5 as well ahead as the others and as a kind of catalyser for the other MDGs as well?

Baroness Vadera: I really agree with you on that. I think that we need to push harder in terms of international advocacy. We have got this call to action for the MDGs coming up in 2008 and the UN Secretary-General has agreed to a meeting at the UN General Assembly in September. What we would like to do, and I know that the Prime Minister is personally very interested in that, is to push on MDG 5, not just because it is the most neglected and it is the one that is most off-track but, also, it affects MDG 4[2] very significantly. It is the best tracker of overall health care and health systems. So one of the things we would like to do is up our own game, in terms of advocacy. Two things that we are trying to do are we have managed to persuade the Norwegians when they started on their initiative, which was just on child mortality, to include maternal health. So they have a big piece of advocacy work which we have been trying to assist them with and they have got these champions in Indonesia, Mozambique and Tanzania and other places. So we are trying to put some effort through that. The second is that we are talking to the Japanese, because they have the Presidency of the G8. In fact I was talking to the Sherpa yesterday, who is visiting, and I am going to be going to Japan in February of next year. It is really interesting because they were influenced by us— we sent them privately papers— and the Sherpa told me that he had read one of the Prime Minister's speeches— I could not quite figure out which one—

Q252 Chairman: Which Prime Minister and which speech!

Baroness Vadera: They had made a statement that they are going to make health one of the priorities, but really interestingly they are looking at maternal health and health systems. The foreign affairs minister made a speech actually saying that post-war Japanese experience showed that you have to do disease-specific things, like TB,[3] which they had in Japan, but you need the health systems and action on maternal mortality. He has made a speech about that which reflects some of the work we have input. So I think it will be quite an exciting year, and I do think that the whole issue of political leadership and advocacy is very, very central. However, we also need it in the country; it cannot just be us leading, but I think that is a much more difficult thing because sometimes (and I mean no disrespect) male politicians in Africa find it a bit uncomfortable. I think we need to find a way of getting champions. We are talking to the elders group— Mrs Michel and Mary Robinson and people— and we need voices and champions that will put it really centre-stage on the agenda.

Q253 John Battle: That is an encouraging answer, and if others are looking to us to lead, what about not just in-country but the UN? We channel our money through the UN; are there enough champions in the UN in this area?

Baroness Vadera: I thought you were going to ask me if there were too many champions in the UN! I think that there are now champions in the UN. I had the opportunity, while we were working on developing the International Health Partnership, to work very closely with Margaret Chan (WHO),[4] Anne Veneman (UNICEF)[5] and Thoraya Obaid (UNFPA)[6] and it is quite interesting that there is this group of women leaders now, and they have got a greater sense of this. In the IHP[7] we are going to put maternal mortality— I hope they will agree in the meeting that we are going to have in January— as one of the key indicators or one of the key outcomes in terms of how we evaluate success. I do think that the UN agencies have actually come together a bit more on this, and I think the women leaders are helping and the IHP is helping.

Q254 Hugh Bayley: Your evidence reported the UK as the biggest donor to WHO, the second biggest to the UNICEF, and one of the largest donors to the UNFPA. What evidence is there that the UN is a good channel through which to place money which has a demonstrable impact on improving maternal health?

Baroness Vadera: When it comes to the funding that we put in through the core funding, they obviously report back to their own boards, and we have pushed quite hard on improved evaluations at the board level of the core funding, and we have our own tracking system for impact, when we do give specific

[2] To reduce child mortality

[3] Tuberculosis (TB)

[4] ixThe World Health Organization (WHO)

[5] The United Nations Children's Fund (UNICEF)

[6] The United Nations Population Fund (UNFPA)

[7] The International Health Partnership (IHP)

funds. We have also developed the multilateral development effectiveness indicators in which we monitor each of the agencies and their effectiveness. I am not going to deny that there is a lot more we could do or the UN could do in terms of impact and effectiveness. The point about the UN is that it is trusted on the ground by the countries and, particularly, on sensitive issues like this, it makes it more effective. Secondly, when it comes to conflict situations we, very often, have very little choice other than to work through the UN. Sometimes, obviously, we can use NGOs[8] but the UN remains the biggest and it leads the Health Cluster, for example, in many situations. We do have to use them. In my previous existence I spent quite a lot of time on the High Level Panel for UN Reform and looked at evaluation methods as well. I think some of them are showing some signs of improving, particularly UNICEF and UNFPA.

Q255 Hugh Bayley: You anticipated my next question about too many champions. What impact does the fragmentation of the UN system have on the effectiveness of their work towards this particular Millennium Development Goal? Also, in your evidence, you talk about a pilot study in a number of countries— Tanzania, Mozambique, Rwanda and Vietnam and others— where the UN has agreed to bury its logos and operate around one lead agency. Is that working and when will that become the norm? Possibly, when will that become the norm in New York as well?
Baroness Vadera: On the issue of the impact of fragmentation, I would say, historically, it has had an impact on this particular MDG, disproportionately, because this MDG is very dependent on health systems. If you really want to tackle systems then you really need co-ordination. There are some MDGs where a more vertical approach can work better. So I do think it has had an impact but it is one of the main reasons we launched the International Health Partnership, to actually bring them together. I was very encouraged by what I have seen, in fact, from the UN agencies and the WHO, in particular, championing this. On the International Health Partnership the problems we have seen around co-ordination have not been through the UN agencies; it has been a couple of the others, which has been interesting. On the issue of the One programme, which is one office, one budget, one leader, we were very much champions of that and directly funded that. I was in Rwanda recently, one of the pilot countries, where it seemed to me to be working very well. I was actually addressing the donors' conference, where co-ordination is the big issue. It seemed to be working very well. My sense is it is quite dependent on the UN leader. That is the impression I got, and it was a really good one, of Rwanda, but I hear that in a couple of countries there have been issues. I think the problems are being sorted. They have decided to roll it out on a kind of volunteer basis, and I think 32 countries have expressed an interest. They will be doing an evaluation a year from launch, and then trying to roll it out. We attempted at the time of the UN High Level Panel that I worked on, because Gordon Brown, then as Chancellor, was on it, to set a target but they felt it would be better coming from the country. It is interesting that countries have expressed an interest in doing this.

Q256 Hugh Bayley: That means that during the coming year, 2008, it will roll out in 32 countries?
Baroness Vadera: No, it will not roll out to 32 countries in the coming year. I would say, possibly, by 2010 it would have rolled out to significantly more countries, but they are going to evaluate it during the course of 2008; they are going to evaluate the current pilots during 2008, but there are seven or eight more that might be rolled out.

Q257 Hugh Bayley: I am bound to say the clock is ticking. The MDG is a 2015 MDG, and if you do not start better co-ordinating the UN until 2010 what are the chances of meeting the Goals?
Baroness Vadera: We continue to press very hard. At the first meeting we had with the UN Secretary General this was the issue that was raised. So we do press very hard. As I said, the reason I am hopeful is that it is coming from the countries that they want this, and I think that might push it further forward. The other thing we are attempting to do— there have been countries who wanted to join the IHP, so we are trying to find the countries that join the IHP to be the same as the countries who have the One programme, to bring them together. Currently, we have Mozambique but we will have Ethiopia and Rwanda who are both going to join the IHP, so we will start to get a sort of volume, I think.

Q258 James Duddridge: In the maternal health sector, where is DFID's comparative advantage? Have they got a comparative advantage?
Baroness Vadera: I think part of the fact that you are having this Committee shows that we have a broad understanding of this issue and a cross-party understanding of this issue, and the comparative advantage is in being able to do and say difficult things; that we are able to champion something that not many countries very easily champion. It is, basically, us, the Scandinavians and the Dutch, but in terms of scale we are able to come out and champion, for example, access to safe abortion, which they do as well but they do not have the same scale. The fact that we have this depth of understanding also means that we can focus on things that sometimes people think are slightly dull, like health systems, which are very important. I think the fact that we give predictable, long-term financing, which is very central to health systems, is also our comparative advantage.

Q259 James Duddridge: Are you concerned that given the requirement to reduce headcount, despite our comparative advantage, other international players are unrealistic about what can be expected of DFID, because it is not just about money, you need individuals to help deliver the strategy.

[8] Non-governmental Organisations (NGOs)

Baroness Vadera: Yes, I very strongly believe it is not just about money. One of the tests that I apply to any of the submissions that come up is that if it is just about the money we spend, then that is not good enough because we need to be adding value. DFID has had an 11% headcount reduction since 2004, and I do not think it has affected its performance. I guess, coming from the Treasury, you might say that I do not think efficiency affects performance. However, we also, in the Spending Review settlement, have agreed that two-thirds of the frontline offices will not be subject to headcount reduction and will be allowed a 1% increase in real terms. That is, really, where we need the health advisers. So we have got 53 health advisers, 39 of which are in countries.

Q260 James Duddridge: To clarify that, that headcount reduction on the front line is not as aggressive—
Baroness Vadera: There is not a reduction in the front line.

Q261 James Duddridge: Is that matched by a more aggressive reduction in terms of back-office back in Palace Street?
Baroness Vadera: We have the same requirement as all the other departments for the headquarters, which is 5%. In terms of the frontline programme we have this protection and indeed have allowed a 1% increase for two-thirds.

Q262 James Duddridge: What will the overall reduction be, from a DFID viewpoint? Is there a specially negotiated settlement for DFID globally as well?
Baroness Vadera: No, there is not an overall for DFID globally; it is the headquarters which has the 5%. It is the frontline which is separated out.

Q263 James Duddridge: Returning to maternal health issues, what are DFID doing to make sure that they are more co-ordinated with other donors to make sure there is not duplication and that both DFID and other countries do what they are good at rather than simply duplicating or chasing the more high-profile tasks or countries?
Baroness Vadera: This is obviously a very big issue so we launched the International Health Partnership in September this year. The principles around it are that the big eight agencies, health agencies, which were the UN, GAVI[9] and the Gates Foundation, would abide by three principles: that we would be led by country-owned plans and have a health plan, that we would be co-ordinated around that plan and that the plan needed to focus on the development of sustainable health systems. Those were the three principles. We have now got eight countries, the first wave of countries, and the point about that is to have the discussion, the dialogue, to ensure exactly what you are saying, which is that we are not duplicating— that everybody is doing a piece of it or, indeed, doing it through a single pool, which would be even better. Sometimes we are not able to do that with the vertical funds but with the bilateral donors we can. In terms of PEPFAR (US President's Emergency Fund for AIDS Relief), which is a very significant health funder now, in so many countries. They did not join the International Health Partnership but, in fact, have, in principle, signed up to the principles of it, and we are now working with them on how we operationalise that, so if they are funding nurses who are providing ARVs (anti-retroviral medicines against AIDS), then we are talking about whether we can provide the marginal additional costs for them to also provide the other services. I have a meeting in January, which the head of PEPFAR and I will be co-chairing, to talk about exactly how we operationalise these overlaps and how we ensure that we are funding something that is going to be sustainable and create something that is going to survive in the long term.

Q264 James Duddridge: Are you happy that the co-ordination between DFID and the EU is effective?
Baroness Vadera: On health care systems, I would say that they are. I am not going to comment on a couple of other areas that I have noticed in my travels, but maybe in one of the other committees we can pick up on that. I do think that on health I had not seen them as a major player in terms of the countries that we are working in. We have not had significant problems with them. I would say the problems have really been round PEPFAR and the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM)— some of the vertical funds.

Q265 Chairman: Can I press you a little harder, Minister, on the staffing constraints? We have had evidence that suggests that your sanguine view about efficiency is not entirely shared. One specific piece of evidence from Immpact (the Initiative for Maternal Mortality Programme Assessment) says that DFID staff "are frequently overstretched by the volume and range of work they must undertake, so that their potential for providing leadership and influence cannot always be realised."[10] That is a general view. It has come up elsewhere in evidence, which I have not got to hand. There are suggestions that on this particular area of maternal health there are staffing constraints that are affecting the delivery of programmes.
Baroness Vadera: I did read quite a lot of the evidence and I noticed that a lot of the NGOs talked about that but there was a specific comment on research as well. I do not think the numbers have reduced and I do not anticipate that in-country, in terms of health advisers, it will have a significant impact. I think everybody is always stretched and we are working in a field where the need is, in one sense, endless. So I do feel reasonably confident that we will be pushing on the maternal health agenda and we will ensure that we are sufficiently resourced to do that, both in terms of funding as well in terms of people.

[9] The Global Alliance for Vaccines and Immunisation (GAVI)

[10] Ev 10

Mr Rogerson: Can I just add to that? We are trying to make the best use possible of our bilateral relationships, particularly with European Union members, such as the Netherlands. In some countries we have taken over their co-ordinating lead from them and in others they are offering to take it over from us. This is not a one-shot solution but it does help make the maximum use of the few people on the ground that the bilaterals can have.

Q266 Chairman: As you will be aware from the debate we had in the House, the Committee at this stage has said they accept the constraints on the Department and the Department is adjusting its priorities within that framework, but we have expressed concerns that decisions might be taken sometimes which would be different if there were not those staffing constraints.[11]

Baroness Vadera: I understand and I accept that and we will be vigilant, particularly in this area, if we are going to give it a big push in the New Year. Andrew is right to point out that we do work with others but we are not driven by the staffing constraints in working with others; we are driven by the Paris principles. So I think that on that we are very clear that actually the value we add is not just about our money but that we are influencing and effecting good health outcomes.

Q267 John Bercow: Minister, at the Partnership for Maternal, Newborn and Child Health Board meeting in Addis Ababa earlier this month DFID resigned from the Board to be represented from now on by the Norwegians. Why?

Baroness Vadera: I think, because they are leading on the MDG 4 and 5 initiative and we are co-ordinating behind them, that was considered, again, in terms of the spirit of the partnership, to be the most effective way forward.

Q268 John Bercow: That raises the obvious question of whether—

Dr Tyson: I would just come back and say that DFID has been very influential in creating quite a lot of these partnerships. There is the Maternal, Newborn and Child Health, the GAVI Alliance, the Global Fund, the Health Metrics Network, the Global Health Workforce Alliance. These were all global partnerships set up, initially, to address under-resourced areas and areas of under-focus. I think we agreed that we do not have the capacity to continue to serve on the management boards of all of these. For example, with the Global Alliance on Vaccines, we were there for the first three years, we rotated off and we came back three years on. Similarly with the Global Fund, where we have been on the board for, I think, the first three years, and we are in a constituency with other partners. This is very much the case with the Partnership for Maternal, Newborn and Child Health, and I think you will see, if you look across the various partnerships, that we will actively engage on the board for a period, we will try and work through others, perhaps we will come back to it and we will spread ourselves in a more rational way.

Baroness Vadera: It is about us, I think, being good at the start-ups and ensuring that we move on.

Q269 John Bercow: That is fine, as long as there is not a discontinuity resulting therefrom. In other words, from coming off and going back on again. If you are satisfied there is no discontinuity of policy or loss of effective action, so be it. This is not, in any sense, a joke question; it is a serious question: do you know, off the top of your head, on which boards of international initiatives DFID sits? It is relevant in the sense that where increasingly you are required with a rising budget to be accountable, both to a domestic audience and, perhaps, more widely, it is quite important to know exactly what you are on and what you are not on— where you are in a primary leadership role and where you are not.

Baroness Vadera: On the whole, I would say that I am aware. The one that is fixating me the most, at the moment, is the Global Fund, where I am very pleased that we are on the board because we have given them a long-term commitment and there is no secret about the fact that we have some issues and, therefore, the board is important to us and we ensured that we maintained it. With GAVI we have less of an issue. For example, with the IHP there is not a board, it is a kind of working group and it is actually meant to be led by the health agencies but we ended up having observer status, which is quite unusual for a bilateral donor. Obviously, one of the other big agencies is the World Bank. So I think we do have an awareness of the fact that we need to influence these agencies, and I would say that one of the things that I am pleased by, but feel we could do more, is the whole influencing strategy; that DFID is influential; we have now become the largest donor for a lot of multilateral agencies and I know that we have a voice, but I think we could be more concerted in ensuring that we have objectives for what we are trying to influence them to do and we definitely did that, for example, for the Global Fund using our ability to raise issues, and in fact I had a long discussion with the Chairman about it yesterday.

Dr Tyson: We are trying to take a pragmatic approach to these and we have worked in partnership with other European donors. An example would be Roll Back Malaria and Stop TB. These are very substantial partnerships. For a number of years we have sat on the Roll Back Malaria Board, and we have represented the Dutch and they have represented us on the Stop TB Board. Last year we exchanged board seats although the Dutch have recently requested a return to the former position because they felt that with changes in their own administration they have greater strength in TB. We have been happy to do that.

Q270 John Bercow: I do not sniff at the significance of that but I am concerned about the question of leadership more widely, specifically amongst southern partners. Minister, I simply remind you that you yourself referred, briefly, much earlier in

[11] HC Deb 15 November 2007, cols 869-928, debate on International Development

this session, to the imperative of securing safe abortion services. In a sense, the question I want to ask you gives you an opportunity to place beyond peradventure your position on the record. You were, I think, at one point, going to speak to Global Safe Abortion hosted by Marie Stopes International in October but had to pull out of that engagement— I am sure there were perfectly good reasons for that and I am not here to pick an argument over that— but I wonder if you could just take this opportunity to underline your support for the provision of such services to reduce maternal mortality and morbidity. Also, I wonder if I can inveigle you into something a little beyond that. If we are going to talk about leadership and changing the attitudes of southern partners I wonder whether you think that Britain, perhaps in concert with others, might start to be as robust in arguing for safe abortion services amongst developing country leaders as the United States is, sadly, robust in the wrong direction by taking the, dare I say it, evangelical view as far as contraception and abortion are concerned? I know there is always the danger of being accused of ultra-imperialism but if a judgment has to be made between maternal and child health on the one hand and bearing the scars of being attacked by others for one's cultural imperialism, presumably your shoulders are broad enough to bear the burden of the latter?

Baroness Vadera: I am delighted to have the opportunity to restate very clearly our commitment to access to safe abortion if it is within the law. I would just like to be clear about the fact that my very first speech, before my maiden speech, ever, as a Minister, or as anything else, indeed, was on World Population Day for Marie Stopes and, I think it was, the APPG.[12] That was when I talked about access to safe abortion, contraception and to birth attendants as the three key things to do. That was my very first speech before I did anything else. The reason I was unable to go was because I went to New York to try and secure, which we have now secured, having the MDG day in September, which I hope will very much highlight maternal health and mortality. So, if anything, we feel, halfway through the MDGs, we have to up the game on this. I think the issue of leadership in southern countries is a lot more difficult. I do not think it is because of a fear of being controversial. Our position is very clear about what we say within the ICPD[13] but I think the issue is: will it work? If we were to just become evangelical about this and go to country I do not actually think it would end up with having an impact because I do not think that you can change people's minds, particularly on cultural issues like that. I do not think, even if we did manage to get anywhere because they felt dependent on us in any way, that they would be committed to rolling it out effectively. What we do better is if there is, as I said, some interest where we can go and provide evidence, fund NGOs and fund civil society. It is always better to give the voice to women in those countries directly for them to be the advocates than for us to be the advocates. I think that is more effective as we have seen. We have done that in Nepal, and we have been doing that in Sierra Leone where we are about to start a maternal health programme. I actually have had discussions privately, for example, when I was in Rwanda, and President Kagame is very committed and they are now thinking about using maternal mortality as an indicator of their health, and access to family planning, in particular. So there are ways in which we do this but becoming the public advocate could, in fact, make us less effective rather than more.

Q271 John Bercow: Very briefly, if I may, Chairman, I want to wrap two into one. The DFID annual report for 2007 referring to financial year 2005-06 makes it clear that, excluding budget support, maternal health expenditure amounts only to £16 million out of a total health spend of £200 million. So it is a relatively small proportion. I just wonder whether that, alongside what has been a very sharp reduction in absolute dollar terms, in donor support for family planning since 1995, is in any sense a cause of concern for you, and if so whether you propose to do something about it. The related matter is whether you feel that in terms of improving health performance, there is something to be said for DFID in its advocacy role advocating the para-medicalisation of medical procedures so that suitably trained nurses as well as doctors can perform worthwhile procedures.

Baroness Vadera: There are about three or four questions there. On the issue of our direct spend on maternal health, in fact, it has increased since then; it has doubled from that and will be doubling again.

Q272 John Bercow: Doubled from what?

Baroness Vadera: From before the £16 million figure. It went from £16 million to £23 million and is projected to go to over £50 million— about £53 or £54 million— by next year. That is very significant because our programmes in India and Pakistan on reproductive and maternal care, of which portions are directed to maternal health, will be coming through. We do have increasing specific targeted maternal health care programmes. We have also got Ghana, which is going to have a health SWAp[14] which will be focusing on MDGs 4 and 5, we have got Sierra Leone coming on-stream, so, in fact, we do have an increase very significantly. I do want to say that the issue of budget support is important. One of the things we found, and we have evidence of, in an early programme from, I think it was about 1995, in Malawi (in 1995 to 2000 we ran this programme) was that if you just do vertical programmes without ensuring that you are taking care of the rest of the system you cannot always sustain it, and we were not able to sustain it effectively. The most effective way to deal with maternal health care is to have health workers, skilled attendants and midwives and actually you need to have them in the budget line, and the best

[12] All Party Parliamentary Group (APPG)

[13] International Conference on Population and Development (ICPD)

[14] Sector Wide Approach (SWAp)

and most effective way to do that is to also be working on budget support and health sector support. We do need to be doing both. Another thing we need to be doing and will be doing— we have actually just been having that discussion recently— is that when we are doing budget support the big headline indicator for health has traditionally been on immunisation rates, which is easier to do because, as I said, you can get coverage more easily. Once it gets to beyond 85% coverage, you do need to move on. So we are talking about whether, when we are renewing budget support, we should be asking countries to move from immunisation to maternal care.

Q273 John Bercow: I absolutely understand what you say about the budget line, and I am grateful for and have some enthusiasm for what you have just said about the significant increase in the figures from relatively low figures about which I was complaining, so that is a case of immediate gratification, if you like. I still feel, going back, to what you were saying earlier about relatively patriarchal societies— I do not think you used that word but that is the implication I drew from it— in which, frankly, men either do not want to talk about these things or, if they do, they have got pretty— how can I put it— atavistic views on these matters. In that sense, surely, that rather underlines the importance, from the other side of the equation, and underlines the need to have strong civil society programmes as well, so you are backing civil society organisations that are acting as advocates for women's health. In that sense, I am mildly concerned that the Civil Society Challenge Fund does not fund even the most successful advocacy programmes after the completion of the first round of funding. I think I can almost anticipate that an experienced Treasury hand is going to say: "Well, Mr Bercow, you cannot fund things forever", and I accept that, but is there not a danger that just as something is starting to bear fruit it is cut off at the stem— if that is not a mixed metaphor? I just wonder whether you can hold out some hope that projects which are of demonstrable value are not going to be subject to an arbitrary and capricious cut.

Baroness Vadera: Going back to the first question, which is about patriarchal societies, it goes back to the point that I made at the start, which is that there is no magic bullet; you need the health systems and you need the workers in the budget line, because if you do not have the workers in the budget line we cannot actually support the outcome. However, in certain countries we do need to have, exactly as you said, the approach which targets maternal health because of some of the, perhaps, invisible, social-type barriers. So we do have that in Nepal, Bangladesh, India and Pakistan, so in the sub-continent where this is an issue. In post-conflict countries where there are specific problems— Burundi, Sierra Leone and even Ghana where we are actually, even though it is the most advanced in many senses, possibly, most likely to reach the MDGs in sub-Saharan Africa— we have this issue, and that is why we are focusing on it, in terms of the health sector programme on MDGs 4 and 5. I think it needs both approaches, and we have to make an assessment on the ground of how we do it. I think, also, helping in the budget support to get the indicator moved to maternal health would focus minds on this as well. I think, from reading the evidence, I have a sense of which specific organisation you are talking about. I would say that we do pride ourselves on giving predictable funding, and that is, in fact, one of our comparative advantages. When we make an assessment of applications for civil society we do have to look at the value added and we do have to make a comparison. So there are choices in that, and I do not think we can always please everybody but we do have partnership agreements with certain agencies that give them a core funding that ensures some predictability. I know that IPPF (the International Planned Parenthood Federation) has that and I know that Marie Stopes do not have that and they are not successful. I cannot really answer for every organisation.

Q274 Sir Robert Smith: Earlier you mentioned how Japan is trying to prioritise health at the G8 Summit. Did their awareness of the maternal health issues come at their own initiative or was it prompted by DFID?

Baroness Vadera: I would not want to start to attribute causality here. I could be being flattered by the Sherpa who came in yesterday. I had quite a long conversation about this issue because we were both at the replenishment of the Global Fund. Unfortunately, I think I probably accosted him on this and he went away and he read up about it and then his foreign affairs minister made the speech on 25 November. We have had discussions and sent them papers but they do, in this very interesting speech, refer specifically to their own post-war experience. It is difficult to say. The one thing they did pick up on that was specific to us was the fact that we said that the horizontal issues were not receiving attention and the health systems needed to, and they picked up on that because of their own experience and they picked up on the fact that maternal mortality is one of the best trackers of the effectiveness of health systems. They seem to have put something together but I would be flattering myself if I said it was entirely due to us.

Q275 Sir Robert Smith: Do you think the other players at the G8 will be up for making it a priority?

Baroness Vadera: The Germans made a piece of it a priority, obviously, this year in the commitments they made around HIV/AIDS which really focused on mother to child transmission and paediatric care. So I think if they see this as a continuation of what they did that would be possible— in one sense it is about making everybody feel ownership of it. The Americans could view this, again, as part of what they already do, in terms of PEPFAR, as long as they do not see it as a kind of attack on the vertical, in terms of their approach. There are ways of including other people. I think it always comes down

to implementation. We can do a lot at the G8 but we have got to implement what we do, and that is always an issue.

Q276 Ann McKechin: I think it struck us in our inquiry just how often women are invisible within their own society, even to the fact that their births and deaths are not registered in their own countries. A recent study by Médécins Sans Frontières in the DRC[15] found maternal death rates to be 10 times higher than the national reported average of 520 deaths per 100,000 of live births, which is a completely horrific figure. In these circumstances, and given that it is important that we have some degree of accurate information, what is DFID doing specifically to try and improve the routine availability of maternal health data?
Baroness Vadera: We are the biggest funder of statistics but, of course, maternal health data has been notoriously difficult to get. We do fund a variety of programmes as the Health Metrics Network. Stewart works directly on that so he might want to say something about that. We are also going to be funding the census which is one of the best ways of doing this, and I know you have had evidence from Immpact about the work that they do to try to find easier and quicker ways of doing it, and Professor Graham is advising you and knows more about it than most people. So we are working to track this information, and it is very important because I think it is possibly one of the reasons that we have not been as effective as we could have been on maternal health; you are pitching to a minister of health for funding and you cannot track what the data is and what your results are going to be, and that actually makes it quite hard. So I do think it is quite an important element of the piece. Immpact is the most ambitious programme on maternal health that we have got so far.

Q277 Ann McKechin: Should we make the priority maternal health data or should we just prioritise general health data? Which should have the biggest priority currently?
Baroness Vadera: It is the most difficult to do, but we do think, as I say, that it tracks health systems very well and is sometimes used as a proxy for health systems. So in one sense it would be good to track a lot more than one thing. We should track as much as we can but it is about the effectiveness and the impact of what we are doing, and maternal health is one of the best indicators.

Q278 Ann McKechin: So, from your point of view, this should be the priority?
Baroness Vadera: I think it should be a very significant priority, yes.
Dr Tyson: I would just add we do fund the Health Metrics Network with a group of other donors; it is another one of these global health partnerships addressing neglected areas, and that really is trying to put in place the building blocks of a comprehensive health system right from vital registrations— so registering births and deaths. Not many countries do that and it is a very big step. It is working in about 70 countries, it is developing situation analyses of what is there at the moment, where the gaps are and where the bottlenecks are— where there are opportunities to move forward. I think that sort of systematic approach is very useful and, at the same time, taking opportunities to get better data. The Immpact programme has developed a relatively low-cost method to assess maternal mortality and you have heard a lot about that and, also, other tools that have been around for many, many years but have not been as extensively used as we would hope; things like maternal death audits— on every woman who dies in a health facility— to try to look, in a non-threatening way, at why that happened in a non-threatening way, to try to learn lessons and to try to change practices. I think it is trying to do both approaches at the same time, really, to get the best possible data.

Q279 Chairman: Can I reinforce that? In your evidence to the Committee you quote the figure that 529,000 women continue to die. The note says that this is actually the figure for 2000 and is based on estimates developed by WHO, UNICEF and UNFPA. Yet the evidence from Immpact and from Médécins Sans Frontières suggest that is rather a precise figure, given the method of recording is so poor, and that, if anything, the situation is substantially worse. If you are going to have targets you do need to have base information. Would you accept that we need to update that information and perhaps produce a range, which also shows that the upper limit might be a lot worse? Related to that, when you were talking to John Bercow about whether there is family planning or safe abortion— it was a point I made at the end of the last evidence session— essentially, if you have very high figures and you know what the percentage reduction is if you have access to safe abortion, you are basically saying to people: "If you don't pursue these policies on giving access to abortion or family planning you are condemning X-thousands, or tens of thousands or hundreds of thousands of women to death". I take the point about the culture, but those are pretty dramatic statistics. Do you not think we could do better to confront people with the horrors of this information?
Baroness Vadera: This is like music to my ears because I have this issue about spurious precision. We have quite lively debates in DFID now about why numbers differ depending on the source. For me it is imperative. If you cannot show the results and you cannot show the numbers and you cannot show the impact of policy then we are not going to win the argument. So I very much agree with that. I would rather, in the interim period while we are trying to improve data systems use ranges, but we have to accept that in some countries it is going to be really difficult. I was in the DRC and the idea that we could actually be able to get very serious data out of the DRC in the foreseeable future is just not very realistic, or Afghanistan. Sharing data and having

[15] Democratic Republic of Congo (DRC)

some common ground on which we can influence policy makers is really important, so I completely agree with you.

Chairman: I hope our report might help on that.

Q280 Richard Burden: In, I think, one of your first answers this morning you described the Global Fund as "fixating" you at the moment. I would like to ask you one or two things about that fixation. Whatever else it has done, and it has done a lot of good stuff, the Global Fund has not necessarily done a great deal to reverse the trend of separate policy and financing strategies for HIV, on one hand, and maternal, sexual and reproductive health on the other. Given the emphasis you have consistently put today on the importance of developing integrated health strategies and particularly strengthening health systems, how do you feel that we can move forward to get the Global Fund to contribute better to that?

Baroness Vadera: I can see that I am going to get into trouble now with Michel Kazatchkine when he reads this transcript! I think we have a great opportunity with the Global Fund. It has a great chair now who is very businesslike and understands these issues and Michel Kazatchkine who is also aware of them. They have signed up to the International Health Partnership and we are using that to point out the areas where they are doing well and the areas they are not. It was the most fabulous sight: when they arrived to the first IHP meeting— Mozambique is one of the countries— the Mozambique Health Minister was pointing at him and in the end he had to agree to change quite a lot of the things they were doing in Mozambique. They have sent a special group to change that and so they are much more integrated into the overall Mozambique health plan. Now, we are talking to the Zambians and we are having the same issues there. Yesterday I raised that with the chairman and he immediately said that he would raise it and deal with it. I think there is a huge willingness, but I want to be clear that it is variable. It is not that they consistently do not do it; it is just very variable and it depends on the strength of the country in terms of their own ability to influence it. When I was in Ethiopia they were funding health extension workers alongside us; in Malawi they fund health workers, co-funded by DFID. It is the variableness we need to fix. We need to make sure it is consistent and systematic. Mr Bercow asked about the issue of the board and we are doing this mainly through the board but also in private discussions. In their evaluation, we are going to ask them— and they have agreed— to evaluate not just the immediate impact of what they do but the impact on the overall health systems of what they do and that is very important. Secondly, at the most recent board meeting they agreed— and this was based on discussions that I started in July with Michel Kazatchkine— to have a gender strategy which will ensure that it is linked more seriously into the maternal health piece. We are already starting to talk to them about what might be in that and the board has asked them to do that. There is a change and there is a willingness. They have their portfolio committee looking at giving guidance on how applications are made so that the applications can be more integrated and can fund health systems. I think this is an opportunity. There is also an opportunity with PEPFAR coming up: the current chairman is very willing and very aware of these issues and we are going to be talking about how we integrate them into health systems. This could be a big prize really. I am sorry; I am showing my fixation again.

Q281 Richard Burden: That is interesting. From what you have just been saying, you seem to be suggesting that it is very much a function of the Global Fund itself to be able to push that kind of agenda. We may have misunderstood but we had evidence a week or two back from the representatives of the Global Fund, amongst one or two others, and there was an issue there about how far the Global Fund should be responsible for promoting integration between sexual and reproductive health, on the one hand, and work specifically on HIV/AIDS, on the other, and how much that should be the responsibility of donors themselves. When that issue came up, the representatives said that the Global Fund does not decide which country should ask for this or that but it is more up to DFID, to the World Health Organisation, to more technical agencies to be encouraging countries as to what they could apply for. What you have said today does not particularly agree with that. You have said that it is certainly up to those agencies but also it is a responsibility of the Global Fund itself.

Baroness Vadera: This relates exactly to the issue of variability. It is not their responsibility, in one sense, to be working on maternal health, it is their responsibility to do HIV, but they cannot be an obstruction and they do have to work with others. They are willing to do that and they have shown serious signs of being willing to do that. Their portfolio committee was charged at the last board meeting to go away and look at the guidance that they give to countries about the applications they make and in terms of the flexibility they have. It is true that if the countries push hard they can get a lot further in terms of getting flexibilities from the Global Fund but I think we also need to be making it clear to countries that that is possible too.

Q282 Richard Burden: My last question is in relation to DFID's own strategies for integrating HIV/AIDS work and maternal health work. You are amalgamating the HIV/AIDS policy team and the reproductive and child health policy team. How far is that contributing to the process?

Baroness Vadera: It is slightly difficult for me to judge because I have only been there since July and they have been amalgamated since then, so I do not know how it operated before. Obviously we are in discussions now to develop our renewed HIV/AIDS strategy, which we are going to publish in the spring, and we are integrating the two elements in there. We are having the discussion and it is good to have a discussion with the same bunch of people really. I do think it will make a difference.

Q283 Jim Sheridan: I understand that we are in the process of exploring setting up the Global Fund for Women's Health. What is the rationale behind that? I would not underestimate for a moment the horrific statistics in terms of the maternal mortality but would you not agree that men have a responsibility also for that mortality in terms of their sexual behaviour, infection, et cetera. I am wondering why you have to set up this committee, if I may call it that, mainly for women's health. My concern is that then allows the males to abdicate their responsibilities and to say that this is mainly a problem for women and therefore women have to deal with it. Basically, what is the rationale behind this decision? What do you hope to achieve?
Baroness Vadera: It is not what we are advocating, in fact. There was a suggestion on the second day of the Women Deliver Conference that there should be a specific vertical fund. We would agree with you. We do not think that would necessarily help for a whole number of reasons. One of the reasons is the one you have mentioned, but one of our issues, as we have discussed earlier, was the duplication and proliferation issue and the fragmentation issue: to be adding to that would not necessarily help unless you take away things from others and you cannot take things away from others because it is important that they are integrated. This is a very hard area to start to fragment and we would accept the view that we do not think that a single new fund or agency would help. You do need to be effective in the mainstreaming. There is an issue here: if we say we cannot do this, we cannot fragment and therefore there has to be mainstreaming, then the mainstreaming does have to work and be effective and we need to be quite vigilant about that. That is why having specific indicators and specific focuses on maternal health is a more useful way than perhaps to set up a single fund.

Q284 Jim Sheridan: If DFID is not supporting this committee—
Baroness Vadera: It is a fund. It is not a committee.

Q285 Jim Sheridan: I am sorry. If DFID is not supporting the fund, is it dead and buried? Is it finished?
Baroness Vadera: Would you suggest that DIFD is overpoweringly influential? Perhaps it is not!
Mr Rogerson: I think it is just an idea.
Baroness Vadera: It was an idea that was floated. During the course of the conference it all came about through the whole issue of why there is not enough focus on the issue, rather than because people thought that operationally that was needed. I think it is better to do an advocacy campaign around lots of different things like the Japanese or the Elders or the G8 than to have a separate fund.

Q286 Jim Sheridan: The only reason I mentioned a committee is because if you are going to set up a fund then it follows that you are going to set up a committee to look after the fund.
Baroness Vadera: It is our view that it would be adding to the proliferation.

Q287 John Battle: Perhaps I could go back to the International Health Partnership that Gordon Brown launched and which you have referred to and press you a little on the targeting, if you like, or the pilots. Seven were chosen. One of the people who gave evidence said: "It is important to learn from pilots but we need to make sure that all the 75 high burden countries move quickly to reach the assigned targets under the MDGs. It is not enough to take seven or eight countries to start with and assess them at the end of 2008."[16] When listening to your response to John Bercow's question on pilot schemes and funding things to get them off the ground, I was thinking that too often we light pilot lights and then snuff them out before the main oven is burning. In this area we cannot really wait for the pilots. What is DFID trying to do to ensure that the Partnership gets engaged with those 75 high burden countries, as they are called, and quickly?
Baroness Vadera: There is always a trade off. We did have a very long debate about this while we were developing the IHP. It is eight now because Mali has joined: it was meant to join but was not ready and so it joined very soon after that. We picked the eight because they were in a wide range in relation to where they were in terms of the effectiveness of the health sector plan. We wanted to make sure that the eight agencies were working effectively regardless of the state of the plan or the effectiveness of a government in terms of the "ask". We know that if a plan is good and the government is very effective it is easier for donors to be coordinated. We have chosen a range and we are trying to find ways to change the practices of the agencies. That is the example I was giving Mr Burden of seeing the Global Fund doing really well in Ethiopia and not so well in Mozambique, and trying to make it systemic. If you roll it out to 72 countries, what are we going to change in the behaviour of the Global Fund unless we have targeted it, pointed it out and they have changed it systematically? That is a very important thing to do.

Q288 John Battle: I can see that you do not go straight at the 75 countries, but are you engaged in that move from the seven or eight to the others? Have you bunched them into groupings?
Baroness Vadera: We have had a lot of countries express interest in doing this. I suspect we will go with the ones which have expressed interest because it shows their willingness and ability to do this. One of the problems that we have in development is that it is all about implementation. It is boring and it takes time but it is all about implementation. I am really loath to go with something that is half-baked, where we have not sorted the systems issues out or figured out what all the problems are. The point about the IHP is not to say: "Here's the template; everybody is going to do this" because every country situation is different. We have to figure out how people work on the ground in varying circumstances

[16] Q 9 [Dr Songane]

and ensure their headquarters are aware of it and know about it. If we do not get that right and we roll it out then it is not going to be effective.

Q289 John Battle: You are not hanging back waiting for the pilots to be reviewed in 2008; you are engaged to move down that track.
Baroness Vadera: Yes. I have been lobbied by the Rwandans very heavily. We are telling our country teams on the ground and the other agencies' country teams on the ground, even if they are not an IHP country, "Here are the principles. You should already be starting to look at these principles." I just do not want to move until we have really figured it out.

Q290 Ann McKechin: I wonder if we could move to the issue of maternal health in conflict settings. DFID currently funds a range of partner organisations, mainly NGOs and multilateral bodies, in most conflict areas. Particularly in countries like the DRC or Afghanistan, where we have large bilateral programmes, what can we do to ensure that reproductive and maternal health are suitably prioritised in a conflict setting?
Baroness Vadera: I do not know what you would describe as conflict or post-conflict but we have certain countries where it is difficult to be active— and I am talking about Somalia or Sudan, where we have to fund through the UN system or through NGOs. In post-conflict situations we do try to talk to them as soon as we can. I was in the DRC earlier, as I mentioned, and I raised the issue directly with President Kabila. We are funding already a lot of the NGOs but I would really like to be able to move to funding something more systematic and not just the emergency relief. The DRC is still slightly divided: in the east you have this incredible violence against women which is leading to fistula and all sorts of other problems, and then the west is a little bit more stable. We are in discussions about trying to get it more systematised but, if you are going to do systems, you have to have capacity in government and that is really the fundamental issue. In Sierra Leone— if you classify that as post-conflict— we have been working with the government on a health plan, which they are about to finalise. Sierra Leone is absolutely the single worst country in terms of maternal health indicators. We are working to get them to focus. We do try to move as quickly as we can. In Afghanistan we fund health workers through the Reconstruction Fund and we have recently seen— but again it comes back to the problem with figures— a reduction in maternal health issues.

Q291 Ann McKechin: You have talked about the weakness of the evidence base. To what extent do you think that the priorities should be for, firstly, DFID, but, secondly, for the multilateral organisations such as the UN in strengthening the evidence base and trying to use best practice from other post-conflict areas which can be replicated in other areas, so that we do not have to reinvent the wheel every time we come to a conflict area.
Baroness Vadera: I think there is best practice, but you get into the problem which Mr Battle was questioning me on as to whether we are going to wait and then roll something out when people are in need. There is a lot of evidence base now. I think our biggest learning place was Nepal post-conflict. They had managed in this period to have an impact. Roll-out has been quite speedy and they have done some really interesting things including involving the non-state sector in a social/private contracting structure. We have given direct payments to women to access transport— rickshaws and so on. There are certain things that you learn and the DFID programme is something we could learn from and replicate, because it is really seen to be very successful.

Q292 Ann McKechin: Are there still problems about coordination between bilateral donors, multilateral donors and the NGO sector? Is that still a problem when it comes to rolling out maternal health services in post-conflict areas?
Baroness Vadera: Yes. It is always a problem, in post-conflict areas particularly, because people come in and you cannot work with the government, the government is not effective, so there is really nobody coordinating, so it tends to be more exaggerated than it is in other situations. To go back to the IHP: Nepal is an IHP country and we have tried to use that as a mechanism to get donors to coordinate. When we were in the DRC we seemed to spend quite a lot of time on the coordination issue, but it is inevitably a problem because there is not an effective state to interact with.
Dr Tyson: Nepal has had 10 years of conflict and yet the programme worked all the way through that period. The focus of the maternal health programme was the Maoist area in the far west of Nepal. I was there last week. Throughout that time both sides valued the services that were being delivered and that enabled them to carry on. That has been a testament to good practice. I was told that there are between 20,000 and 35,000 NGOs working in Nepal that have come in through this period, so you can imagine the problems that governments have in the peaceful period in trying to bring them together. It is always one of the issues on which we are attacked— you know, "How do you get NGOs represented in the International Health Partnership?" What is an NGO? Who can represent the body of special interest? It is something we are struggling with in a number of those areas.
Ann McKechin: Should we get a certification scheme in place, so that if you reach a certain level of coordination you will get a certificate?

Q293 Chairman: NGOs may be a good thing but you can have too much of a good thing.
Baroness Vadera: It is not just coordination. We are paying with it not being the most efficient way of doing things.

Q294 Chairman: In Annex 2 to your evidence, you talk about the role of budget support in the context of maternal health and you make the point that it is quite difficult to follow through exactly how much of

the budget support does deliver maternal health benefits. When we are visiting countries where budget support is a significant part of the UK contribution, the DFID team will tell us that one of the virtues of budget support is that it gets you a seat at the table; in other words, you are working in a kind of partnership with the government. If that is the case why is it not possible to get a little bit more direct handle, without putting conditions, on exactly how the budget support is being used specifically to deliver maternal health? You also say: "A process is underway to bring DFID's statistical monitoring systems in line with the OECD . . ."[17, 18] I wonder if you could give us a bit of information as to what that means in the process.

Baroness Vadera: The seat at the table is, in one sense, about influencing the decisions and the policy and the allocations of spend within the budget— and that is fairly critical. We can influence the amount that is allocated between sectors and into the health sector. It then becomes an issue of statistical systems and tracking— and we have had the discussion about tracking the indicators, et cetera. As I said before, I think it will be an important move for us. It will be good in terms of a change of mindset. There are certain headline indicators in budget support and it has traditionally been immunisation rates. If we could move that to maternal, because that is a better tracker of the effectiveness of the health system, then we will ensure that we have greater focus and we are going to try to start to do that. The tracking system that we are implementing is basically automating the tracking of our own funding. It is called ARIES.[19] It is being rolled out over the course of the year and means that we could then track quite a lot of sub-sectors and sub-indicators that we were not able to before. It was semi manual before. I think that will help. It is already in process at EU division and it is going to be rolled out in the course of the next 12 months.

Q295 James Duddridge: Best practice seems to be around sharing information. Will ARIES be published on the web, or a distilled version?

Baroness Vadera: I do not know.

Mr Rogerson: It is primarily an internal management system but presumably we will continue to publish the statistical data that results from it in the normal annual reports and compilations.

Q296 James Duddridge: Certainly, when we are talking to people, the more that can be shared the better the possibility for coordination.

Mr Rogerson: Yes.

Baroness Vadera: Were you talking about sharing the information that comes out of it or sharing the systems?

Q297 James Duddridge: The information not the systems. Although, if our comparative advantage is being at the cutting edge in persuading people, why should DFID have a single management information system? Perhaps there needs to be coordination there as well.

Baroness Vadera: I think it is meant to be a system for live management of the information. When we are asked to publish information, we will be using the ARIES system to provide also for whatever we do publish. You ask the system to provide certain tracking and then you can make that information available.

Q298 James Duddridge: I suspect the Committee will be interested more broadly in that system and understanding a bit more about what value it could add.

Baroness Vadera: Maybe we could send you a note.

Q299 Chairman: Related to that is the role of civil society— not necessarily the 34,000 NGOs but some of the good ones to help in that process. In other words, if they know there is some commitment by the government of their country to improving maternal health then they can clearly be instrumental in monitoring it. You specifically also say in your evidence to us that the department seeks the support of the IDC[20] to work with parliamentarians in developing countries on this issue. That is something we as a Committee have an interest in. Hugh Bayley has left but he is with the Westminster Foundation for Democracy and also the Parliamentary Network of the World Bank which we understand is likely to be revamped— at least, that is what we were told. Do you have any means of proactively encouraging the development or the support for local NGOs as part of the process of helping to raise both awareness and monitoring performance on maternal health? Do you have any specific thoughts on how the Committee particularly might help in terms of the links in that area?

Baroness Vadera: Because we think holding governments to account is better done by civil society than by us we have the Governance and Transparency Fund, which is going through its process of assessing applications. I am certainly hoping— and we have yet to see the applications, the assessment is coming out— to see a really strong focus on gender issues, women's groups, including maternal health. I think that is a very important area. You will know that women's gender issues are very much at the heart of poverty, so I expect a lot of that will come through the Governance and Transparency Fund. Once the allocations have been made and the applications have been assessed, perhaps we could advise you of that. For me, the role of parliamentarians is very important. I have in the past had discussions with Mr Bayley about this. I know we have used the parliamentary group for things like female genital mutilation. When it comes to really sensitive issues it is almost easier not to have it as part of a donor relationship but as a relationship

[17] Organisation for Economic Co-operation and Development (OECD)

[18] Ev 23

[19] Activities Reporting Information E-System (ARIES)

[20] International Development Committee (IDC)

between parliamentarians. I do not know what we specifically do in that area but perhaps we should think about that.

Dr Tyson: Last week I was at a sector review in Nepal, looking at progress and where the programme is going. It was an unusual experience for me because most of my experience has been in Africa. In Nepal it is about government talking to donors with very few other parties in the mix, yet if you go back to Uganda and look at how they run it they would have parliamentarians, civil society, the press. To try to encourage those processes in other countries in Africa, we have encouraged or facilitated people from one country going to another: parliamentarians, civil society groups, and to learn from the positive experience and try to take that back. In Nepal, when we go back a year down the road, we will see that they took on the message about the need for a much more inclusive process that brought in all those other players. That is a very simple example but one that can move us forward.

Q300 Chairman: We will come back to the parliamentary network when we are talking about the World Bank. They seem to be upgrading that. The Committee is planning to visit Nigeria and Ghana next year. We always try to seek out parliamentarians but it may be appropriate for us to look for parliamentarians who have a particular interest in this issue as part of it. It does say in your evidence that you want to work with the Committee but perhaps you might want to give some thought to how that would be.

Baroness Vadera: Perhaps we should take the visits as a specific ask and give you some suggestions, to see what to do and what to push for. Particularly if we are having this focus on MDG 4 and 5 in the Ghana programme—

Q301 Chairman: I was thinking of Ghana in this issue particularly.

Mr Rogerson: Ghana would be a good example. The nature of the parliamentary scrutiny on the budget, for example, has been toughened up considerably and so you could ask questions of your peers about how they look at the balance of health spending.

Q302 Chairman: I guess this is not the appropriate place to pursue that. We have had evidence that there was some discontinuity in the programme which raised some criticisms of DFID. The point is that is the opportunity to find out exactly what the perception on the ground is on these kinds of things.

Baroness Vadera: Yes.

Q303 Sir Robert Smith: We have already touched on the crucial role of human resources. Unless there are people to do the delivery then you are not going to tackle this goal. There is obviously the supply side but then there is the worry of a brain drain, in a sense. The Royal College of Obstetricians and Gynaecologists were saying to us that there ought to be a model that allowed professionals to come here for two years to get their training and then they would go back, rather than having them stay here. What sorts of joined up discussions are there in Whitehall to try to tackle this problem of skill shortages and avoiding sucking them away from where they live?

Baroness Vadera: We have an inter-ministerial group. The NHS signed a code of conduct in terms of not poaching and not actively recruiting where there are skills shortages— which is about 150 countries, so that is quite a lot. There has been significant reduction in certain countries that we track of people migrating. It is not just active recruitment. When we were working on the emergency human resources programme in Malawi, it was interesting that there were more health workers and doctors and nurses who were in Malawi not in the health system but doing something else— because there was not sufficient pay and they could not guarantee a proper functioning system. We have ended up doing salary top-ups and golden hellos and innovative things to try to get them back in. So it is not just an issue of poaching. We have had a decline in the UK.

Q304 Sir Robert Smith: Do you work with the private sector?

Baroness Vadera: Yes. They signed up. We say that if the NHS is using a private provider then they should have signed up to this code. We encourage the private sector to sign up to this code as well. It is an important area. We are also working with the EU to try to get other countries involved. It is not just about us. Although English as the natural language is an important attraction, I think it is quite important that we—

Q305 Sir Robert Smith: Do you still see a model whereby coming here for two years is a useful way of getting the skills to take back?

Baroness Vadera: I think it is. I know there are already programmes in place. I think that works quite well at the high end— for very skilled doctors mainly. I think there is an issue about whether we should be assisting in sending trainers, because you get to know people and you get better sustainability than if you just have a group of people coming over here. In specialist areas they obviously do. The report talks about you could have better interaction between the NHS and health workers and the service here and developing countries, and we are going to be responding to that in the New Year.

Q306 Sir Robert Smith: How are you looking at the pull within countries towards the cities? What strategies are there to persuade the health professional to stay in the rural community?

Baroness Vadera: Using and training workers who are from the local community for certain things always works more effectively, and having a tiered system that ensures you have community health workers on the ground. In the case of maternal health, obviously those women would like to be given a training gap, but then being able to ensure that there is a system, if they recognise warning signals, for them to need to move on to the next stage. I think that works. We also do salary top-ups.

We have a lot of schemes in Malawi. As I was saying, we have exactly that, salary top up and things, but it is one of the most difficult things. Maternal health is not just the best indicator of a health system, it is one of the best indicators of access and poverty too because you can see where the problem is. It is really inequitable. In rural areas in India the level of access is significantly lower than for women in urban areas. It is a very difficult issue, particularly for maternal health.

Q307 Jim Sheridan: I wonder if you could expand what you have said. You say you spot recruit from people from other countries. In another life on another committee I visited Nigeria and met a very excited parliamentarian who was also a doctor who was extremely angry that he was not allowed to come to the UK. What practical steps do you take to stop people from Nigeria coming to this country?
Baroness Vadera: There is obviously a new system now, a points-based system. I was in Nigeria earlier in the year, in August or September, and I had a very direct discussion with the Minister of Foreign Affairs about the immigration from Nigeria and doing a bilateral compact, which we have had before. We are going to review that, to look at that issue. As I say, we are trying to stop doctors from coming here but what you were witnessing was the other side of the equation. It is probable that he was not practising as a doctor.

Q308 Jim Sheridan: He trained in Edinburgh.
Baroness Vadera: This is the problem we are encountering. You train them but they are not working in the system.

Q309 Jim Sheridan: Nepal has come up several times this morning, where perhaps the Nepal experience can be replicated and others where it is difficult to transfer from one situation to another. Specifically on the question of the experience of women advocating to improve maternal health, how far do you feel the Nepal experience can be replicated and how do we do that?
Baroness Vadera: I could give you my view but there is an expert sitting next to me who has just come back.
Dr Tyson: It is always very dangerous to try to replicate too much. Nepal was the first country I worked in 27 years ago for Save the Children, so I had some comparison there. We have tried to do two things in parallel. One was to invest through flexible, long-term predictable support to a reformist government that was trying to deal with all the difficult things— how does it recruit staff? How does it get money down to the system? How does it strengthen the information system? That was one arm. In doing that we were working very closely with the World Bank and European bilaterals. That was the longer-term agenda. At the same time, we were investing in frontline services. Doing both together— and we have done that in Bangladesh, Malawi and a number of other countries— I think is the right way to go. The nature of the frontline service is also comprehensive. It was not just dealing with one of the problems; it was dealing with family planning, safe abortion services, safe facilities for women to deliver in, investing in voice and accountability through civil society groups, working with local radio and working directly with the community, making sure that there were low-level community health workers from that community, trusted by that community who were there when needed. It was using innovative approaches that may or may not be transferable, using cash incentives or vouchers to attract them to come and deliver in a safe environment, but it was having to build up infrastructure and blood transfusion services and transport facilities. That takes us back to the beginning of the day: it is about building that system. The really encouraging thing was hearing the Nepali ministers using maternal health as their marker of progress— we have said it time and time again but they said it: if we can put in services at the district hospital level that enable us to deal with maternal health issues, then we can deal with surgery, other medical problems, road traffic accidents.
Baroness Vadera: In terms of women's groups, there were specific elements of Nepal which I, travelling between countries, have found interesting, and one of them was the community health workers and particularly the fact that women felt more comfortable with them: they were local, they knew them, and therefore that works. The cash incentive is worth considering looking at because you need to have certain incentive structures. I have seen that incentive structure replicated. We have it in India now. In Nigeria they have a very interesting system that they are experimenting with. In India I found they were paying anybody, a neighbour or a friend, who had brought the women into a facility so that they could have skilled attendance. There was also the transport piece, the rickshaw service they had. They are two or three things that are replicable. It is much more difficult to look at replicating local women's groups and networks because they tend to be very individual to the country. You just tend to have a very individual cultural and social set of issues. That is much harder to do. Possibility on the sub-continent it might be easier and in Africa there might be quite different models in terms of accessing.

Q310 Ann McKechin: We visited the project in Malawi last year and exactly those points were raised. There was no civic society organisations at all. They had to be started from scratch so it has taken much longer but I think they are doing very good work. I was very impressed by it. I think you are right: it is not one-size-fits-all that is going to work.
Baroness Vadera: No, it is not. Once you create a women's group it becomes quite interesting because you can do micro-credit through it and childcare. There are lots of different elements you can do if you can create the women's group but in the main they do not tend to exist. That is the whole point about them being voiceless: they are voiceless in that they do not have immediate advocacy in any way.

Q311 Richard Burden: When we were in Ethiopia earlier this year, we were all impressed by the work of the health extension workers there. In that particular context we were looking at water and sanitation. The impact of the contribution of women in not the most remote villages but relatively remote villages was phenomenal. It did seem that that kind of model could be taken up and used in a much broader way on perhaps some of the agendas we are talking about here.

Baroness Vadera: It is very different but similar to the experience in Nepal. In one sense, it is finding women locally and training them and making them community health workers. It is a very important dimension and a lot of people describe them in slightly different ways, as low-level intervention, but it is very critical. So long as you can give them access to transport and training and supplies and everything else around them, it is one of the most effective ways of doing things in remote areas. Also, women prefer to stay in their local community. In Ghana we have funded giving motorbikes to health workers. In Pakistan we have a lady health workers scheme. It is something that is one of the common features.

Q312 Chairman: You have already mentioned the problems of unsafe abortion and the fact that literally tens of thousands of women die as a result of that. Other evidence tells us that quite a lot of women find they are forced into sex, they have more children than they want, they have unwanted pregnancies because they do not have access to family planning or that they are married at a very young age. There is a picture in today's *Metro* I think of a 40-year old man and his 11-year old wife in Afghanistan. We know that young girls are more like to die in childbirth in that situation if they get pregnant and it would be better having a safe abortion. What can DFID do to ensure that at least where abortion is legal, women understand their rights and can get access to them. Many, we understand, either are not aware or fear they will in some way or other be punished or penalised, so they resort to unsafe abortions and many die or suffer severe disabilities?

Baroness Vadera: This is one of the hardest areas because it is about getting into people's homes and how they interact and how they feel about it. There are things we can do. We do promote and fund certain agencies that can work to ensure that women, in particular, are aware of their . . . I think "rights" is difficult, but the fact that there are services that are available. It has been very effective in Bangladesh, where there are centres. They are called Menstrual Regulation Centres— which is obviously just a terminology issue— but that has ensured that women are aware, feel safe, do not have stigma and can access safe abortion. That has led to a reduction in maternal mortality. There are things that can be done but I am not going to pretend this is the easiest area to work in.

Q313 James Duddridge: This is the first time you have come to speak to us in roughly six months into a job. What have been the surprises, both welcome and unwelcome within the job? What are the strengths and weaknesses of the department? What are your first impressions of DFID?

Baroness Vadera: If it was a surprise, the more I have done the more I have enormous respect for the people: how much they know, their integrity in doing the right thing. The more I travel, the more I am proud of the fact that DFID is the leading agency in the world. I sort of knew that but you have to be there to feel it and I am very proud of that. In terms of my areas of focus, I, the Secretary of State and others are very interested in ensuring that we look at issues around growth and not just around the social expenditure side because in one sense this is really the only thing that is going to make development sustainable and the expenditure we are talking about in social services sustainable. We are working on a growth strategy. I am delighted you have talked about data, evidence and numbers and tracking because it is something we raise very regularly and it is one of the areas I press on. At most meetings, I will say, "What is the impact? Where are the numbers?" being harder edged about that. It is there, it is not that it is not being done, but it is making sure that we are able to access it or communicate it. I and the Secretary of State would really like to make 2008 an opportunity to mark the hard work of the MDGs and make sure DFID is able to have that influential role. It plays a very important role. Maybe I am a little bit surprised about how influential it is. It boxes a little bit above its weight, even thought its weight is getting heavier all the time.

Q314 Chairman: Could I thank you very much for your first evidence session in front of the Committee. The Committee regards itself as interested in what works. Our engagement with the department, whilst it does not mean that we do not criticise them, the criticism is always constructive, in as much as all these questions have to be asked and impact and effectiveness has to be monitored. That is what we are trying to do. The Committee would share the same view as DFID. We have travelled quite extensively and wherever we go, when we talk to other donors and recipients the image of the department is extremely high and its reach and influence is extremely far. The truth is, I guess, that all of us are proud of what is achieved, but we are also conscious of the fact that the budget is growing, the ambitions are growing and we have to be sure that we continue to deliver effectively. We see the role of this Committee as being to assist in that. This particular inquiry is clearly prompted by the fact that this Millennium Development Goal is furthest off track. That is why we decided to do it— and John Bercow, I know, was particularly keen that we should— but I think it would be fair to say that, whilst we knew that, having taken evidence the Committee has been frankly shocked at the status of women and the suffering that they undergo for something which in many, many cases is avoidable and where there is much that can be done to raise the

status. We did realise that it was not that different in developed countries 100 years ago and we have to try somehow or other to help developing countries to travel 100 years in 10 rather than have to wait 100 years themselves to catch up. I hope our report will make a constructive contribution to that. This is the last evidence session we are taking. If there are any particular issues that have arisen that on reflection you would wish to add to or reinforce, we will be very happy to receive that.

Baroness Vadera: I am really delighted that this subject was my first, because I do feel very strongly about it. I think this report will be very important and I would like it to feed into the attention that we need to give to advocacy and somehow also be able to be used in countries. It is not just about the international advocacy and what donors do but what happens in country. If we can find a way of using that, it would be absolutely fantastic. I have read a lot of the evidence that has been given and I have been as shocked as you. You do know it, but, when you start to realise, some of the things we know are very shocking and perhaps we do not pay enough attention to them, so I am really pleased you are doing this. I would like to use the report when it comes out.

Chairman: We will produce the report very early into the New Year. Thank you very much

Written evidence

Memorandum submitted by the Department for International Development (DFID)

September 2007

ACRONYMS AND ABBREVIATIONS

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
AusAID	Australian Aid
CAP	Country Assistance Plan
DAC	Development Assistance Committee of the Organisation for Economic Cooperation and Development
DFID	Department for International Development
DoH	Department of Health
DRC	Democratic Republic of Congo
EmOC	Emergency Obstetric Care
EHRP	Emergency Human Resource Programme
FCI	Family Care International
FIGO	International Federation of Gynaecologists and Obstetricians
FGM	Female Genital Mutilation
FP	Family Planning
GFATM	Global Fund to Fight AIDS, TB and Malaria
GHWA	Global Health Workers Alliance
GTZ	German Technical Cooperation (Deutsche Gesellschaft fr Technische Zusammenarbeit)
HAC	Health Action in Crises
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICPD	International Conference for Population and Development
IDA	International Development Assistance
IDC	International Development Committee
IHP	International Health Partnership
IMMPACT	Initiative for Maternal Health Programme Assessment
IHP	International Health Partnership
IPPF	International Planned Parenthood Federation
JICA	Japan International Cooperation Agency
MDGs	Millennium Development Goals
MH	Maternal Health
MNH	Maternal and Newborn Health
MSF	Médecins Sans Frontières
MMR	Maternal Mortality Ratio
NGOs	Non-governmental Organisation
NHS	National Health Service
PMNCH	Partnership for Maternal, Newborn and Child Health
PMTCT	Preventing Maternal to Child Transmission
PRSP	Poverty Reduction Strategy Paper
PSA	Public Service Agreement
RCH2	Reproductive and Child Health 2—Programme in India
RCOG	Royal College of Obstetricians and Gynaecologists
RH	Reproductive Health
SAAF	Safe Abortion Action Fund
SGBV	Sexual and Gender Based Violence
SMP	Safe Motherhood Programme
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SSS	Sampling At Sites
SWAps	Sector Wide Approaches
TB	Tuberculosis
TBA	Traditional Birth Attendant
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNITAID	International Drug Purchasing Facility
USAID	United States Agency for International Development

WB	World Bank
WHO	World Health Organisation
VITA Trial	Vitamin A Trial

Facts and Figures on Maternal Health and MDG 5

Millennium Development Goal 5: Improve maternal health
Target: Between 1990 and 2015, reduce the maternal mortality ratio by three quarters

The problem

- MDG 5 aims to "improve maternal health" as well as to tackle maternal deaths. Over 300 million women in the developing world suffer from short or long-term illness or disability because of problems in pregnancy and childbirth[1].
- 529,000 women continue to die each year during pregnancy or childbirth, most of them in sub-Saharan Africa and Asia[2]. This is equivalent to one death every minute (or a global maternal mortality ratio of 400 per 100,000 live births).[3]
- The most common clinical cause of maternal death is severe bleeding which, if unattended, can kill even a healthy woman within two hours. The second most frequent cause is infection, the third is unsafe abortion[4 5].
- There is no greater inequity in health than maternal mortality—the chances of suffering a maternal death over a woman's lifetime is one in 6 in Sierra Leone compared to one in 3,800 in the UK—a 600 fold difference[6]. See Figure 1 to see where death rates are highest.
- To achieve a three-quarter cut in maternal mortality ratio from the global worldwide estimate of 430 in 1990, we need to reduce to a level of just over 100 by 2015. Currently the global estimate is still as high as 400, and for Africa, the almost double—at 8307.

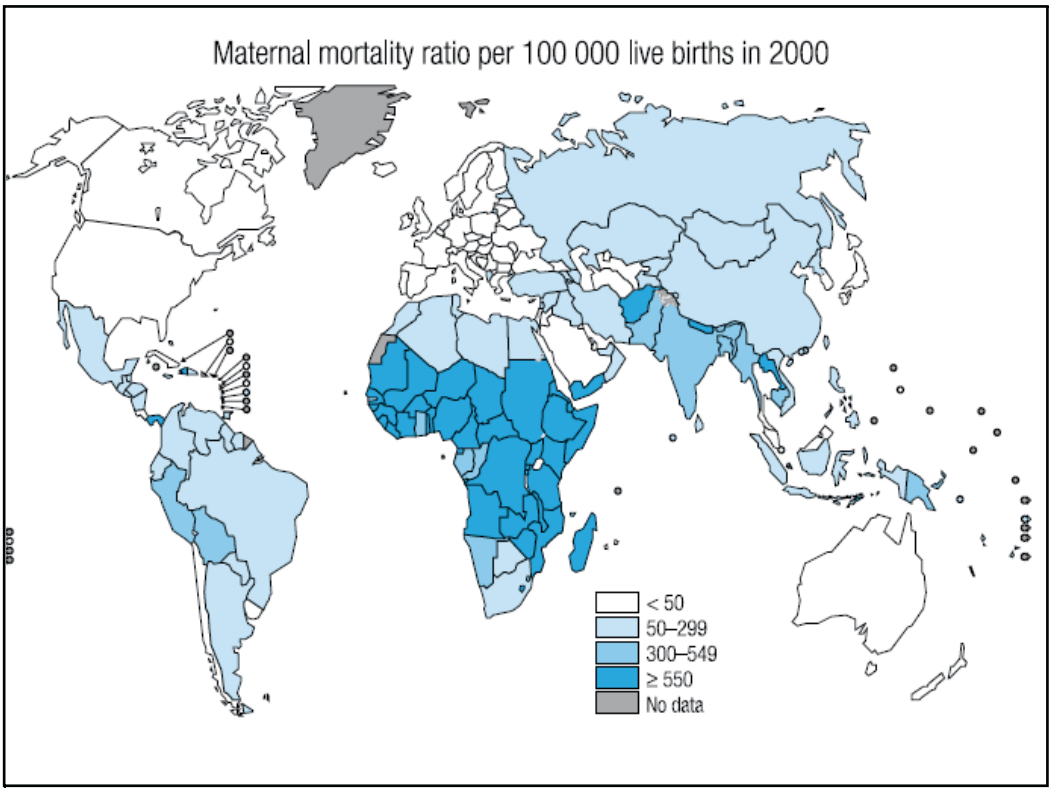
What is needed?

- Improving maternal health cannot be achieved without strengthening the health systems that underpin delivery of health services. Currently there are not enough trained and motivated health workers to deliver basic services—a global shortage of four million is predicted by 2015. In 57 countries, the health worker crisis is deepening through chronic underinvestment; losses to HIV/AIDS and out-migration of staff (see Figure 2).
- Improving the functioning of health facilities saves the lives of mothers, but to reduce maternal mortality in line with MDG 5, access to specific skilled health workers such as midwives and obstetricians is also needed as well as access to safe abortion and family planning services[8].
- Maternal health cannot be isolated from other health concerns—the health and survival chances of mothers and their babies are largely determined by sexual and reproductive health before pregnancy, as well as care during pregnancy, at birth and after the birth[9]. Because deaths of newborn babies around the time of birth form nearly 40% of total under five deaths, efforts to achieve MDG 5 overlap considerably with efforts to achieve MDG 410.
- Millions of women are still left without professional care at the time of birth—many give birth only with the help of a non-qualified health worker. Nearly one in four women in developing countries undergoes childbirth alone—or with only a relative or neighbour to assist them; this has not changed since the early 1990s[11].
- Assistance at childbirth is only one part of the healthcare that is needed—women also need antenatal care, and postnatal care—for mother and for baby too. This "continuum of care" should also include pre-pregnancy care eg family planning[12].

Progress in tackling MDG 5

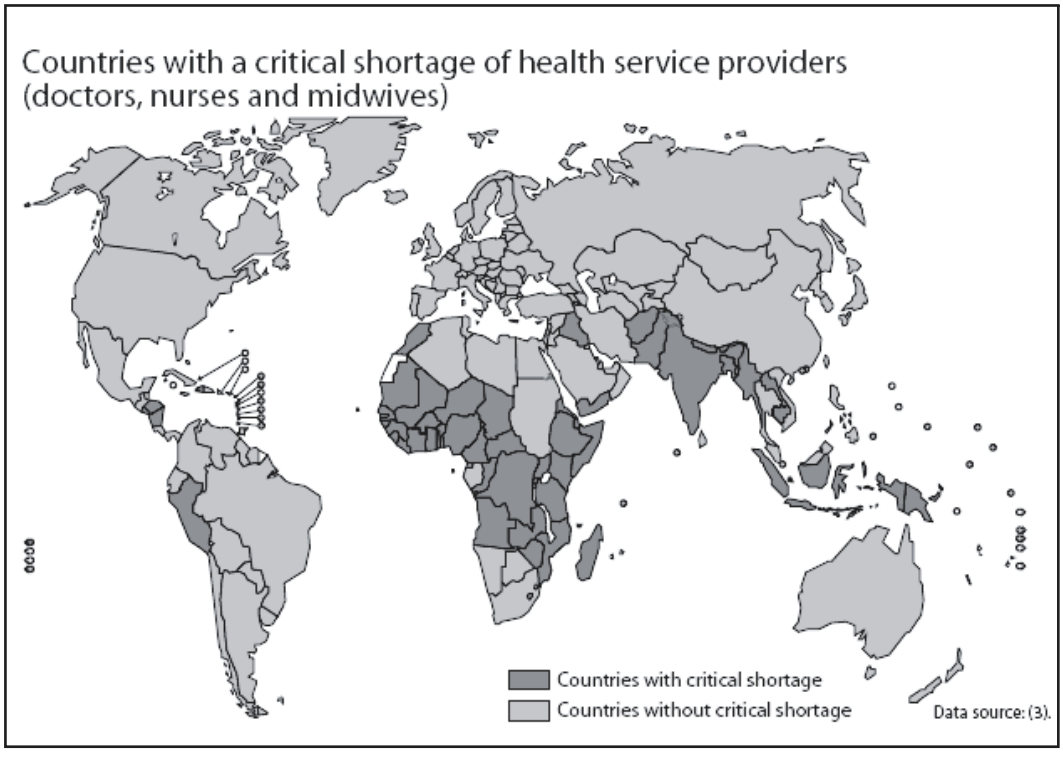
- A few countries have managed to halve their maternal mortality rates over short periods[13] but overall there are only a few signs of progress towards meeting MDG 5—globally we are lagging far behind the rate of decline needed, especially in countries and areas which already have very high mortality.
- The proportion of women who have the assistance of a professional such as a midwife at childbirth is slowly improving—despite a rising number of births—since 1990 the proportion of women with a health professional assisting at birth has risen from 43% to 57%[14].
- The key constraint to progress is the lack of a viable and effective health workforce. It is estimated that 36 out of 46 African countries have critical shortage of doctors, nurses and midwives and that African countries face a shortfall of nearly 1 million health workers—many of which are needed specifically for maternal health[15].

Figure 1—Dying to give birth: Maternal death rates around the world



Source WHO (2005) World Health Report 2005—Make every mother and child count, Geneva page 15

Figure 2 —The health worker crisis—countries with critical shortages



Source WHO (2005) World Health Report 2006—Working together for health, Geneva page 12

Executive Summary

An estimated 529,000 women die as a result of pregnancy and childbirth each year. 99% live in developing countries. Countless other women survive but suffer serious complications in pregnancy and childbirth. Yet the health of women is critical to a country's social, economic and political development, but it is rarely a political priority, because of the low socio-economic and political status of girls and women in developing countries. It is clear that political commitment, especially in developing countries, to make the difference for the poorest women is lacking.

A maternal death is a death like no other. The social and economic consequences are great, especially for surviving children. Progress on MDG 5 is vital for the achievement of MDG 4 and other MDGs.

Eight years from 2015, progress is too slow and without a new impetus many developing countries will not achieve this MDG by 2015. Maternal deaths demonstrate the greatest difference in health between rich and poor women within and between countries. The chances of suffering a maternal death over a woman's lifetime is one in six in Sierra Leone compared to one in 3,800 in the UK—a 600 fold difference. In 1990 the global average was 430 deaths per 100,000 live births. In 2000 it was 400 deaths per 100,000 live births and 830 per 100,000 in Africa.

Most progress is being made in Asia, but less so in Africa where even basic health services, including the skilled staff needed to prevent maternal deaths are simply not available without new impetus. But DFID has learned from its experience in India, Bangladesh, China and elsewhere (See Question B) that significant improvements can be achieved in maternal health, where health systems are being strengthened and where specific sustained investments are made (within health systems strengthening) to improve maternal health. There are no quick fixes. It is clear that improving maternal health requires a functioning and equitable health system that can meet the specific needs and rights of women in pregnancy and childbirth. Long-term underinvestment in health systems—trained staff, clinics, supplies of essential medicines, management and information systems—means that few health services in developing countries can provide the range of care needed. Women need to be able to access emergency obstetric care (such as a caesarean section or treatment for post-partum haemorrhage) in a facility where there are skilled birth attendants (midwife, obstetrician, and anaesthetist) and the supplies and equipment necessary (eg blood transfusion).

Experience has also shown that maternal health cannot be tackled in isolation from improving overall sexual and reproductive health and rights (eg family planning and preventing unsafe abortion) or by addressing the social and economic barriers that women face. Nor in isolation from other diseases, particularly AIDS, TB and malaria (MDG 6), which further increase the risk of illness and death in pregnancy and childbirth (recent data indicates that a women infected with HIV is four times more likely to die than a women without HIV infection).

Monitoring trends in maternal mortality poses particular challenges. Few countries record maternal deaths. The most recent global data available refers to the year 2000. This is when many of DFID's investments into MDG 5 were being established. The next set of data (referring to 2005) is expected to be released in October 2007. DFID has invested with others in the development of new low cost methods to measure maternal deaths.

DFID's approach to addressing maternal health is set out in the strategy *Reducing Maternal Deaths: evidence and action* (2004). Since the strategy was published, DFID has made significant contributions to progress within countries such as China, Bangladesh, India, China, Nepal and Nigeria through an approach which combines broad support to the health system along with specific interventions to catalyse action on AIDS, TB, malaria, immunisation as well as maternal and child health. DFID works with and through partners on health—namely governments, UN agencies, non-government organisations—so the contributions DFID makes to maternal health in any country are part of a bigger international effort. Only through building a health system that is both functional and ensures the needs of women and children are at the core of policy and implementation can progress towards MDG 5, as well as MDGs 4 and 6, be accelerated. There needs to be, in parallel, a push to raise maternal health to a broader development and rights issue.

The progress made and lessons learned from these and other investments provides the evidence on what needs to be done to scale-up further, even if it is not yet enough to make a dent in the global figures on maternal mortality.

DFID is committed to strengthening health systems and improving the way international agencies and developing countries work together on health. The UK Prime Minister launched the International Health Partnership (IHP) on 5 September 2007 to intensify coordination at country level around national plans. The IHP is part of a wider *Global Campaign for the Health Millennium Development Goals* and outlines a new agreement between developing partner countries and international partners to accelerate action to scale up coverage and use of health services, and deliver improved outcomes against the health related MDGs. The campaign will further increase political action on the health MDGs through a global network of leaders along with civil society action.

DFID has also played a leading global influencing role in relation to women's sexual and reproductive health. This includes convincing Norway to include MDG 5 in their MDG initiative (originally focussed only on MDG 4); encouraging three global health partnerships dealing with maternal, newborn and child

health to merge as the Partnership for Maternal, Newborn and Child Health (PMNCH); maintaining a focus on SRH through support for contraceptive commodity security, increasing access to safe abortion and obstetric fistula services and action against female genital mutilation. DFID has brought influence to the new health, nutrition population strategy of the World Bank and the development of the maternal health plans of the Bill and Melinda Gates Foundation by, for example, bringing the focus to health systems rather than vertical initiatives or single technical solutions. DFID has highlighted maternal health in discussions with UN agencies. DFID has supported global efforts to raise the profile and accelerate action including the 2007 "Women Deliver" conference.

This memorandum to the International Development Committee (IDC) is organised into three parts: Part 1 aims to explain why and how DFID works to address maternal health. Part 2 provides DFID's specific response to the eleven questions posed by the IDC. Part 3 is DFID's Progress Report on maternal health 2006–2007 to which much of the evidence is referenced throughout Part 1 and Part 2.

Part 1. Overview

1. *Why DFID gives priority to MDG 5: "Improving maternal health"*

1.1 Millennium Development Goal 5 is off-track. Many developing countries are at risk of not achieving this MDG. An estimated 529,000 women die as a result of pregnancy and childbirth each year, and countless other women survive but suffer serious complications in pregnancy and childbirth. This is largely preventable with the knowledge and interventions at hand today. The health of women is critical to a country's social, economic and political development, but it is often a low political priority, because of the low socio-economic and political status of girls and women. The link between poverty and maternal health has been clear for more than a century. In Peru, for example, there is a six-fold difference in maternal mortality between rich and poor[16]. Maternal deaths represent the greatest difference in health outcomes between rich and poor women within and between countries[17].

1.2 Maternal health is vital for the achievement of the other MDGs: a maternal death is a death like no other. The consequences are great especially for surviving children. A newborn baby is three to ten times more likely to die within its first two years of life without its mother[18]. Girls whose mothers have died are more likely to perform poorly at school, or drop out altogether, face a higher risk of malnutrition and premature death, and a life of increased economic hardship[19] than boys in the same situation. Also—because newborn deaths are more frequent than deaths later in childhood (nearly 40% of all under five deaths occur within the first month of life) the MDG 4: "Reduce child mortality" will not be met unless newborn deaths are reduced[20]. The great majority of deaths can be avoided by making sure that maternal health care is improved.

1.3 While maternal mortality is a key indicator of maternal health, maternal health is not solely about what happens during pregnancy or around childbirth. It is inextricably linked to poor sexual and reproductive health, for example lack of access to contraception, information and safe abortion services, and unequal gender relationships. It is also closely linked to HIV which is increasing maternal mortality in some sub-Saharan countries: a woman infected with HIV is four times more likely to die in childbirth than a woman who is not infected[21]. These health issues need to be addressed holistically, not in isolation from each other, through the development of functional health systems.

2. *DFID's approach and action to address maternal health*

2.1 In 2004, DFID launched the strategy *Reducing maternal deaths: evidence and action*. DFID remains the only major bilateral to have a strategy on how to catalyse progress towards achieving MDG 5. Each year DFID provides a Report to parliament on progress against the four priorities of the strategy. The second report was published in 2007 and is at part 3.

The strategy identified four priority areas for action by which to catalyse progress towards MDG 5.

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

2.2 **Priority 1: Advocate-raise the profile.** The low political profile of women and maternal health is one of the biggest obstacles to progress. DFID has actively supported a number of major new initiatives which focus on advocacy for maternal health. The Partnership for Maternal, Newborn and Child Health (PMNCH) brings together key actors across maternal, newborn and child health (see question I below for more detail). DFID influenced the direction of the Norwegian Initiative to accelerate progress on MDGs 4 and 5, which originally focused only on child health. It includes a high-level political advocacy strategy and a new civil society campaign to hold governments and donors to account. DFID has supported UNFPA's global campaign on obstetric fistula and efforts to reduce female genital mutilation; contraceptive commodity security and is one of the few donors to actively promote efforts to prevent unsafe abortion. DFID has actively promoted maternal health in dialogue with UN health agencies (WHO, UNFPA and

UNICEF) and has pursued a systems strengthening agenda in contributions to the World Bank health, population and nutrition strategy. DFID has worked closely with the Bill and Melinda Gates Foundation in developing their plans to increased investment in maternal and reproductive health. At country level (eg Malawi) DFID works through civil society organisations to create awareness of women's health and to help local groups and health providers be accountable to clients. Where we support sector wide approaches we ensure that maternal health is central to the monitoring framework. In addition, DFID supports major global events that advocate for improved maternal health such as the "Women Deliver Conference" taking place in London October 2007.

2.3 **Priority 2: Scale-up evidence based interventions.** DFID provides substantial support to broad based efforts to strengthen health systems through working with governments; the UN, non-government organisations and other partners (refer to D). In addition DFID supports specific maternal health programmes in Africa, Asia and other regions. Annual DFID health spend has increased to about £800 million (2005–06) DFID's approach is evolving as new evidence emerges (see Question B). For example, we learned from projects in countries such as Malawi that, without a health systems approach in which skilled birth attendants are supported, little progress can be made in reducing maternal deaths. We have learned—from Bangladesh and Nepal for example—that, even where a health system is weak and access to skilled birth attendants limited—gains can be made through focussing on family planning and preventing unsafe abortion. Evidence that non-health sector factors are important, has led to DFID investments in Nepal, China, Kenya and Sierra Leone that address obstacles to maternal health beyond the health sector, such as infrastructure, transport, communications and water and sanitation. While these interventions are not yet adding up to enough to impact upon either national or global data, they provide a strong bedrock of experience and evidence on what need to be done going forward. (Specific examples are described in response to questions B, C, D, F and K).

2.4 **Priority 3: Address wider social and economic barriers to access.** DFID supports a range of country and international initiatives that tackle the wider barriers to access. In Nepal, Bangladesh and Cambodia DFID is supporting programmes that are introducing innovative financing mechanisms to cover the costs of transport, health service charges, or medicines. The DFID supported RCH2 (Reproductive and Child Health) programme in India is providing conditional cash transfers to women who deliver their babies in a health facility and to pay for transport and other expenses. In Africa DFID's influence has resulted in the removal of user fees for maternity services, with considerable impact in countries such as Burundi. DFID has supported work with African parliamentarians on female genital mutilation, which has led to a joint WHO/UNICEF/UNFPA statement, and has directly influenced the development of the Ethiopian Government's Adolescent and Youth Reproductive Health Strategy.

2.5 **Priority 4: Develop and apply new knowledge.** DFID has a significant portfolio of research on maternal health which not only informs the way in which DFID approaches maternal health, but brings influence on policy and implementation amongst governments and international partners. One example is the Initiative for maternal mortality assessment (IMMPACT) which has successfully developed new, low-cost and more rapid tools for measuring maternal mortality which for the first time allow the possibility of dis-aggregation of data to sub-national levels, and more regular collection. Given serious weaknesses in measurement and data on maternal health, this is a highly significant initiative since "what you count is what you do". The immediate impact of this research is to have raised the profile of and potential for, monitoring maternal deaths to the extent that maternal deaths are likely to be one of the key results used by donors in the shift to performance-based financing. Immpact's new tools provide efficient ways to track these results, costing between about a half and a third per death revealed compared to other mechanisms.

2.6 DFID has funded the Obaapa VITA trial in Ghana which will soon bring to a conclusion a global debate on whether or not Vitamin A supplementation in pregnancy can help reduce maternal deaths. A full list of investments is shown in the table below. A number of these programmes are still at early stages of development but together, they have the potential to generate better evidence on maternal health, which could improve both DFID's and the global response.

DFID's Current Research Portfolio into Maternal Health

IMMPACT: "The Initiative for Maternal Mortality Programme Assessment" was set up to develop new, faster and cheaper ways of measuring maternal mortality. One outcome is the development of the "Sampling at Service Sites (SSS)" methodology that by collects data from women where they gather in large numbers (eg markets and clinics) and is providing quick and cost effective data comparable to the standard Demographic and Health Survey. IMMPACT has developed new tools, costing one third per death revealed compared to other means that have revealed hidden deaths of 1,000 women across three countries. These deaths were missed by routine reporting systems. (2002–06; £7.5 million).

The Obaapa Vitamin A trial in Ghana is the largest global research programme determining the effect of Vitamin A on improving maternal health. Results will be available in 2009. The trial demonstrated that early breastfeeding (within one hour of birth) significantly increases child survival rates. (1999–2009; £6.5 million).

Realising Rights: Improving Sexual and Reproductive Health for Poor and Vulnerable Populations is mapping neglected SRH conditions and finding interventions for improving access to SRH services and rights for the poor. The project has led to better understanding of the economic impact of safe abortion—per patient cost of post abortion care lies between US$ 96–131 and the global cost to health systems from US$ 509–676. (2005–10; £2.5 million).

The Centre for Health and Population Research focuses on maternal, neonatal and reproductive health as well as infectious diseases. It has led to new ways to scale up access to services for women with restricted mobility outside their home through use of community health visitors (2006–11; £7.5 million core funding).

HRP: Human Reproductive Programme (WHO joint Special Programme) supports the generation of knowledge, products and capacity to help countries meet the sexual and reproductive healthcare needs of their populations. The project has provided evidence of obstetric problems following FGM and ongoing research on injectable contraceptives for men. (2006–09; £5.5 million).

Research and Capacity Building in Sexual and Reproductive Health and HIV in Developing Countries is strengthening the evidence base to enable policy makers to identify and prioritise interventions to improve reproductive and sexual health and reduce HIV incidence among the poorest in Africa and Asia. Project has influenced WHO treatment guidelines on herpes/HIV and on making rapid diagnostic tests for syphilis more affordable. (2005–10; £2.5 million).

Achieving MDGs 4 and 5: Strategic research to develop the evidence—base for policy for mother and infant care at facility and community level is exploring opportunities for improving integrated mother and infant care and providing evidence on interventions to improve the survival of women and infants through community interventions and health services delivery. The project has led to significant improvements in newborn care in targeted women. (2005–10; £2.5 million).

3. *What we know has worked, and what we are learning*

3.1 There is now a broad consensus that the primary determinant of maternal health is how well health systems function. DFID's 2007 Health Strategy places clear emphasis on health system strengthening[22], requiring long term predictable financing; skilled personnel; a predictable supply of drugs and equipment; access to clean water and sanitation; non-health inputs (infrastructure, power, transport and communications); and an effective health management information system (HMIS). This will require sustained effort and investment. The recently launched International Health Partnership (IHP) provides a platform for health systems strengthening and for better coordination of donors around national plans.

3.2 But for maternal health in particular, health systems need to include specialist skills and facilities to ensure that every woman can be assisted at birth by a professional skilled attendant (a midwife or doctor with midwifery skills), backed up by referral to emergency obstetric care, when needed[23]. The provision of a caesarean section, for example requires a surgeon, a midwife, an anaesthetist and a blood transfusion as well as the drugs and supplies to enable skilled birth attendants to do their job. These specialist facilities are fundamental to health systems, so the indicators that demonstrate an improvement in maternal health can serve as a tracer or proxy for the functioning of the entire health system. For example, the skills, drugs and supplies needed to provide emergency obstetric care enable emergency care for newborns[24]; a higher level of care to those who need surgery following a road traffic accident for example, or to a child with a broken leg, or anyone who needs a blood transfusion.

3.3 Through our investments in Nepal and Bangladesh for example, (see Questions F and G), DFID is finding that family planning and safe abortion care are also important to tackling maternal health problems. In these countries, availability of a skilled birth attendant at birth remains extremely restricted and referral systems are weak, but access to other reproductive health services have been strengthened and this appears to have been a significant element in reducing maternal deaths in some areas[25].

- In Matlab, a rural area of Bangladesh where maternal mortality has decreased by over 50% in the last 15 years, a focus on family planning and preventing unsafe abortions through access to menstrual regulation[26] may have been critical, along with a reduction in income poverty and better access to health facilities.[27]
- In Nepal a reduction in abortion-related mortality is expected to result both from a steep decline in fertility and also from the recent legalisation of abortion along with the provision of safe abortion services. Before legalisation, more than 50% of hospital admissions for obstetric complications were related to unsafe abortion.[28]

3.4 Furthermore, DFID and its partners have recognised that, 20 years after the launch of the Safe Motherhood Initiative, the political will to address maternal health is still lacking in many countries[29] (see also Question A). This means that what has been a mainly technical approach needs to become a political one, based on a better understanding of the incentives that governments in developing countries have to respond to women and to maternal health specifically[30]. Efforts on advocacy ("raise the profile" in DFID's maternal health strategy) are intended to address this.

Evidence from several countries points to a number of critical factors that have led to significant reductions in maternal mortality[31]. Maternal mortality reduction in developing countries is cost effective when appropriate healthcare service scale up policies are adopted, focused wisely, and adapted incrementally in response to country contexts and systems capacity[32]. This is especially the case where there is the political will to back up expansion of services with investment in education and women's rights (as exemplified by the Kerala experience in India).[33]

Sri Lanka, Malaysia and Thailand achieved significant improvements in maternal health by[34 35]:

- providing long-term investments in maternal health services and midwifery training;
- expanding the availability of services;
- emphasising the improvement of quality with regulation, control and supervision of medical facilities and medical professions;
- removing financial barriers to maternal care; and
- improving information systems to confirm progress.

More recently Yunnan, Egypt and Honduras halved their maternal mortality in seven years by[36]:

- focussing on skilled birth attendance and professional training networks;
- ensuring availability of facilities providing services;
- ensuring financial accessibility to all women; and
- strengthening the links in the health system especially referral chains.

4. *How DFID finances maternal health*

4.1 Spending on health overall (and within that specific financing for maternal health) has increased significantly in recent years. Overall health spend is now close to £800 million annually; £515 million bilateral and £285 million multilateral). DFID finances maternal health through a range of channels (see Annex 2 for further explanation):

- Bilateral programmes[37]:
  - direct contributions to the government's national budget (general budget support);
  - direct contributions to the budgets of certain ministries such as health (sector budget support);
  - programmes and sector support specifically for maternal health;
  - support for technical cooperation;
  - grants to civil society organisations; and
  - humanitarian assistance.
- Contributions to multilateral agencies.
- Partnerships with non-government organisations.
- A range of research investments.

4.2 An increasingly significant financing modality for funding maternal health is through multilaterals. Between 2002–03 and 2006–07 DFID spent £538 million on health, through key institutions such as the EC, UN, and the Global Fund for AIDS, TB and Malaria. Figures given in the table below are for general health spending, because it is not possible to identify how much of our total contribution on health was allocated to maternal and newborn health interventions by these multilateral institutions.[38] The figures shown in the following table demonstrates that multilateral spending is a significant part of DFID's activities. The wide range of complementary financing instruments highlights the importance of monitoring overall country outputs and outcomes rather then DFID specific inputs such as finance.

DFID's Health Spending through Multilateral Institutions 2002–03—2006–07

EC (estimated allocation on health)	£167 million
WHO	£146 million
Global Fund for AIDS, TB and Malaria	£118 million
UN Population Fund (UNFPA)	£ 77 million
UNAIDS	£ 30 million
GAVI	£16.5 million
UNICEF (including education, water and sanitation and other non-health interventions)	£94.3 million
Total	£648.8 million

5. *How DFID measures progress in maternal health*

5.1 MDG 5 provides a global political framework to monitor progress in improving maternal health. Clear targets to achieve the MDGs have been set for 2015 and are monitored annually through the collaborative efforts of agencies and organisations within the United Nations system. The critical concern in monitoring progress towards MDG 5 is that few countries record maternal deaths. The most recent estimates of maternal mortality available, agreed by WHO/UNICEF/UNFPA, refer to the year 2000. This is when many of DFID's investments in MDG 5 were established. The next set of data from countries, referring to 2005, will soon be released (October 2007).

However, significant declines in maternal mortality are not expected until{the end of the decade. This is largely{because of the time needed to improve health systems, including training health workers and improving ways of data collection. The 2005 country data will reflect information on maternal deaths that could have taken place anytime after 2000—though most will refer to the period 2002–2005. This is why the support from DFID to the IMMPACT research that has developed fast and accurate tools to measure maternal deaths is of such significance.

5.2 DFID proposes to include maternal health in its new public service agreement (set out in July 2007) along with other MDGs, and to include the maternal mortality ratio as the indicator of progress. At country level there are various intermediate indicators of progress including access to emergency obstetric care (EmOC), the proportion of women who are delivered by a skilled birth attendant, the proportion of women who are receiving caesarian sections or access to drugs to prevent bleeding after delivery. DFID has supported countries such as Malawi and Nepal to include these process indicators within their national health management information systems.

5.3 DFID prepares an annual progress report on maternal health. This demonstrates accountability to parliament, helps to sustain the focus on maternal health in country programmes and at policy level, and in demonstrating commitment strengthens our influence over others.

6. *Progress made in Africa, Asia and other regions*

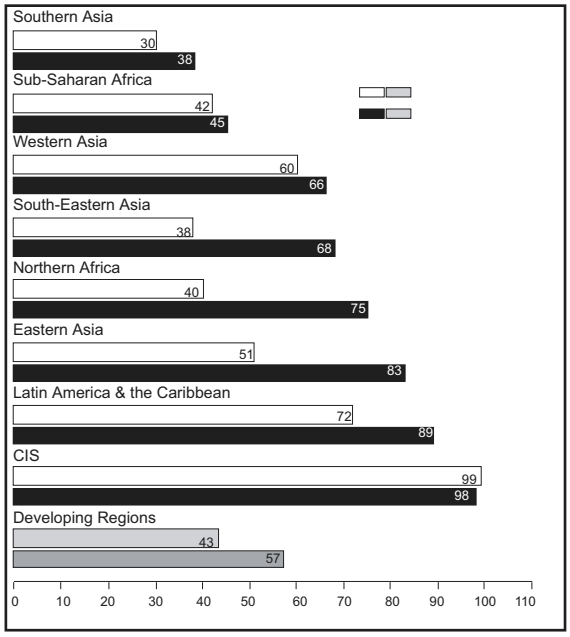
6.1 Eight years from 2015, progress towards MDG 5 is disappointing[39]. In 2000 the global estimate of maternal mortality was 400 per 100,000 births, compared with 430 in 1990. To achieve the MDG a global figure of just over 100 needs to be reached by 2015. 95% of the world's maternal deaths occur in Asia and Africa, with each continent contributing almost the same number of deaths[40]. A number of middle income countries have shown that halving maternal mortality in less than 10 years is possible.[41] Africa by contrast, lags behind other world regions in terms of decline[42 43]. Reducing maternal mortality by 75% between 1990 and 2015 would require a 5.5% annual decline, but there is no strong evidence to suggest that a significant global decline is underway, let alone enough to achieve the MDG globally[44]. It remains very difficult to collect accurate data on maternal deaths and trends. The DFID investment in new methodologies through the IMMPACT programme promises new low-cost tool (SSS—see Section 2) that could allow more regular and more disaggregated surveys that can provide data comparable with that provided by periodic high-cost DHS surveys.

6.2 Trends in the proportion of women who are attended by a skilled professional at birth can give a better picture of progress because the data are more reliable[45]. In developing regions overall the proportion of births attended by a skilled professional has risen from 43% to 57%—a significant increase over the first 15 years of the MDG period (see Figure 3)[46]. But the picture varies by region. South-east and Eastern Asia are making rapid progress, and Northern Africa, Latin America and the Caribbean have also made good progress[47]. However sub-Saharan Africa as a whole has shown very little progress over that time: key services, including access to midwives, obstetricians and emergency obstetric care, are not available to many women. And the levels of skilled attendance in South Asia remain worryingly low—still less than 40%. There DFID's concerns include gaps in trained staff in rural areas, cost and exclusion related to caste, ethnicity and other social factors.

6.3 Despite the poor overall picture there are a number of countries where DFID has supported intensive and sustained investment, that have demonstrated impressive improvements in the levels of institutional deliveries and declines in maternal mortality.

These include parts of Bangladesh, India, and China, Nigeria, and Nepal[48], are described in detail under Question B and demonstrate clearly that success is possible.

Figure 5: Proportion of births attended by skilled health professionals by region[49]
1990–2005



7. *Looking forward*

7.1 DFID has been a leading advocate for action on maternal health. Looking ahead, DFID needs to continue to influence international and country level partners to give priority to this MDG. Sustained focus on health system strengthening (ensuring that maternal health is given high priority in national health plans) through the new International Health Partnership that the UK was instrumental in developing will be at the heart of DFID's approach going forward. Other critical elements of our approach going forward are set out in Question A.

Part 2: DFID's Response to 11 Key Questions

A. *How donors—and DFID specifically—can catalyse progress towards MDG 5*

1. We have growing evidence of successful approaches. Donors including DFID, can help to catalyse progress towards MDG 5 by; intensifying action, investment and expertise on health systems strengthening; addressing socio-economic barriers to accessing maternity care (as we set out in response to question J); investing in research[50]; recognising the links between SRH, AIDS and maternal health; and using influence to raise the political profile of maternal health, especially within developing country governments (as described in response to question D, on Pakistan).

Improving coordination and focus on health systems strengthening at country level:

2. In September 2007 the UK launched a new international initiative—the International Health Partnership (IHP), to promote better coordination among international agencies, donors and developing countries around national health plans and more effectively use resources to strengthen national health systems that. Countries will have one health plan, with health system strengthening (so essential to MDG 5) at the core. Longer-term financing will give greater scope for countries to develop human resources, including skilled birth attendants[51]. Seven countries form the first wave of members of the IHP: Burundi, Cambodia, Ethiopia, Kenya, Mozambique, Nepal, and Zambia. Donor governments and international agencies that represent half of the world's aid spending are also signatories to the Compact which underwrites the partnership. The IHP has the potential to have a major impact on maternal health, because of its focus on health systems strengthening, including skilled health workers.

Acting on the linkages between maternal health, sexual and reproductive health, and HIV and AIDS:

Family planning and preventing unsafe abortion

3. If women can exercise choice about when and how many children they have, the chances of dying in pregnancy and childbirth are greatly reduced. Yet the world's poorest women have least access to, and choice of, contraception[52]. So sexual and reproductive health problems remain a major cause of death among the poorest populations[53], and levels of unplanned or unwanted pregnancy remain very high[54].

Despite commitments made at the International Conference on Population and Development (ICPD) in 1994, sexual and reproductive health still does not get the attention it warrants nationally or internationally. More work is needed to address the global undersupply of commodities for family planning. DFID has been at the forefront of efforts to prevent unsafe abortion, in particular in response to the prohibition of US funding for abortion related services. Progress in this area is likely to remain difficult due to diverging views on preventing unsafe abortion.

HIV and maternal health

4. More attention is also needed on the relationship between maternal health and AIDS. AIDS is now the single largest cause of maternal mortality in some parts of sub-Saharan Africa. More than 2 million pregnant women are estimated to be living with HIV but in 2005 only 11% of them received anti-retroviral drugs to prevent the transmission of the virus to their child. In some locations AIDS related TB is now the leading cause of maternal mortality[55]. A woman infected with HIV is four times more likely to die in pregnancy and childbirth than an uninfected woman. DFID has merged its AIDS team and the Reproductive and Child Health teams to maximise linkages.

Making maternal health a political priority

5. The landmark Global Safe Motherhood Conference in Nairobi in 1987 was the first time the global health community became aware of the unacceptably high level of maternal mortality. 20 years on, and 8 years from 2015, insufficient progress has been made. The UK is clear that political priority is needed.

6. Achieving MDG 5 will require, above all, a significant shift in the commitment of developing country governments to prioritise maternal health. Few governments are elected on the basis of a commitment to better health, even less the health of women. Politicians, chiefs, local and religious leaders, have little incentive to place the health of women as a priority, in large part because the low status of women in many cultures limits their political power. As a result, maternal and reproductive health issues are often marginalised in health planning and budgeting. Political leadership has been a major factor in countries—such as Honduras—that have witnessed improvements in maternal health[56].

7 In India and Nigeria DFID is supporting media and civil society efforts to both increase political accountability for maternal health. DFID is also a major supporter of international advocacy efforts (refer to Part 3). DFID needs to use its influence to continue to raise the profile of maternal health on the political agenda, by using our presence at country level to keep maternal health high on the agenda in policy, planning and budgeting discussions. Taking a "rights-based approach", in which maternal health is linked to national governments' legal obligations grounded in human rights standards and principles, is another means of creating political accountability. DFID seeks the support of the IDC to work with parliamentarians in developing countries on this issue. DFID is already active internationally on key initiatives intended to generate renewed political priority for MDG 5. Many of these are described above. DFID has also supported preparations for the Women Deliver Conference in London, in October 2007.

B. *How effectively DFID is working with recipient countries to make emergency obstetric care available and to ensure that adequate numbers of skilled birth attendants and other staff are being trained to meet MDG 5, and are integrated within a robust health system*

- There are not enough health workers to deliver even basic health services -the global shortage is estimated at 4 million by 2015.
- Many countries have less than one health worker per 1,000 people—but the minimum recommended is 2.5 per 1,000.
- Most health workers are typically concentrated in urban area or the private sector.
- In 57 countries (mainly in Africa) the crisis is deepening because of long-term, chronic underinvestment; losses due to HIV and AIDS; and outward migration of skilled staff.

DFID, Working together for better health 2007 (p 24)

8. In many countries in Africa the lack of human resources for health is a key limiting factor to progress[57]. There is no single intervention or quick fix due to the complex mix of "push" and "pull" incentives (eg poor salaries and working conditions) and context specific issues (eg conflict, HIV and AIDS) which lead to undersupply and out-migration of health workers. Recruitment, training and retention of health workers are complex issues that must be tackled within the context of broader health systems, public sector and macro-economic reform[58]. A predictable and sustained investment in health systems—as envisaged by the IHP—is essential for tackling the human resource crisis in health.

9. A number of DFID country programmes tackle human resources constraints directly, with impressive results in some cases. For example, DFID is providing technical assistance to develop human resource plans (Nigeria, Somaliland and Kenya); supporting broader civil service reforms through direct budget support (Tanzania); financing projects to train health workers and develop institutional capacity (Somaliland,

Malawi, Zimbabwe and Uganda); engaging in health sector policy dialogue through health sector support in (Ghana, Uganda, Zambia and Mozambique); and supporting the post conflict reconstruction of health services (Sierra Leone). China, India and Malawi provide further good examples as highlighted below.

10. The centrality of health workers to reaching MDG 5 was seen very starkly in Malawi. DFID funded the Malawi Safe Motherhood Project (SMP) (£9.2 million from 1998–2004) yet impact on reducing maternal deaths was less than expected[59]. Importantly, it was the data on access to emergency obstetric care from the Malawi SMP, which highlighted the lack of skilled birth attendants and catalysed action by DFID to strengthen human resources for health. Lesson learning from this project led to investment in a major new initiative in Malawi.

Malawi Emergency Human Resources Programme (refer to part 3)

— DFID is providing £55 million over six years to fund the Emergency Human Resources Programme (EHRP). Early findings are that 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.

— 52 Service Level Agreements (SLAs) have been signed by District managers with the Christian Health Association of Malawi (CHAM) to provide maternal and neonatal services free of charge.

— 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.

In Nigeria DFID provides £56m 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. Over one year the numbers of women attending hospitals within two pilot areas for emergency obstetric care rose by 50%.

11. In Asia, most countries are still seriously off-track on MDG 5. In South Asia in particular, the low status of women in society, and their low levels of literacy, add to the risks they face through lack of access to adequately skilled health workers in properly equipped facilities. Most women still do not do not have a safe delivery, or access to emergency care for the unpredictable life—threatening complications that will arise.

But despite being off-track on MDG 5, progress is being made towards improving maternal health. Innovative schemes are being developed to provide incentives and rewards for skilled doctors, nurses and midwives to work in rural areas. In Bangladesh, India, Nepal and Pakistan, DFID is supporting programmes to accelerate progress to reduce maternal and child deaths, in addition to broader health system support. In Nepal and Cambodia DFID provides specific support to the provision of safe abortion services. A shortage of skilled staff remains a key constraint to better access to services, especially for rural populations. In China, major improvements were visible in 97 counties where DFID was involved in interventions that strengthened the health systems, including human resources. Examples such as these demonstrate that investing in maternal health does work and gives us evidence that can be used for scaling up. These countries are described in the box below, (India, China) and on page 22 (Nepal) and page 24 (Pakistan, Cambodia).

In India, DFID has committed £252 million to the Government of India's national Reproductive and Child Health (RCH 2) Programme (2005-11). RCH 2 aims to improve reproductive and child health, and in particular to improve the health outcomes of the poorest and socially excluded groups. It has supported the recruitment and training of more skilled birth attendants, and the resourcing and staffing of health facilities to provide 24-hour emergency obstetric care. The programme has led to impressive gains in the increase 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 State 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[60].

In China significant gains have been made by a 10 year jointly funded DFID (US$42 million), World Bank (US$85 million) and the Chinese Government (US$43.7 million) programme that targeted MDG 5 in 97 poor rural counties. There have been dramatic gains in reductions in maternal mortality. The approach taken in China has included a focus on strengthening the health system and human resources, as well as working on non-health sectors such as infrastructure.

— The number of maternal deaths fell from 125 to 68 per 100,000 between 1998–2005 in one area and from 91–84 per 100,000 between 2002–05 in another area.

— Institutional deliveries (ie births in health facilities instead of at home) increased from 5.7% in 1998 to 40.6% in 2005 in Qinghai and from 14% to 44.5% between 1998 and 2005 in Ningxia.

12. At global policy level DFID is supporting: work to slow down out-migration of health workers through work with the UK DoH/NHS; the Global Health Workforce Alliance (GHWA) in reducing heath worker shortages; work with the UK's Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives in providing training in Somaliland. DFID's support to PMNCH includes resources to enable the Federation Internationale de Gynecologie et D'Obstetrique (FIGO) and Health Care Professionals to better track developments in increasing skilled birth attendants.

C. *The steps DFID is taking to mainstream maternal health across related policies*

13. DFID promotes policies across a range of non-health sectors that help improve maternal health. For example DFID is working to ensure investment in water and sanitation, infrastructure, transport and communications are linked to improving maternal health. In Nepal and Malawi DFID has worked to develop appropriate transport systems that best support women in accessing health services. In Sierra Leone DFID is supports the strengthening of health systems for maternal and child health through a joint approach to improving water and sanitation. The total £82 million commitment (£50 million for health over 10 years and £32 million for water and sanitation over five years) will ensure that water-related infection is prevented in the home and community (where the majority of deliveries take place) and that health facilities have, at minimum, water supplies and toilet facilities for patients and staff. DFID is working to ensure that maternal health is well-reflected in its new water and sanitation policy update, which is under preparation at the time of writing.

The Nepal Safe Motherhood Project (1997–2004) and Support to Safe Motherhood Programme (2004–2009).

In addition to its health sector budget support, DFID is providing £20m (2004-2009) to the national Safe Motherhood Programme, including financial aid to government, technical assistance, and direct support to UNICEF. The programme includes an innovative cash transfer scheme to women for delivery by skilled health workers. The results of the Nepal programme have been impressive:

— the caesarean section rate increased almost three fold (from 1.0 in 1996 to 2.7 in 2006).

— delivery by trained health professionals almost doubled (from 9% in 1996 to 19% in 2006).

— after the legalisation of comprehensive abortion care in 2002 (implemented from 2004), large numbers of women are using safe abortion services from private and public facilities.

— the total fertility rate (ie total number of live births a woman has, on average, in her lifetime) declined by 33% (from 4.6 in 1996 to 3.1 in 2006).

Importantly, DFID support to improving maternal health in Nepal mainstreams non-health sector support such as:

— construction of health facilities to ensure safe access to operating theatres and delivery rooms, as well as toilets and showers, solar panels to provide hot water;

— building of bridges to improve access to health facilities;

— design and development of cycle ambulance rickshaws and other local transport; and

— communications through radios.

— in addition, DFID has supported £11 million for water and sanitation and £35 million for the transport sector over the past five years in Nepal.

14. Within the health sector, DFID actively works to make appropriate linkages between health issues and interventions that impact on maternal health. DFID is active internationally in efforts to improve sexual and reproductive health, to tackle HIV and AIDS, and to control malaria and TB through multilateral and bilateral channels. DFID is a key donor to Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) having committed £359 million through to 2008. DFID also supports UNITAID, which provides funds for the provision of drugs and diagnostics for AIDS, TB and Malaria. The UK is making a 20-year contribution, starting with £15 million in 2007, and, subject to the outcome of a joint assessment of the performance of UNITAID, rising to £40 million a year by 2010. At country level, DFID programmes address the linkage between these issues. In Zimbabwe, DFID is supporting a programme to reduce the impact of HIV on maternal health through increased access to family planning and anti-retroviral drugs; and in India, in addition to RCH2 (described above) DFID supports the revised National Tuberculosis Control Programme II and the National AIDS Control Programme.

15. DFID also has a series of policy papers that shape and contribute to our efforts on maternal health action[61].

D. *How achieving MDG 5 is being prioritised and integrated into countries' overall healthcare provision*

16. DFID's approach varies across regions and is country specific. DFID's core 26 countries have a Country Assistance Plan (CAP) or equivalent. This is usually premised upon a government poverty reduction strategy paper (PRSP). Where DFID is providing financial support directly to the government's budget DFID can play a role in, for example, encouraging monitoring frameworks to include measures of health outcome. Where we are providing support at sectoral level, (eg Nepal, Malawi) DFID typically works with the government and partners in country to develop, implement and monitor health plans. This provides an important opportunity to influence health sector policy, including bringing increased attention to maternal health issues. In some countries, however (eg Tanzania) DFID opts to leave this role to other agencies.

17. In India, Bangladesh, Nepal and Pakistan where DFID provides significant direct support to health programmes, maternal health has been a priority issue for country offices in policy dialogue with authorities. In Pakistan for example, DFID has a 10-year development partnership arrangement with the Government of Pakistan in which the Government commits "to improve health service delivery and particularly in maternal and neonatal health". Specific funding for maternal health has been committed to help accelerate progress, as described in the box below. DFID also supports family planning programmes (key to maternal health) in South Asia, as part of broader reproductive health programmes.

In Pakistan, DFID has had a significant influencing role with the government in raising the political profile of maternal and newborn health to the extent that the Government of Pakistan has committed to financing a major new National Maternal, Newborn and Child Health Programme, to which DFID confirmed a contribution of up to £90 million over five years in October 2006. Importantly, DFID's recommendations on channelling resources directly to the districts and encouraging good performance through financial rewards have been accepted.

This will expand maternal and newborn care, and support the creation of a new cadre of community midwives, and the promotion of effective maternal and child health behaviour by families. DFID support includes £69 million to the Government, £9.5 million in technical assistance, and an £11.5 million research and advocacy fund to promote equity and social inclusion, and increase knowledge about what works. This fund includes supporting civil society and the media to create coalitions for change and raise awareness.

In Indonesia recent DFID support includes £4.2 million to GTZ for a three year Maternal Health and £9 million to UNICEF over three years to replicate an AusAID funded project in a further nine provinces. This is aligned behind an existing District Health Strengthening Project

In Cambodia DFID's support to maternal health comes within a broader programme on "Increased access to health services and information" and has a focus on MDG 5 and halting the spread of AIDS. DFID is one of many donors to this programme, including the WB, ADB, USAID, and Germany, France and Belgium.

18. In Africa significantly more DFID funding flows through budget support than in Asia. A share of this supports strengthening of the health system. And it is often supplemented by additional direct programme investment in health (as explained in Section 4). DFID has sought to support governments to focus on MDG 5 through programmes and policy dialogue on health: in Kenya (see below); in Angola (where we fund UNICEF which is working to ensure that child and maternal health care are part of the Government's medium term health plan (2009–2013); in Sierra Leone where the post-conflict reconstruction of the health system includes an explicit focus on reproductive health; and in Burundi where the abolition of user fees for maternal deliveries and healthcare for children was implemented in May 2006 with dramatic effect (see below).

In Kenya DFID is supporting a £7.5m Essential Health Services Project over 5 years, working alongside the government and with UNICEF, WHO, UNFPA, EC. This supports MDG 5 by strengthening the overall provision of health care by the government through:

1. Strengthening reproductive maternal health services in Nyanza province.

2. Broader technical support on maternal health and health systems.

3. Support to sector planning, co-ordination and monitoring processes.

4. Provision of socially marketed contraceptives.

In addition, DFID Kenya is supporting a programme that, through social marketing of bednets to prevent malaria has decreased the number of low birth weight babies born from 18% in 2001 to 13% in 2005. This suggests that fewer pregnant women were infected with malaria which can result in low birth weight babies. Malaria related outcomes for pregnant women are still being documented.

E. *How DFID is supporting the 2006 recommendation by the UN General Assembly for an MDG target for universal access to reproductive health*

The 2005 World Summit recognised the central place that improving sexual and reproductive health (SRH) plays in achievement of the MDGs. The Summit also recognised the absence of SRH from the current MDG 5 target and indicators. In 2006 the UN Secretary General recommended a new target for MDG 5.

MDG 5
Goal: Improve maternal health
Target: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio'.
Indicators:
— Maternal mortality ratio (MMR)
— Proportion of births attended by skilled health personnel

Proposed additional target: *"Achieve universal access to reproductive health by 2015".*
Proposed new indicators:
— unmet need for family planning,
— age-specific fertility rate (15–19)
— attendance at antenatal care.

19. In discussions on progress towards the MDG at the 2005 World Summit, the UK sought to ensure reproductive health was well reflected in the outcome. This provided the basis for recommending the MDG 5 target on reproductive health which DFID fully supports. The UK has continued to press for the inclusion of this new target in the MDG framework.

20. The 2007 UN Millennium Development Goal's Report makes good reference, for the first time, to the critical need for reproductive health services to improve maternal health, including antenatal care and family planning. It is disappointing, however, that no explicit mention is made in this 2007 report of the new target, nor of the proposed new indicators. We expect the new target and indicators to be formally reflected in the August/September 2007 Secretary General's Annual Report though this is subject to negotiations at the time of writing.

21. DFID continues to work towards the achievement of the proposed new target in countries. In Sierra Leone, for example, the first step to addressing maternal health has been to assist the Ministry of Health to develop a sexual and reproductive health policy.

22. In addition to supporting the new target, DFID was active in influencing the Maputo Plan and the 2007 G8 process to fully reflect reproductive health.

The Maputo Plan was unanimously agreed by the African Union{Health Ministers when they met in September 2006.{UNFPA and IPPF, with support from DFID, were{key to enabling this meeting to take place. The Plan of Action includes support for better{family planning, improved contraceptive commodity security and action to reduce unsafe abortion. This demonstrates the commitment of African health ministers to the issues covered in the new MDG 5. target

At Heiligendamm in June, the G8 reaffirmed its 2005 commitment to universal access to comprehensive HIV prevention, treatment and care by 2010 and made commitments that will significantly assist in funding and developing national AIDS plans. These include providing $60 billion funding over the next few years, with $4.8 billion for sexual and reproductive health:

— $1.5 billion for the prevention of mother to child transmission.
— $1.8 billion for paediatric treatments.
— $1.5 billion for family planning.

F. *The progress being made in reducing maternal deaths from unsafe abortion (which account for 13% of all maternal deaths)*

— Unsafe abortion is preventable. An estimated that 68,000 women die each year from unsafe abortion—98% in developing countries. Many more suffer injury and infection (IPPF 2006).
— Of the 210 million pregnancies each year, about 46 million (22%) end in induced abortion, 19 million occur in unsafe circumstances.
— Accurate measures are difficult to come by given the legal and political implications—deaths may be attributed to miscarriage or causes other than abortion. So global figures are likely to underestimate the scale of the problem.
— In some countries (such as Nigeria and Cambodia) unsafe abortion accounts for 30-40% of maternal deaths (WHO). 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[62].
— Young women are particularly at risk—in Africa almost 60% of all abortions occur to women less than 25 years of age.

— Medical abortion—simply taking an "abortion pill" (misoprostol) in early pregnancy—is safe and affordable, but access remains limited.

23. Safe abortion saves lives by reducing recourse to unsafe abortion[63]. DFID is able to support action to prevent deaths from unsafe abortion, wherever this is legal and are able to support post-abortion care services in all contexts. In South Africa, DFID supported work in South Africa translated into a more liberal abortion law. As a result deaths from unsafe abortion declined by 91% between 1994 and 2001.

In Cambodia DFID is providing £2.2 million to support the Ministry of Health's plan to reduce unsafe abortion and increase access to family planning. This includes support for raising awareness among policy makers, women and health providers that abortion is now legal and providing training; equipment and supplies; research; and family planning and safe abortion services. This is being managed within a wider framework of support to health jointly with JICA, UNFPA, WHO, UNICEF, USAID, GTZ, WB and ADB.

A large proportion of maternal deaths in Nepal are due to unsafe abortion. Following widespread social pressure, in March 2002 the government legalised abortion. DFID has supported this effort, contributing to the evidence of the effects of unsafe abortion, and preparing policies in the build up to legalisation. In the three years since the national programme was initiated, DFID support has helped train 351 service providers and established 163 simple, safe and woman friendly service sites in public hospitals and in private and NGO clinics. By December 2006, 70 of the 75 districts had at least one safe service site and 85,984 women had received abortion services. (DFID Health Strategy, 2007)

24. DFID welcomed the establishment of the International Planned Parenthood Foundation (IPPF) administered Safe Abortion Action Fund (SAAF) launched in February 2006 to act to prevent unsafe abortion. DFID has committed £3 million (US$5.9 million) over two years. Denmark, Norway, Sweden and Switzerland have joined in support of the SAAF. The scale of unmet need was demonstrated when the $11.9 million fund attracted 222 applications totalling $43 million in the first call for proposals.

25. DFID is working to make medical abortion more accessible to women in developing countries, through funding the Concept Foundation to develop and gain regulatory approval of a low-cost, quality generic "abortion pill" for use in low-income countries; as well as the advocacy work of the International Consortium for Medical Abortion to develop accessible information on medical abortion for policy makers, providers and users.

G. *How effective family planning is being promoted as a way to improve maternal health*

— Family Planning is one of the most cost-effective preventative health measures available. $1 million invested in FP averts 360,000 unwanted pregnancies, prevents 150,000 induced abortions and save the lives of 800 mothers and 11,000 infants (UNFPA).

— 137 million couples who have expressed a desire to space or limit their family size have no access to contraception and a further 64 million couples rely on less effective traditional methods. Meeting the unmet need for family planning{would avert 52 million unintended pregnancies each year; preventing 142,000 pregnancy-related deaths (often linked to unsafe abortion) and saving 1.4 million baby's lives (through better birth-spacing).

— World population will continue to grow from 6.5 billion at present to over 9 billion by 2050. Over 99% of this growth will take place in developing countries with a significant proportion taking place in sub-Sahara Africa (even allowing for increased mortality from AIDS).

26. The ability of women, and men, to choose how many children they have and when they have them is critical to achieving all the MDGs, including MDG 5. It has been estimated that, globally, promotion of family planning has the potential to avert 32% of all maternal deaths[64]. It is clear that more action is needed on family planning.

27. Despite clear evidence that there is huge unmet need, family planning supplies are inadequately financed, whether through domestic budget allocations or global financing initiatives. There is a trend of stagnating spend on family planning—between 1995 and 2003 direct donor support for family planning supplies and services decreased from $590 million to $460 million—while support to HIV and AIDS for example, is rising. Global commitment to support African Governments in implementing reproductive health programmes has weakened and funding has decreased. Government commitment is also weak. Among DFID's 16 PSA countries in Africa for example, only 10 report budget lines for SRH supplies. Progress is slow given the political sensitivity surrounding SRH and the low priority afforded to family planning. Even in well performing countries such as Uganda and Tanzania, national budgets are at zero or allocations are under spent. Donor dependence is high, funding fragmented and co-ordination weak.

28. The impact of family planning on maternal mortality reduction can be seen in Bangladesh. Halving of the fertility rate over two decades and reduction in deaths from unsafe abortion has been instrumental in reducing risky high parity births (4th, 5th and even higher order births are more dangerous for the mother) as well as reducing unwanted births. This has been critical, along with increased use of services, to reductions in maternal deaths in some parts of Bangladesh.

29. DFID is a leading bilateral provider of condoms and other reproductive health commodities to developing countries. UNFPA estimates that some 1 billion condoms supplied by donors were used in developing countries in 2001, nearly half of these provided by the UK. For the past 10 years DFID has been the fourth largest provider of condoms, supporting the distribution of about 150 million condoms annually. We are currently providing £80 million over 4 years to UNFPA as core budget support (DFID is the fourth largest donor). Access to and use of quality FP services is one of 5 outcomes under the RH goal in UNFPA's new medium term strategic plan, 2008–2011. 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. And DFID is actively exploring the possibility of increased funding for commodities through UNFPA. DFID is currently examining the possibility of investing more through UNFPA to help address this problem.

H. *How effectively DFID works with bilateral and multilateral donors, NGOs and other stakeholders to promote maternal health*

30. DFID's new Health Strategy (2007) outlines how we work with partners to achieve greater harmonisation and coordination within the international health architecture. The UK's Prime Minister launched the new health initiative, the International Health Partnership (IHP) on 5 September 2007. As described under Question A, this includes a compact between country governments and donors and other stakeholders to better coordinate at country level to unlock financial and other barriers to strengthening health systems.

31. DFID's influence on maternal health is clear in other ways too. For example, DFID advocated that MDG 4 and 5 were closely linked and Prime Minister Stoltenberg decided to expand the scope of the initiative to include both MDGs. The Gates Foundation and the MacArthur Foundation seek advice from DFID in the development of maternal health strategies and global approaches. DFID's influence was critical to the establishing of the Partnership for Maternal, Newborn and Child Health (PMNCH) which merged three previously competing partnerships, and DFID is a Board member. DFID was also requested by the UK's Royal College of Obstetrics and Gynaecology (RCOG) to bring its experience to its new International Advisory Board. DFID's has also sought to bring a greater focus to MDG 5 internationally, including within UNICEF which is traditionally focussed on child health only.

32. DFID has also pursued innovative approaches to collaboration with other bilateral partners. Lessons learned from work in countries (such as the Yemen, below) indicates that DFID needs to agree the extent to which we wish to devolve management to silent partners, including on policy decisions. DFID needs to make case-by-case judgements on how far DFID policy is likely to be implemented on the ground when we work through partners.

The Yemen Maternal and Neonatal Health project

DFID is investing in maternal health in the Yemen, working through our partners, Netherlands and UNICEF. The programme start-up has been delayed. DFID has learned that it can take longer than expected to get action on the ground when working through other partners, when DFID remains "silent" (ie DFID provides funding but does not provide technical assistance). The capacity of the UN as an implementing partner was overestimated in the Yemen. It will be important going forward, for DFID to accurately assess the implementation capacity of potential partners, and make case by case judgements on how effectively DFID policy is likely to be implemented in practice.

I. *What leadership the UN is providing and how well co-ordinated its Agencies are*

The United Nations has the legitimacy to convene and monitor international efforts in addressing maternal health. Different parts of the UN system are contributing towards the achievement of MDG 5 through:

- Co-ordinating gender and MH/RH action in emergency situations (UNFPA).
- Leading and hosting international partnerships and initiatives (WHO).
- Leading the International Coalition for RH Commodity Security (UNFPA).
- Leadership—eg joint statement on female genital mutilation (WHO, UNICEF, UNFPA).
- Setting of norms and standards for national MH policies (WHO).
- Building government capacity to plan and deliver health services (WHO, UNFPA).
- Procuring essential health commodities (UNICEF, UNFPA).
- Training health workers (UNICEF, UNFPA, WHO).
- Advocating and working with specific population groups (UNICEF, UNFPA).
- Creating demand for services and monitoring progress through national surveys (UNFPA).

33. There is a generally agreed division of labour between the different UN agencies on maternal and child health. However, duplication, mandate overlap and competition for donor funds and government time continue to reduce the effectiveness and efficiency of the UN response to MDG 5 in country.

34. DFID recognises and supports the UN's niche role in addressing maternal health and is seeking greater effectiveness and accountability from them for delivering on MDG 4&5. DFID is driving efforts to improve multilateral coherence on MDG 4 and 5 through the establishment of the PMNCH; by providing multi year funding to WHO, UNFPA, UNICEF and the WB connected to Institutional Strategies; and through the pursuit of UN reforms recommended by the UN Secretary General's High Level Panel for System Wide Coherence, of which Gordon Brown was a member. DFID has been influential in the development of UNFPA and WHO's new Strategic Plans that will guide their global, regional and country programmes.

The Partnership for Maternal, Newborn and Child Health (PMNCH)

DFID was instrumental in the creation of the PMNCH, which brings together three previously competing health partnerships: the Child Survival Partnership, Healthy Newborn Partnership, and the Partnership for Safe Motherhood and Newborn Health.

Hosted by WHO, the PMNCH was established to support the achievement of MDGs 4 & 5 through:

— Accelerating coordinated action at global, regional, national, sub-national and community levels.
— Rapid scaling-up of proven cost effective interventions.
— Advocacy for increased commitment and resources.

The PMNCH has combined various existing networks—thereby rationalising the international architecture and increasing coordination and provides a good example of multilateral leadership.

35. We continue to call for agencies to show international leadership in tackling maternal health and seek evidence of effectiveness so that our investments can be linked to results. The ability of the UN to deal with sensitive issues, for example UNFPA championing the management of unsafe abortion, is constrained by the fact that it must work through building consensus with all of its member states. The diverging views of member states has resulted in UNFPA being under intense scrutiny and has not allowed them to work within the full parameters of the ICPD Programme of Action.

DFID funding to UN agencies working in Maternal Health

— 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.
— In 2006, DFID was the second largest donor to UNICEF providing a total of £105 million (US$186 million) of which £19 million was core funding. In 2007, Ministers have agreed to increase core funding to £21 million in recognition of UNICEF's progress on system-wide coherence and its voluntary review to strengthen the organisation.
— The UK is the largest donor to WHO, providing £18 million per year assessed contributions from the Department of Health and £50 million core funding over the last four years from DFID.

36. Moves towards a more coherent UN are underway in eight pilot countries (Albania, Uruguay, Cape Verde, Tanzania, Mozambique, Rwanda, Pakistan, Vietnam) under the framework of a "One UN" with one leader, one programme, one budgetary framework and one office. There are encouraging early signs in these pilot countries that the impact of the One UN approach has been to prompt the UN to reorient its work around national development priorities and to address their working practices to work more coherently and effectively. A review will report progress in March 2008. The reorientation of the UN country programme around national priorities should increase coordination of agencies working on maternal health, enable more systematic barriers to be addressed (eg infrastructure, women's empowerment) and increase the UN's accountability to the government and donors.

Working with the UN on maternal health in countries

UNFPA and UNICEF working on HIV and MDGs 4 and 5 in Zimbabwe

DFID is investing £25 million over five years in a maternal and newborn health project that 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.

Post conflict support to MDG 5 through UNICEF in Angola

DFID's support to maternal health is through a general non-earmarked grant to UNICEF which is working towards an integrated programme of health and primary health care, HIV/AIDS, Child Protection, Primary Education and Water and Sanitation.

Joint UNFPA-UNICEF- WHO maternal health programme in Bangladesh

DFID is providing £10 million to the three major UN agencies to reach 47.5 million people to increase access to emergency obstetric care to 45,000 women; avert 900 maternal deaths and 24,000 neonatal deaths.

J. *How DFID is addressing socio-economic barriers to women's empowerment and the low status of women in relation to maternal health*

Empowering women to take control of their sexual and reproductive health is essential to achieving MDG 5. Women must be able to make free (not coerced) and informed decisions regarding their reproductive and sexual lives. But there are barriers at household, community and societal level:

- one in five women around the world will survive rape or attempted rape at some point in their lifetime[65]. In Kenya[66], Bangladesh and Peru[67], about 24% and in South Africa[68] about 30% of women say their first sexual experience was forced;
- gender norms dictate that decisions and resources are controlled by others. For example, many women in need of emergency obstetric care have to wait for their husband to make a decision as to whether or not he will finance the costs;
- physical barriers such as lack of roads and transport prevent access to health services;
- health services are unaffordable, of poor quality and staff attitudes are often discriminatory and disrespectful; and
- harmful traditional practices, such as female genital mutilation and early marriage put young girls at greater risk of ill health and even death.

37. DFID is recognised for its strong defence of women's sexual and reproductive rights and has worked closely with other like-minded European partners (eg Norway and Sweden) to repeatedly defend strong sexual and reproductive health and rights (SRHR) language in international negotiations (eg at the World Health Assembly, the G8 and the UN summit on MDGs). This has inter alia, helped keep the possibility of a new reproductive health target alive. In an era of powerful conservatism on these issues, the UK is recognised as a leader. Most recently this involved difficult EU negotiations to agree consensus on SRHR language in relation to progress on maternal health at the 2007 World Health Assembly. In this our objectives has been to maintain the consensus that was achieved in the ICPD.[69] This is often the subject of opposition from others and with the expansion of the EU has increased. DFID sees maternal health at the core of women's human rights and has developed guidance (How to Note) on promoting a rights based approach to maternal health policy and programming.

38. Adolescent girls are particularly vulnerable. DFID has supported (2001–07) Population Council's nine country programme of research on adolescent girls transitions to adulthood, which has identified the particular vulnerabilities of young girls aged 10–14 years, to poor SRH and HIV and AIDS. These result from social and economic disadvantage, gender norms and relationships, traditional and cultural practices, such as early marriage and FGM. The evidence has directly informed the development of the Ethiopian Government's Adolescent and Youth Reproductive Health Strategy and was used by the Population Council in its significant contribution to the 2007 World Development Report. We are using these important findings to inform our SRHR and new HIV policy approaches.

Female genital mutilation—a violation of human rights

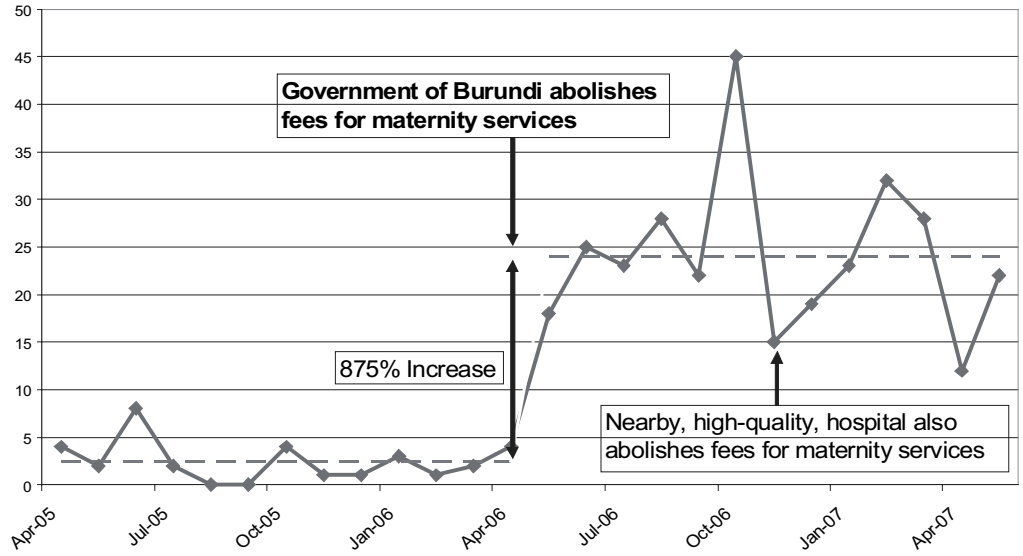
Every year, up to three million women and girls are subjected to female genital mutilation, some of whom die as a result of the procedure. Others may be left with long-term health problems and are at risk of life-threatening complications including obstructed labour, neonatal asphyxia and fistula, during childbirth.[70]

39. DFID strongly supports the elimination of FGM and regards it as both a violation of human rights and an important maternal and neonatal health issue. We have supported a number of initiatives including an African Parliamentarians Conference in Senegal in 2005, in partnership with UNICEF which resulted in an African Parliamentary Union Declaration. "Violence against women, abandoning female genital mutilation: The role of national parliaments". We also supported an African regional workshop, in Nairobi in July 2006, with WHO on harmful traditional practices. The workshop aimed to develop a legal framework for child protection that brings together legislative, welfare and social services, police and justice systems, basic service providers and civil society, to protect girls in a comprehensive way. This led to an African Parliamentary Union This took account of the joint WHO/UNICEF/UNFPA statement on female genital and will be drawn upon by DFID in its engagement as a member of the donor working group on FGM.

40. DFID and other partners are supporting innovative work in a number of countries to overcome barriers to access to maternity and health care for the poorest and excluded women, eg in Bangladesh, Nepal, India and Cambodia. These include providing cash, or vouchers to pregnant women to pay for transport, medicines and services. This is a very new area of work and evidence to date is thin. However, an evaluation of the DFID-supported Nepal government's cost-sharing scheme for safe deliveries is underway and will provide important lessons for the international community.

41. DFID and WB policy is to support countries to abolish user fees. Such a policy change can have a dramatic impact on access to maternal health services, even in fragile states. The graph below shows what has happened in one health facility in Bubanza province in Burundi over the year since maternal health services became free[71].

Numbers of Babies Delivered at Bubanza II Health Centre Burundi



Source: DFID

42. Maternal and child health also depends on men's role in SRHR and HIV prevention and there is a need to emphasize men's responsibilities in this regard. DFID recognises this need and is providing support to IPPF to draw together learning and inform the development of an information package on men, gender equality and health by WHO, IPPF, Engenderhealth and others.

K. *How the international community can improve maternal health in crisis and conflict settings*

- Women and children account for two thirds of the 24 million displaced people worldwide.
- Conflict places women at greater risk—from sexual abuse, sexually transmitted infections and unwanted pregnancy—and prevents access to safe abortion and emergency obstetric services.
- Conflict prevents women from accessing reproductive health and family planning services much needed where sexual abuse and infections are rife.
- In Africa, conflict is one reason (along with AIDS and lack of basic services) why maternal health is not improving.

43. By 2010, half of the world's poorest people might be living in states experiencing or are at risk of violent conflict. Some 70% of these are women and children. Conflict both destroys the health systems needed to provide reproductive health services and access to emergency obstetric care, while increasing the need for these services. Yet a crisis can provide opportunities to increase health provision where relief services are able reach vulnerable communities.

44. DFID is increasing both its expenditure and involvement in these environments and is working with developing countries and other international partners to better co-ordinate overall efforts to improve security and to build capacity to prevent and respond to conflict.

Following the Pakistan earthquake in October 2005 a specific working group was set up under the health cluster to coordinate the response to maternal and child health needs in earthquake affected areas.

45. DFID supports the work of WHO, UNFPA and UNICEF in fragile states in providing maternal and reproductive health services if a state is unable to do so due to conflict or a humanitarian emergency. These agencies have a critical role in the transition from relief to development through re-establishing government capacity to provide services. Support includes funding for WHO's Health Action in Crises (HAC) (£6.2 million /2003–07), UNFPA's provision of reproductive health commodities in fragile states (£5 million 2007–08) and UNICEF emergency feeding of children and pregnant/nursing mothers. DFID is also encouraging better co-ordination and harmonisation within the UN. For example the WHO HAC leads the

global humanitarian "health cluster" (an inter-agency humanitarian response mechanism) and UNFPA coordinates gender mainstreaming in emergency situations. The response to maternal mortality forms a part of this broader funding in crisis and conflict settings.

46. DFID's bilateral programmes also work to develop the capacity of partners to provide maternal health services in conflict and post conflict situations.

Examples of DFID support to MDG 5 in conflict and post conflict environments

Somalia: £2.1 million over three years to a consortium of NGOs to deliver health services and improve access to maternal health services.

Sudan: support to 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.

Liberia: support to Merlin, Save the Children and the International Rescue Committee to deliver health services including support to hospitals that are the sole providers of emergency obstetric care.

DRC: support to health services through the Humanitarian Pooled Fund, including:

- help for victims of sexual and gender based violence (SGBV);
- the provision of post exposure (to HIV) prophylaxis; and
- the development of a dedicated facility for the treatment of fistula in DRC—this is higher than usual proportions of fistula cases due to more sexual violence than is normally the case.

Sierra Leone: £50 million over the next 10 years in rebuilding the health system to deliver basic services in sexual, reproductive and child health. Sierra Leone has the highest maternal mortality in the world, at 1,800 per 100,000 live births. Access to Emergency Obstetric Care outside Freetown is negligible and only 4% of women are able to access contraceptives.

Burundi: DFID provided £1.5 million as a "peace dividend" in the post-war period to enable the President to scrap user fees for maternal and child health and further supports MSF Belgium to deliver emergency obstetric care.

Annex 1

EXAMPLES OF DFID'S INVESTMENTS IN MATERNAL HEALTH[72]

Examples of DFID's Direct Investments into Maternal Health in Asia

Country	*Programme*	*Amount*	*Timeframe*
India	Reproductive and Child Health (RCH) 2	£252m	2005–11
Nepal	Support to Safe Motherhood Programme (SSMP)	£20m safe motherhood £15m HIV AIDS	2004–09
Pakistan	National MNCH programme	£90m (£69m to GoP; £9.5m technical assistance; £11.5m research and advocacy fund)	2006–11 5 years
Bangladesh	-Joint UNFPA-UNICEF-WHO maternal and neonatal mortality reduction programme	£10m	2007–12
Cambodia	Reduction in maternal mortality project Equity Funds	£2.2m £500,000	2006–10
China	Basic Health Services Project	£21m	1999–2007
Indonesia	Improving maternal health Improving maternal health	£4.2m (as component of GTZ project) £9m (through UNICEF)	3 years 2006–09 3 years 2006–09

Examples of other DFID Investments in Asia that Contribute to Maternal Health

Country	*Programme*	*Amount*	*Dates*
Bangladesh	Health, Nutrition and Population Sector Programme (HNPSP)	£100m	2005–10
India	West Bengal Health Sector Strategy. Orissa	£100m	2004–10
	Andhra Pradesh	£50m	2007–12
	Madhya Pradesh	£40m	2007–10
		£60m	2007–12
Nepal	Nepal Health Sector Programme (£30m, 2004–09)	£30m	2004–09
Pakistan	National Health Facility	£68.5m (next phase under design)	2003–07

Examples of DFID's Current Direct Investments into Maternal Health in Africa

Country	*Programme*	*Amount*	*Years/dates*
Zimbabwe	Maternal health and HIV AIDS	£25m	2007 for 5 years
Nigeria	PATHS	£56m	2002–08
Sierra Leone	SRH-MNCH Health Systems	£50m	10 years
	Strengthening with water and sanitation	£32m	5 years

Examples of other DFID Investments in Africa that Contribute to Maternal Health

Country	*Programme*	*Amount*	*Dates*
Malawi	Health sector programme	£45m	6 years 2005–11
	EHRP	£55m	
Kenya	Essential health Services Programme	£7.5m	2005–10
Burundi	MNCH Programme	£1.5m	
Somalia	NGO consortium improve access to maternal health services	£2.1m	3 years

Annex 2

DISTRIBUTION OF DFID'S FINANCIAL RESOURCES ACROSS A MIX OF AID INSTRUMENTS; AND METHOD FOR TRACKING MATERNAL HEALTH SPEND

DFID employs a range of aid instruments to support maternal health

The choice and mix of aid instruments is made according to the country context. This range of flexible financing mechanisms is important in delivering different objectives. For example, support through non-state channels is likely to be needed if the aim is to address "sensitive" issues such as preventing unsafe abortion or addressing female genital mutilation[73], or where funds are provided to support civil society or the media hold the government to account on delivering health services.

On the other hand, budget support to national governments enables DFID to invest in a predictable way in a number of sectors (health, water, education) that have an impact on maternal health. It also helps us to provide long term investment in health systems, which as described above, are central to DFID's approach to improving maternal health. However, as discussed above, general budget support makes tracing DFID investment in maternal health and its impact complex.

How DFID measures its financial support for maternal and newborn health

DFID measures maternal health spending by marking new projects and programmes with a maternal and newborn health or reproductive health sector code, which allows us to track spending over time and across different programmes. Sector budget support that is aimed solely at these issues will also be counted in the same way.

But there are three important channels where the picture grows more complex: (a) the multilaterals, (b) general budget support and (c) sector budget support that aims to strengthen health systems. Each of these contributions will help to improve service delivery for the health sector, and create spillover benefits for maternal health; but it is not possible to identify how much they directly benefit maternal health programmes within partner countries.

DFID does not earmark for sub-sectors such as maternal health, so we can only estimate how much of our multilateral spending targets maternal and newborn health. The same can be said of general budget support, which is provided directly to national governments, who make the sectoral allocations. The allocation of general budget support towards the health sector is derived from the proportion of national spending on health as a share of the entire national budget. It is not possible to say how much of national spending, and therefore our general budget support, was spent on health sub-sectors.

The share of general budget support provided to Africa since 2002 that can be attributed to health is approximately £171 million. Similarly, sector budget support for wider health systems amounted to an additional £48 million for Africa, which will have contributed towards our maternal health goals as well. As such, the figures do not represent the entirety of DFID's expenditure, and should be used with caution.

As discussed above, the distinctions between the health sub-sectors places an artificial distinction amongst the interventions. A process is underway to bring DFID's statistical monitoring systems in line with the OECD, which promises to improve our capacity to track spending.

Further information

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37 DFID works in 150 countries through its support to the multilateral system, and has 64 country offices. Most aid is provided to 26 countries (16 countries in Africa and nine in Asia). Africa: DRC, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Sierra Leone, South Africa, Nigeria, Rwanda, Sudan, Tanzania, Uganda, Zambia, Zimbabwe; Asia: Afghanistan, Bangladesh, Cambodia, India, Indonesia, Nepal, Pakistan and Vietnam; and Middle East: Yemen.

38 DFID does not earmark our funding to the multilateral in this way.

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60 DFID Maternal Health Factsheet 2007

61 Position Paper on Sexual and Reproductive Health and Rights; Policy Position on Preventing Unsafe Abortion; Taking Action (and forthcoming AIDS strategy); DFID's White Paper, "Eliminating World Poverty: making governance work for the poor" (2006) committed us to making our work on gender equality and women's rights more of a priority; The Health Strategy (2007), and Gender Equality Action Plan GEAP (2007) reinforce DFID's commitment to gender equality and rights as core elements in DFID's approach.

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Memorandum submitted by the All Party Parliamentary Group on Population, Development and Reproductive Health

As the Chair of the All Party Parliamentary Group on Population, Development and Reproductive Health (APPG on PD&RH), I am writing to welcome your inquiry into Maternal Health. Improving maternal health and reducing maternal mortality by three quarters remains a great challenge.

The APPG on PD&RH has been very pleased with the UK Secretary of State for International Development and the Chancellor of the Exchequer's efforts over recent years in developing pro-poor polices.

DfID's Maternal Health Strategy, published in 2004 and their first progress report in 2005 both provide clear information on DfID's intentions and accomplishments.

DfID has taken steps to mainstream maternal health across related policies including HIV/AIDS, Sexual and Reproductive Health and Rights (SRHR), Gender equality and general health policies. The latest example being this year's new health strategy: Working together for better health.
DfID is and remains a leader in advocating for improved SRHR policies and services and linking SRHR, including maternal health with poverty eradication.

In support of our submission to the DfID's Select Committee inquiry, I would like to draw your attention to the Parliamentary Bangkok Statement of Commitment, 21st-22nd November, 2006 (full statement attached as appendix 1).

Around 300 parliamentarians, NGO representatives and UN officials from over 100 countries assembled at the UN Conference Centre, Bangkok, in November, 2006 to review, discuss and plan new initiatives on population and development, reproductive health and HIV/AIDS-related issues.

Parliamentarians from around the world committed themselves to:

(a) "Attain at least 10% of national development budgets and development assistance budgets for population and reproductive health programmes including HIV and AIDS prevention and especially, family planning and reproductive health commodities.

(b) Ensure that the new target on universal access to reproductive health is immediately and fully integrated into national development strategies and is given highest priority in the plans, implementation and monitoring of relevant government ministries.

(c) Mobilize our governments to support the adoption of indicators by Member States of the United Nations to monitor the target of universal access to reproductive health by 2015 and to use those indicators as soon as they are adopted, supplemented by additional programme indicators responsive to national needs.

(d) Work closely with our national authorities to ensure that the reform processes being undertaken in the United Nations protect, promote and enhance sensitive mandates such as population, gender equality and sexual and reproductive health and that these areas are recognized as central to the support of the United Nations for national development.

(e) Ensure that when laws are passed and or policies adopted they are implemented. We must further ensure that laws and policies include a provision for reporting to the parliament on the progress of implementation.

(f) Build networks, coalitions and partnerships with our parliamentary colleagues, government officials, local NGOs and individuals in order to create the political will and build the mass support needed to overcome opposition and to clarify misperceptions about population and reproductive health issues.

(g) Advance awareness of, and legislation and policy to address, the linkages between people, reproductive health and the environment, including the need for sustainable production and consumption patterns, sustainable and equitable natural resources use, and measures to prevent environmental degradation and to take action on climate change.

(h) Learn how to work effectively with the media to ensure that our messages reach the widest audience possible.

(i) Create partnerships with regional parliamentary groups and UNFPA to develop effective mechanisms to network with other parliamentarians to exchange experiences and accurate information, including model legislation and policies, share our successes, learn from our failures and monitor our work.

(j) Lead national efforts to ratify and implement key provisions of all relevant international conventions on the protection and promotion of the rights of people, including indigenous people, migrants, refugees, people with disabilities and other marginalized and vulnerable groups.

(k) Ensure that national legislation takes into account the aspirations of young people and their sexual and reproductive health and rights, recognizing that they have a crucial role to play in decision-making and development processes.

(l) Urge governments and the private sector to give priority to and increase resources for continued research and development of new disease prevention technologies, such as vaccines and microbicides, as well as promoting access to the newly developed HPV vaccine that potentially protects against cancer of the cervix.

(m) Action to manage and prevent STIs in order to increase wellbeing, and prevent infertility, cervical cancer, maternal and newborn complications and deaths, and vulnerability to HIV/AIDS."

The Bangkok Statement of commitment also reads:

"The Road Ahead

11. We need to package the clear evidence that addressing population issues and sexual and reproductive health are central to the achievement of development goals, in order to facilitate national policy dialogue and legislation and to review more effectively budget proposals.

12. We must convey information to the public, our parliamentary colleagues, government officials, and the media in clear, concise and simple language, including the following messages:

(a) Every minute a woman dies of pregnancy-related complications, including unsafe abortions, almost all of them in developing countries.

(b) Obstetric complications are the leading cause of death for women of reproductive age in developing countries.

(c) One third of all pregnant women receive no health care during pregnancy; 60% of deliveries take place outside of health facilities; only half of all deliveries are assisted by skilled birth attendants.

(d) Some 200 million women in developing countries have an unmet need for effective contraception. Meeting their needs would prevent 23 million unplanned births a year, 22 million induced abortions, 142,000 pregnancy-related deaths, including 53,000 from unsafe abortions, and 1.4 million infant deaths.

(e) Almost 1 million new infections each day from STIs, including HIV, account for 17% of economic losses caused by ill-health in developing countries, and contribute to an enormous burden of ill-health and death across the globe.

(f) Fewer than 20% of people at high risk of HIV infection have access to proven prevention interventions.

13. We must convey clear messages on the cost-benefit of addressing the unmet needs of 200 million women, including the costs of providing emergency obstetric care, ensuring that all deliveries are assisted by skilled birth attendants and providing services for prevention, care, treatment and support for people living with HIV and AIDS.

14. Most importantly, we must convey in clear and concise terms the human, social and economic costs if we fail to address these population and sexual and reproductive health issues.

15. We must convince our parliamentary colleagues and government officials that:

(a) Quality reproductive health care saves lives, and reduces poverty.

(b) The failure of previous national development plans can be attributed, among others, to the failure to invest in sexual and reproductive health and to promote the rights of women and girls.

(c) The MDGs, particularly the eradication of extreme poverty and hunger, cannot be achieved if questions of population, reproductive health and sustainable development are not squarely addressed through greater investment in education and health, and the prevention of preventable deaths among women.

16. We must engage constructively with all sectors of society, listen to their concerns, discuss perceptions and realities with them and debate sexual and reproductive health issues publicly and in a civil manner.

17. We must secure the understanding and support of different sectors of society that quality reproductive health information and services, that are available, accessible and affordable, including in rural areas, enables women to make choices that safeguard their health and lives, fulfil their potential, and contribute productively to society. Recognizing that unsafe abortion is one of the leading causes of women's death, we must also convey this information to our parliamentary colleagues and to government officials who are responsible for implementing the ICPD Programme of Action."

The APPG on PD&RH encourages Ministers to advocate, during country visits, for increased and improved maternal and reproductive health services. The Bangkok statement of commitment is a useful tool.

Ministries of Finance need to be convinced that improving maternal health is good value for money and has the potential to save the lives of women and children, and therefore has direct positive repercussions on poverty reduction and long-term development.

It is of particular importance that Ministers make reference to the new Millennium Development Goal target under MDG5: universal access to reproductive health and its associated indicators—contraceptive prevalence, unmet need for family planning, adolescent birth rate and antenatal care coverage, as well as the target of reducing maternal mortality and its associated indicators—maternal mortality ratio and proportion of births attended by skilled health personnel.

DfID should especially advocate for support to the more controversial areas of maternal health, including unsafe abortion and access to safe abortion services as well as family planning.

Family planning needs to be more strongly promoted as a way of improving maternal health, as essential to addressing population growth and to ensuring that women have real choice; as well as for more effectively preventing the spread of HIV and AIDS, through services that are integrated at the point of delivery.

DfID must be a leader in seeking to attain at least 10% of its official development assistance for population and reproductive health programmes including HIV and AIDS prevention and especially, family planning and reproductive health commodities.

Long term predictable financing is of particular importance for scaling up maternal and general health services.

Financial and technical support is needed to build up existing country health systems, with attention to basic infrastructure, logistics, supplies, financing, regulatory frameworks for private-public collaboration, insurance, information, management information systems and trained and motivated health workers, which include issues around incentives and staff retention.

As one sixth of the population of developing countries live in "fragile states", where governments are unwilling to provide services to most people, supporting NGOs is paramount.

DfID country personnel must advocate for improvements in maternal and child health. National development and poverty reduction strategies need to reflect an analysis of the challenges and responses needed to reduce maternal mortality.

The APPG on PD&RH welcomes the recent amalgamation of the HIV/AIDS Policy Team and the Reproductive and Child Health Policy Teams into the new AIDS and Reproductive Health Policy Team, as a means to better linking HIV/AIDS and SRHR. It is important that DfID monitor the effective working of this Policy Group to ensure HIV/AIDS and Reproductive Health are given equal status and commitment.

Improving individual and couples SRHR will reduce poverty, deliver development quicker and respond to the needs of poor people.

13 September 2007

Memorandum submitted by Cara International Consulting Ltd (Joint NGO and interested stakeholders[1])

Every minute of every day a woman dies through preventable causes related to pregnancy and childbirth. 99% of these deaths occur in developing countries.

> "Women are not dying because of diseases we cannot treat. They are dying because society has yet to decide that their lives are worth saving"[i]

Background to the Consultation and those Included

There are moments in time when the right voice at the right time can really change the world. This is one of those times. This inquiry can make a difference. By using this inquiry to highlight what needs to be done, by whom and when, we can influence four new leaders. The new UK Prime Minister, the new heads of WHO, the World Bank and the Global Health Fund. These actors can galvanize enormous financial and technical support for mothers, and their children, but they need to know that society believes these women and children are important. This inquiry can help let them know that stakeholders consulted all agree that maternal health is essential. The health and well being of mothers affect the health and well being of communities as a whole.

2007 is also a good time to reflect on lessons learned from twenty years of implementing the Safe Motherhood Initiative, which has enjoyed small scale progress but without sufficient political support to ensure its successes are sustained universally. On 18 October 2007, there will be an international conference

[1] Listed in paragraph 4.

entitled "Women Deliver" that will bring together developing country actors to harness such lessons. The IDC could attend this meeting or seek written or oral evidence from its participants; they will be sharing positive experiences and challenges for maternal health all over the world, while planning how to ensure maternal health becomes a political priority globally. The White Ribbon Alliance are launching an exhibition at the Royal College of Obstetrics and Gynaecology (in Regents Park) on 17 October entitled "Stories of Mothers Lost".

For these reasons The Making Pregnancy Safer Department in the World Health Organisation contracted Cara International Consulting Ltd, to take advantage of this window of opportunity to support as many stakeholders as possible to have their voice heard both for the IDC and the "Women Deliver" meeting. Many NGOs and academics were invited to participate in this consultation through either completing questionnaires based on a modified version of the IDC inquiry questions, sharing their own submissions to the IDC, taking part in interviews, and focused group discussions. Cara International Consulting held a one day consultation on 6 September 2007 to share submissions to date and to gain consensus on the most important issues. This report is the result of that process.

Cara International Consulting Ltd wishes to thank all those who contributed, either through their networks or individually. These include the following organisations: Action for Global Health, Cara International Consulting Ltd., Community Health Action Group, FIGO, Health Unlimited, UCL—ICH, Interact, Interhealth, Keele University, LSHTM, Merlin, MSF, MSI, Partnership for Maternal Child and Newborn Health Advocacy Group, People's Health Movement, Plan UK, Save the Children UK, Maternity Worldwide, Maternal Health Sub group of SRH group, UK Sexual and Reproductive Health Group, White Ribbon Alliance, Women and Children First, and World Vision UK. As this is a consultation document the views incorporated in the larger document reflect many actors and may not be the views of all the respondents; however the main points captured within the executive summary were agreed by those stakeholders who attended the consultation meeting in London on 6 September.

This report aims at ensuring that every mother and woman counts. To ensure that the next maternal health inquiry tells a more positive story. We hope you will support the women who never get a voice and act upon the recommendations in this report, we will be happy to provide oral testimony to support any part of this report.

Facts Regarding Maternal Health

Every year, 50 million women give birth without the help of a skilled attendant.[2] More than 500,000 women die every year as a result of difficulties during pregnancy or childbirth.[3] In sub-Saharan Africa, a woman's risk of dying from such complications over the course of her lifetime in one in 16, compared to one in 3,800 in the developed world.[4] Women continue to die due to preventable causes like anaemia, eclampsia, infection, haemorrhage, obstructed labour and the complications arising from unsafe abortions. In addition to the women who die, many thousands are left injured or infertile after childbirth.

The continued reduction in social spending in developing countries over the last thirty years has left many health systems in a weak state without adequately trained, supported and resourced health workers. This is one reason why women cannot access maternal and reproductive health care. Lack of political commitment to maternal and reproductive health is another reason for the failure for sustained progress in maternal health outcomes. However, maternal health is also affected by social determinants such as poverty, gender inequity, low levels of female literacy and formal education, early marriage, teenage pregnancy, conflict and HIV. Poverty and ill health are inextricably linked, especially in the case of maternal health. This is due to many factors such as hard to reach areas being left without adequate health services, lack of transport facilities to seek care in an emergency, lack of resource mobilisation responsibility within the household, the high cost of maternal health inpatient care and lack of decision making power to seek care when required due to socio-cultural factors such as gender and religion. Health care fees can also push women into further poverty. In the 2005 World Health Report: Making every mother and child count WHO estimated that 100 million people each year are pulled into poverty though paying for health care[ii]: In this report WHO suggested that maternal and child health needed to be viewed as a continuum of care between the home through the community to the health centre and finally when required to the hospital.

> Amanita, from Kailahun district in Sierra Leone, has had seven children, but only one has survived. "They all died as babies," she says. "Some of them we could not take to the clinic because we had no money. I took others to the clinic, but waited to see if they would get better first because we had no money. They all died." [iii]
>
> Satta, from Kailahun district, Sierra Leone, couldn't afford to go to the clinic to have her baby. "When the time came and I had the pain of giving birth I went with my mother to a traditional midwife," said Satta. There were complications with the birth and the midwife said Satta needed to go to the clinic. "It was night and we walked there," said Satta. "People carried me in their arms. I was hurting so much. At the clinic, I had the baby. It was dead." Satta's mother had to borrow

[2] Global Health Council *Maternal and Child Health* 2006.
[3] United Nations *The Millennium Development Goals Report* June 2007.
[4] United Nations *The Millennium Development Goals Report* June 2007.

80,000 leones (£20) from friends so she could pay the clinic bill. She earns a subsistence living through casual work and collecting firewood to sell. "We have no idea how we will pay the money back," she says. "I feel bad because we didn't get the baby and we had to pay a lot of money."

In Sierra Leone the cost to a patient of a caesarean section is the UK—equivalent of £10,000[iv], access to this services may have saved both mothers children.

Executive Summary

International health, health systems, reproductive health, HIV and more recently maternal and child health, have captured the political spotlight in the last few years, thanks to the leadership of DFID, the UK government, and its partners, WHO and civil society activists. NGOs and civil society have finally been listened to and a large percentage of people in the UK and worldwide have called for an end to preventable maternal and child deaths. This call for action has been supported by the realisation by politicians and policy makers that the world will not meet the health related Millennium Development Goals established in 2000, without radical, urgent changes to health and economic policies and increased and sustained political support. To help achieve this goal DFID supported the fledgling Partnership for Maternal Child and Newborn Health (PMCNH), encouraging partners to support an integrated approach to maternal and child health through a continuum of care. The partnership aims to combine advocacy, reality, and technical expertise with effective interventions and evidence based solutions through nationally owned plans and programmes to achieve increased political financial and technical support to improve maternal child and newborn health in developing countries.

DFID and the UK government have also wholeheartedly supported global efforts towards increasing aid effectiveness and harmonisation. They have consistently supported national led programmes to strengthen equitable access to health care while creating opportunities, in selected countries, for civil society and the voices of the poorest to feed into health policy determination. DFID are one of the few health stakeholders actively attempting to implement the Paris Declaration of 2005. DFID must be congratulated for this.

In 2005 the UK government was instrumental in orchestrating global agreement in the UN to add another goal to MDG 5 (The original MDG 5 goal was to reduce by $\frac{3}{4}$ the number of women dying from pregnancy related causes, by 2015). The new goal seeks to achieve universal access to reproductive health services by 2015; however, indicators for measuring this goal have not yet been agreed. The UK government needs to continue to lead the way in ensuring that global commitments to reproductive and maternal health agreed in 2005 are financed and implemented through rights based equitable approaches especially in DFID funded programmes. In order to achieve these goals there needs to be:

Increased and sustained political will—with DFID retaining a strong voice.

Increased support for and listening to voices of the poor, civil society and women themselves.

Urgent increase in long term predictable funding to support equitable and pro-poor health policy implementation and strengthening health systems, including the training and retention of more skilled birth attendants, to provide essential maternal and reproductive health care including emergency obstetric care.

Support to reduce the social cultural political economic and communication barriers which prevent women from accessing health services.

Increased prioritisation for maternal and reproductive health services especially in fragile states and complex emergency situations.

Without these changes we will reach 2015 knowing that we have failed another generation of potentially powerful women from leaving their mark on the world, because we did not act fast enough to implement solutions we know can make a difference.

To support these changes we request that parliament ensure that:

1. DFID be given enough resources and political support to continue its pressure on global actors to prioritise maternal, child and newborn health. One way of achieving this would be for DFID to take a leadership role in the new Partnership for Maternal Child and Newborn Health. DFID also needs to continue to support the normative roles within WHO so that technical support for maternal health will available to programmes as they require it.
2. DFID continue to support the voices of the poor, civil society and the marginalised being included in health policy determination, implementation and monitoring. DFID has led the way with UK civil society and supporting national based civil society groups to hold their governments to account, however, civil society are concerned that the most recent Health Partnership launched on 5 September had little input from civil society in its planning, this needs to be urgently redressed. There is also concern that if DFID continues to channel increased resources through partner agencies like the World Bank, DFID's "value added" of implementing pro-poor health systems through rights based framework will be lost. UK development funds need to prioritise the often overlooked principles of rights and equity so that they reach the poorest populations who need

help the most. DFID should establish more flexible funding pools to enable civil society to apply for resources to hold DFID, donors and national governments to account for promises made in regards to prioritising health for all.

3. DFID continue to invest technical and financial resources into implementing pro-poor health policies and strengthening developing countries health systems. Global ODA (Overseas Development Assistance) has increased in recent years but by only half of what was estimated as needed in 2001 by the Commission for Macroeconomics and Health. At that time they estimated that by 2007 we needed to be investing $27 billion in ODA; the present amount reaches just $14 billion. DFID would need to double its GNI on ODA from 0.43–0.1% to invest its share of ODA.[v] Yet although there have been increases in health aid, this has mainly targeted vertical disease specific programmes, which have led to a skewing of national priorities and a lack of health resources for building strong health systems. This trend needs to change, and DFID needs to ensure that more of its health aid supports maternal health, emergency obstetric health care and health systems strengthening. It is important that DFID maintains sufficient technical capacity to support the effective implementation of pro-poor health policies. This will require an urgent re-think of the current downsizing of technical advisers in DFID's head office and in the field.

4. DFID continue to invest in replicating successful evidence based programmes. For example, emulating their innovative emergency human resource programme in Malawi in other countries facing similar human resource constraints or supporting more countries to implement pro-poor health financing policies as in Zambia where DFID has supported the abolition of health care fees at point of use in rural areas. This has led to increases of over 70% in health care utilisation in some rural areas. Or their comprehensive support of community health programmes, including women's groups, and health systems support in Nepal, to bring about reductions in maternal death rates. DFID needs to invest more robustly in the collection of baseline and impact data in relation to DFID supported national programmes, to ensure that they can measure the impact of their support on improving health outcomes for women and children especially for the poorest populations. Such evidence is essential if DFID is to convince other donors, policy analysts and international health actors to replicate their innovative health programmes.

1. *How can donors (specifically DFID) catalyze progress towards MDG 5?*

1.1 Financing

- The shortfall for funding maternal child and neonatal health is still at least $14 billion—if we are to reach the promised $25 billion estimated as necessary to ensure a basic package of health services is available to all. Donors must begin to be held accountable for fulfilling their long held promises to close the funding gap by investing their promised 0.7 % of GNP in ODA and completing debt relief promises.
- More long term predicable aid needs to be committed to by donors, especially for health systems and human resources for health.
- Civil society need to be supported to hold Developing countries accountable for their promise to allocate 15% of national spending on health as agreed in the 2001 Abuja agreement.
- Increase availability/accessibility of funds for NGOs involved in improving maternal and newborn health globally.

1.2 Policy

- Poverty Reduction Strategy Papers (PRSPs) need to reflect maternal health as a priority and be closely aligned to national budgets as set out in the five year Mid-term expenditure frameworks (MTEFs) and National Health Accounts.
- Move away from vertical programmes to health systems strengthening programmes.
- Support more countries to move away from health care fees at point of service.
- Support more health system strengthening programmes.
- Support the training and retention of more skilled birth attendants.
- Support short, medium and long term human resource solutions.

1.3 Political Commitment

- Galvanize global support for maternal health through increased funding, implementing pro-poor health policies and tracking health system and human resource targets.
- Encourage the integration of maternal health programmes with disease specific programmes like HIV, and Malaria.
- Work closely with civil society.
- Work more closely with health professional organisations and advocates.

1.4 Research

- Support more operational research in reducing the bottlenecks to delivering effective health services to the poor and hard to reach populations.
- DFID is one of the bilateral donors who spend the most money in maternal health. However, with the move to general support money, it is difficult to quantify how much money is spent on maternal health by DFID. We need better tools to track maternal health spending and uptake estimations on the present financing gap.
- Donors need to improve data on maternal mortality, and be willing to fund maternal morality studies in certain contexts.
- Fund more civil society and academic partnerships to carry out operational research and then to support the moving the policies and knowledge into practice.
- Undertake an analysis of successful health programmes supported by DFID in the last 10 years which led to improved maternal health outcomes.

2. *How effectively is DFID working to ensure EMOC is available and accessible with adequate numbers of skilled birth attendants?*

2.1 WHO

DFID supports WHO's normative work in maternal and child health. DFID supported the development of policy briefs to accompany the 2005 World Health Report on Making every mother and child count and they have recently supported WHO and partners to develop standards for maternal health competencies (working with the ICN, ICM and FIGO). These are all important steps towards supporting nations to strengthen their systems, however without more financial and technical support nations will find it impossible to implement these guidelines and standards.

2.2 Professional organisations (RCN RM FIGO ICN ICM WMA BMA)

DFID needs to work more with relevant health professional organizations to strengthen capacity and to promote partnership between professional organizations south to north, south to south.

DFID presently support the BMA to carry out international health advocacy work in the UK.

2.3 European Union

Although the EU has comparable maternal health policies to DFID in relation to supporting EMOC, they have dramatically decreased their health aid this year focusing predominantly on the GFATM, infectious diseases and human resources for health. So their expenditure is not in line with DFID led pro-poor global health policy and practice.

2.4 PMCNH /International Health Partnership

DFID has led the way in both these initiatives; EMOC is featured as a key intervention to promote maternal health. However, DFID needs more midwives and technical health advisers to support these countries as they move from policy to implementation. DFID also needs to encourage WHO to increase the number of nurses, midwives and social development experts they contract at HO and the country and regional offices. There are excellent examples where progress is being made in programmes such as the DFID Malawi emergency health worker programme and the John Hopkins supported Zambia maternal health programme, the World Vision and Save the Children UK EMOC programmes in Afghanistan and the multiple programmes carried out by MSF in conflict affected countries like the Congo, Sierra Leone, and Liberia. Lessons learned from these successful EMOC programmes need to be harnessed and shared with policy makers and national ministries and their partners.

2.5 NORAD's Global Business Plan

DFID and the UK government have worked closely with Norway and the PMCNH to shape the global business plan, but ultimately the money is not enough to support the roll out of EMOC, to all the areas that need it in selected priority countries. Also the selected countries are high population countries that would help to bring the MDG targets back on track; however funds need to reach the countries with the highest maternal death rates like Niger and Sierra Leone.

Maternal morality data needs to be updated urgently, in a recent study conducted by MSF in DRC they found maternal death rates ten times higher (5,200 deaths per 100,000 live births) than the national reported average of 520 deaths per 100,000 live births.[vi]

3. *How effective is DFID in mainstreaming maternal health across related policies?*

3.1 Health Systems

— DFID has been instrumental in putting the strengthening of health systems on the international agenda, and making the case for maternal health as a health system issue.

— DFID has funded programmes to research how much strengthening health systems benefit to maternal health, but this programme funding has been cut by 40%.

— DFID has also been instrumental in requesting that the implementation agendas of maternal, neonatal, and child health be further integrated at international level, in order to facilitate work at country level.

— Although DFID is the best of the donors for funding pro-poor programming. DFID need to establish alternate mechanisms for funding innovative social justice work (and ensure it is tracked and measured effectively) in health to measure the impact of improving social development on health outcomes—there are some DFID programmes starting to do this (eg in Nigeria) but there is still a long way to go between DFID HO policies and implementation of DFID funded programmes in countries.

3.2 Maternal health and HIV

— One area really requiring more integration is DFID voice in HIV regarding maternal health. Many HIV programmes still do not treat syphilis through HIV programmes as they have been set up to distribute ARVs, missing opportunities to treat STIs like this can lead to more neonatal deaths and in the long run more HIV. Such stipulations can be made easily when establishing programme funding calls. (More work is also required in relation to HIV treatment for pregnant women and children)

— PMTCT activities need to be integrated into health systems including antenatal and obstetric systems and become more decentralised with greater attention placed on ensuring HIV positive women are placed on HAART therapy post delivery once their CD4 count reaches less than 350.

— It is essential to extend PMTCT services into conflict and fragile states integrated into the ANC and obstetric care programmes with interpersonal and counseling training given to health workers.

— All services including diagnostics must be free at the point of access so the most marginalised women can access these life saving services.

3.3 Maternal Health and Malaria

— Much more work is required on integrating maternal health into malaria programmes (so there are not stand alone IPT programmes rather than malaria funds are utilised to strengthen Antenatal Care and deliver free anti-malarial treatment and bed nets to all pregnant women. This money is in the GFATM but DFID could do more to use their channels to make sure that there is better integration of maternal health into vertical programmes (especially in the programmes that they fund)

3.4 Aid effectiveness and pro-poor health financing

— DFID has developed a strong maternal health policy based on rights which are not always followed through into programming and funding.

— DFID has led the way on pushing the issue around equitable health financing however their programmes do not always reflect their policies (eg DFID should not fund programmes where equity is not considered). This is really true for maternal health, the cost of accessing services is a real barrier to accessing health care, DFID should be funding more programmes which demonstrate this. Even their programmes in Zambia (following abolition) did not have strong HIS systems establish to measure the impact of abolition on maternal and child health this is essential to be able to persuade other health stakeholders about the efficacy of such prop-poor policies on health access and utilisation.

— DFID should establish mechanisms for DFID country offices to support country based international and national civil society and health activist groups more so that they can hold their governments to account for health promises (including health budgets and prioritising health access for the poor and for women and children.)

4. *How is MDG 5 being supported and prioritized?*

4.1 Technical support

— The number of DFID health advisors at central level (and within countries) has been greatly reduced; this is having a negative effect on health policies and pro-poor practices in the countries where DFID has pulled out. If DFID cannot support more health advisers due to civil servant cuts then they could fund senior level health advisers through NGOs to support the strengthening of national systems.

— There are few DFID Health Advisers with real expertise in maternal health (How many DFID advisers are midwives?). DFID and WHO need to increase the number of health workers included in policy determination (both in country and in HO).

— Although maternal health has had higher visibility most countries are still prioritizing medical or community health programmes rather than increasing the number of skilled midwives.

— Although MDG 5 is now being included as a priority for plans and policies there is little real evidence of increased access to skilled attendants (and even when we do have the health workers other demand side barriers will need to be addressed before utilisation increases like economic and socio-cultural.

4.2 Financial support

— Maternal health does not have a global fund, and the partnership is not a money dispensing institution. However, not clear how all the money generated specifically for maternal health can be dispersed to countries.

— Many countries have developed maternal health road maps but to fund these all we need to invest the $25 billion agreed at the 2005 G8 meeting and this money needs to strengthen health systems and increase the number of health workers especially nurses and midwives.

— Globally there is still an unhealthy balance of health funds supporting behaviour change programmes without supporting the policies which may create an enabling environment for societal changes.

— Too many health programmes and funds are based on vertical disease specific targets—which means that the high visibility of health systems becomes rhetoric unless indicators are established and real pressure is placed on vertical programmes to adhere to and implement the principles established for Global Health Partnerships at the High Level Forum in 2005.

— There is also more work needed to harmonise aid dialogue and PRSP indicators for basic services and mid term expenditure plans and National Health Accounts.

5. *Is DFID's approach to supporting the 2006 MDG target of universal access to reproductive health effective?*

5.1 Policy change

— DFID must be commended for its role in getting the 2006 MDG target agreed, they also spent a lot of time and effort getting the global reproductive health policy approved at the 2006 World Health Assembly—despite enormous pressure from the US to change this fundamentally DFID remained strong and the Global RH policy was approved by over 180 countries.

— DFID also developed a strong rights based maternal health strategy[vii] which incorporates tackling the many complex barriers to improving utilisation of reproductive health services

— However, now that DFID has these policies in place they need to emulate their excellent policy and legal work in Nepal and Ghana in the area of reproductive health and invest in supporting civil society and women's groups to call for national changes in their legal frameworks and in the strength of health systems.

— DFID needs to continue its leadership in this area and ensure that indicators are established and tracked with support from civil society and women themselves to monitor progress in this new MDG goal. The indicators need to include uptake of family planning, number of teenage pregnancies, treatment of STIs, access to HIV prevention care and treatment, and utilisation of health services as a whole.

— DFID have the right policies and plans they now have to expand the countries they support to implement these.

— This is one area where DFID must support equitable access indicators as well as ensuring they support local civil society to hold their governments and global institutions to account.

— HIV is now the leading cause of maternal death in some SSA countries like Zimbabwe and Botswana. More efforts need to be made to harmonise and align HIV programmes with an integrated approach to reproductive and maternal health.

— DFID should collect and develop a successful programme report which can encourage other donors and nations to prioritise this essential area, again there is a strong need to link social development work with this programme, this happens in too few areas. One country where DFID are investing in linking health and social development more closely is Nigeria, support needs to be given to ensure that the social development aspects of the programme are as effectively supported and financed as are the technical aspects and that qualitative research is given as much support and quantitative household surveys etc.

5.2 Funding

— DFID also funded NGOs whose funding for reproductive health was negatively affected by the US gag rule by creating a funding pool to counteract the US law.

— DFID's new funding for reproductive health programmes in Pakistan, Zimbabwe, India, Nigeria and Sierra Leone are all positive steps in the right direction.

— UNFPA have launched a global campaign to end obstetric fistula (DFID donates over $80 million to UNFPA to carry out work like this).

6. *Is progress being made on reducing the number of women dying from unsafe abortions?*

6.1 Advocacy and leadership

— DFID had led the donors in supporting global attention on reducing deaths from unsafe abortions and challenging policies and laws which act as barriers to progress in this area.

— Until there are more reproductive and maternal health services available free at the point of access gains in this area will be slow. The Lancet maternal health series reported that 50% of women in the West African studies did not seek care due to lack of cash. The supports work carried out by Save the Children UK in East and Central Africa and work by MSF in the Great Lakes Region of Africa.

— NGOs are doing some of this work but again there is a need for country led advocacy for policy changes to ensure women have access to effective and comprehensive health services and that more girls are supported to remain in school through secondary levels as there is a direct link between onset of sexual activity and age of first pregnancy with formal education.

— The age of marriage should also be increased and social development and women's programmes could be funded to help catalyze societal change.

6.2 Funding and progress

— Globally, it would seem that progress is slow and there is ample scope for more initiatives to be developed and supported. However, it seems there is limited funding available for work in this area. A positive development is the launch of the IPPF managed, DFID supported, Safe Abortion Act Fund (which has promises of $11.9 million) received 222 applications in its first call for funding. This fund should help reduce the unmet need and support essential work in this area (unsafe abortions account for over 20% of maternal deaths and need to be addressed).[viii] In a study of 12 hospitals in three SSA countries almost all of the maternal deaths in early pregnancy were due to unsafe abortions[ix].

— There has been some progress and some retrogression in Latin America as reported from NGOs.

7. *Is effective family planning being supported in the countries you work in to support maternal health?*

7.1 Advocacy and leadership

The uptake of family planning is affected by many factors from health service availability, to pressure from husbands, cultural norms and religious beliefs. When health systems have collapsed they cannot meet the needs of women. Equally evidence is clear that the more formal education women attend the more likely they are to seek out and utilise family planning methods hence it is logical to understand that there is still an enormous unmet need for family planning especially in the poorest nations, however, by simply providing the commodities does not ensure women will use them. More work in needed on reducing the legal, household, economic, religious and socio-cultural barriers that still prevent too many women from utilising family planning when they may chose to do so.

DFID has been a global advocate for women's right to space their children or decide not to have any. They must continue this leadership while supporting NGOS and UNFPA to continue their innovative research and how to sustainability deliver family planning to the women who want to use it, while also

supporting social development programmes which can help create enabling environments for societal change reducing the socio- cultural barriers. Dialogue needs to continue with religious and political groups that do not allow women to have the choice to access family planning, progress is happening but very slowly.

7.2 Adolescent friendly services

Another specific group requiring special attention is adolescents, more resources need to be channelled to ensure they have access to family planning as well as other reproductive health services including places they can go to discuss relationships, and their reproductive and sexual health. Adolescents have much higher maternal death ratios and can be a good indicator of the strength and responsiveness of the health system. The Child and Adolescent Health department have been supporting legal and policy changes in countries in this area to ensure that adolescents are seen to have the right to appropriate services, they need to be supported to continue this excellent work. NGOs also need to be supported to train health workers in youth friendly integrated programming.

7.3 Global Policies

Family planning is one of the four pillars of improving maternal health (along with antenatal care, skilled attendant delivery and access to emergency obstetric care). These four elements need to be integral to health system development and must include the voices of women and younger girls and men in the planning implementation and evaluation of services.

7.4 Sexual based gender violence

Finally in the case of rape or sexually based gendered violence as occurs in households, communities and as part of conflict tactics, donors need to ensure that access to contraception which prevents unwanted pregnancy is available along with counselling. Health workers need to be trained more effectively in this area.

8. *How effective do you think DFID is in working with bilateral and multilateral donors, NGOs and other stakeholders, to improve maternal health?*

8.1 Supporting harmonisation without losing DFID's voice on equity

- Harmonisation support has left DFID powerless in many countries where their leadership could have led the way to national change.
- DFID has put the most effort time and support to link and support others, however sometimes these harmonisation efforts have led to a loss of DFID voice regarding a focus on pro-poor policies—DFID needs to ensure that harmonisation does not mean a loss of the only real voice for equity in health policy for a
- DFID works with World Bank a lot but this is one case where all their pro-poor policies are ignored and DFID is then associated with programmes and policies which do not support pro-poor access.
- DFID works well with WHO and the new PMCNH—they have been instrumental in bringing this group together.

8.2 DFID needs to continue to support the voices of the poor and civil society

- DFID brings together NGOS and civil society voices often but funding advocacy positions (or operations research surrounding pro-poor health access) at country level would help more NGOs to implement the policies that DFID and civil society have drafted—this has occurred in DFID's HIV work but not many other programmes.
- DFID need to bring NGO's and academics together more—so that research programmes becomes operation research and that they are reaching the most vulnerable—also DFID needs to support more sharing and recognition of qualitative research There are internal issues re: DFID linking effectively between teams and between countries and head office.
- DFID country offices do not link well with research programmes. And vice versa.

9. *What leadership is the UN providing in addressing maternal health and how well coordinated is its agencies?*

- Individual initiatives by UN agencies continue with little evidence of collaboration or coordination and Health Professional Organizations are only slowly being recognized as important to systemic sustainable change.

— Multiple UN agencies have remits which include maternal health. In the past activities have been fragmented and at times competing. For example, WHO has two departments with a focus on maternal health—Reproductive Health and Research, Making Pregnancy Safer—and has experienced frequent changes in leadership for maternal health. The situation has been exacerbated in the past by poor relations with those working on child health at WHO.

— This situation is better now than it was. The recent formation of the Partnership for Maternal, Newborn and Child Health (PMNCH) represents an attempt to improve further co-ordination across various agencies involved in maternal and child health. However, PMNCH does not disburse funds (and has very limited support itself). If substantially increased funds for maternal (and neonatal/child health) are generated, what mechanism will ensure that they are disbursed in a co-ordinated and rational way?

10. *How effective is DFID in addressing the socio-economic barriers to women's empowerment and the low status of women in relation to maternal health*

— DFID's maternal health strategy highlights issues such as gender inequity, domestic violence, inequitable health systems, power imbalances at the household level, low literacy levels and the impact of poverty and paying for health care on poverty however more financial and technical leadership is required by DFID to make progress in this area.

— DFID has funded research on the impact of Women's groups on health outcomes in Nepal.

— Health financing research and advocacy has led the way in real progress and change in five countries this is one of the biggest positive socio-economic impacts DFID has support in the last five years.

— Rights based policies are a step in the right direction but more funds are need for DFID and their partners to implement this policies and to measure the positive impact that this type of programming can have on societal change.

— Social development aspects to health programmes in Nigeria are a good start but DFID needs to start ensuring that all health programmes try and address social development issues and that this is not through communication and IEC material but rather work with communities to create enabling environments for them to hold their own leaders and health system to account while also supporting advocacy for reducing out of pocket expenditure and gender inequity.

— Funding NGOs with academics to measure the impact of such social development programmes is a step in the right direction.

11. *How can the international community improve maternal health in crisis and conflict settings?*

11.1 Political commitment

— More predictable long term aid and Twin track funding to ensure that basic services are supported while policies and systems are developed.

— Investing in people is essential support more NGOs to move beyond adhoc training and encourage programmes that build health worker and health system capacity for the long term.

— Take a Rights-Based Approach.

— Support implementers who will understand the Context and build local ownership and trust.

— Focus on health systems as a whole: vertical approaches can be distorting, particularly where existing health systems are weak.

— Support more research in fragile states with NGOs and academics to measure what is having the most impact.

— Support more health workers to be trained in the management of health in complex emergencies and fragile situations (perhaps link with NGOs and a university and the NHS to train health workers).

11.2 Policy

— There needs to be more focus on developing a policy to improve maternal health in crisis and conflict settings. Organisations like FIGO are prepared to work with DFID on developing such a policy.

— Develop policies that state that all DFID funded programmes need to prioritise the poor and ensure that essential health services are free at the point of access.

— Include those providing basic services in policy determination.

— Better training of DFID and partners in child rights programming and sexually based violence so that channels can be established to reduce vulnerability and protection of women and children in all DFID priority countries.

— Support programmes which will build national capacity.

11.3 Voice and accountability

— Share information and Use appropriate communication.

— Reach Marginalised communities: Build on what exists.

— Develop accountability mechanisms with most vulnerable especially women & children -Support civil societies to have an input this may require funds for transport to get to meetings.

— Support innovative southern based solutions to skills gap and support more countries to reduce the gap (as in Malawi).

12. *Recommendations*

12.1 Political

The newly launched international Health Partnership, launched on September 5th by the UK and German governments and development partners will only be help to improve maternal health if sufficient resources are invested at country level to support national health systems, including increasing the number of skilled birth attendants employed, trained, resourced and supervised. The compact needs to ensure full and active involvement of national and international civil society and professional organisations. These groups an also be supported to track progress of the compact goals inline with the Global Health Partnership Principles.

To get the maternal and child health MDGs back on track REQUIRES making politics work for the poor in the developing countries. More support must be given to ensure Voices of poor, and marginalised including women and civil society groups feed into policies, plans and services relating to maternal and child health care. This requires a shift in attitudes to the poor. Persuading the various stakeholders of the need for changes in the way they think and act is the role of strategic communication. Donors can help: through addressing the issues in the policy dialogue and through offering to help build local capacity on strategic communication.

Support programmes that give voice to women (as "rights holders"), especially those who are particularly marginalized so that their cultures, perceptions and needs are better understood. Also work with "duty bearers", giving them a greater capacity to respond to the challenges they face, encouraging accountability mechanisms that enables them to listen and respond to women concerning their health rights.

Support effective communication strategies by and for women and those who support maternal health rights.

12.2 Financing and Aid Effectiveness

Establish funds to move pro-poor policies into action.

Fund research into DFID pro-poor programmes so that we have evidence to show impact and change perception in international health arena.

Support research that focuses on how to overcome the barriers of accessing services of minority groups such as indigenous women, and then use the research findings to advocate for change.

DFID could support NGO evidence being included in the four workstreams being undertaken to prepare for the 2008 High level forum on Aid effectiveness in Accra. DFID should also encourage WHO to support NGO involvement in their report on donor orphans in health, which looks at the distribution of health aid in relation to need. DFID also need to encourage WHO to include civil society when determining indicators and bench marks for measuring progress in health aid so that measures include health systems, health financing and equity of access, socio-political and legal changes as well as progress in pro-poor policy implementation and accountability.

If a global health focused technical advisory group is to be established to monitor progress on health aid effectiveness (in line with the Paris Declaration of 2005) it would need to have northern and southern civil society voices feeding into it. DFID could fund NGOs to maintain global score cards based on agreed indicators for global health partnerships as indicated within the Principles for Global Health Partnerships.

12.3 Technical and Policies

Continue to develop a Rights based Approach to maternal health, building on the DFID January 2005 Maternal Health Strategy.

Place greater emphasis on equity issues, recognising that nationally conceived maternal health systems will not be an appropriate mechanism to meet the needs of all women.

Work closely with WHO and partners but do not water down principles of equity and voice of the poor.

Support national health systems to source an adequate and reliable supply of health-related equipment and medicines. This need to be delivered by adequate numbers of appropriately trained and rewarded health care workers. It must also ensure that the particular health needs of women, including access to contraception, emergency obstetrics and safe abortion, are given the priority they so clearly deserve.

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vi MSF (2007) Maternal Mortality Study In DRC, submitted to IDC consultation

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viii DFID (2007) DFID's Maternal Health Strategy, reducing maternal deaths evidence and action: second progress report

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Memorandum submitted by Columbia University, Mailman School of Public Health/Averting Maternal Death and Disability Program

Summary

Of the eight Millennium Development Goals (MDGs) established in 2000, the least progress has been made toward MDG 5—to improve maternal health.[5] Maternal mortality remains at unacceptable levels in the developing world in large part because good-quality emergency obstetric care (EmOC) is still inaccessible to many women. In order to effect real change, donor agencies, health organisations and national governments must collaborate to strengthen health systems and improve the availability, quality, accessibility and utilisation of EmOC for women around the world.

1. *Agency Overview*

1.1 Columbia University's Mailman School of Public Health is a leading institution of higher learning in the United States and in the world. Its research, education, and service agenda addresses the critical and complex public health issues that affect millions of people locally and globally.{ The Mailman School is especially known for its pioneering work on women's reproductive health and human rights.

1.2 The Averting Maternal Death and Disability Program (AMDD), based at the Mailman School, was established in 1999 to reduce maternal mortality and morbidity in the developing world by improving the availability, quality and utilisation of emergency obstetric care (EmOC). AMDD believes that sustained reductions in maternal mortality can only be achieved through systemic country-wide improvements to heath systems, inclusive of EmOC.

[5] Simwaka, B N, S Theobald, *et al* (2005). *Meeting millennium development goals 3 and 5.* BMJ. 331(7519): 708–9.

2. *Background*

2.1 Major Causes of Maternal Mortality

According to the World Health Organisation (WHO), a maternal death is "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes."[6] The maternal mortality ratio is defined as the number of maternal deaths that occur per 100,000 live births. Three-quarters of maternal deaths around the world can be attributed to five major causes, all of which can be treated if appropriate services are available. It is estimated that 25% percent of maternal deaths are attributable to haemorrhage, 15% to infection, 13% to abortion, 12% to eclampsia and 8% to obstructed labour.[7]

2.2 Stark inequities between developing countries and developed countries are evident with regards to maternal mortality. Over 500,000 maternal deaths occur each year around the world, and over 99% of these deaths occur in developing countries. A woman's chance of dying a maternal death in the developing world is 1 in 61, and in the developed world, only 1 in 2,800. Further inequities exist even within the developing world; a woman's lifetime risk of maternal death ranges from 1 in 20 in Africa to 1 in 160 in Latin America. Even within Africa, a woman's lifetime risk of such a death is 1 in 16 in sub-Saharan Africa, compared with 1 in 210 in Northern Africa. The major reason for these discrepancies is the lack of appropriate care available in developing countries.[8]

2.3 Even within countries there is inequitable access to the care that does exist, however inadequate. Differential access to care is often determined by degrees of social disadvantage, including those of educational level, wealth, urban versus rural residence, religion, ethnicity, and forced displacement status.

2.4 Approximately 15% of all pregnant women will suffer a direct obstetric complication, either during pregnancy, delivery or following delivery, all of which could lead to death or disability if left untreated. Some obstetric complications can be prevented: active management of the third stage of labour can reduce the incidence and/or severity of postpartum haemorrhage and access to family planning services and safe abortion can reduce deaths from abortion. However, most complications cannot be foreseen or prevented. These complications can only be treated. For this reason, access to EmOC and the presence of skilled attendants during delivery are indispensable in the fight to reduce maternal mortality.[9]

2.5 "Where is the M in MCH?" was a question posed in 1985 by Dr. Allan Rosenfield and Deborah Maine of Columbia University in response to the dearth of attention paid to maternal health within maternal and child health programmes. This article contributed to the creation of the Safe Motherhood Initiative, whose voice has grown over the past twenty years. During the 2000 Millennium Assembly of the United Nations (UN), 147 leaders from around the world signed the Millennium Declaration, which included the eight Millennium Development Goals (MDGs). The fifth MDG calls for the improvement of maternal health. More specifically, member countries intend to reduce their maternal mortality ratios by 75% between 1990 and 2015.[10] Data suggest, however, that progress has been slow, and maternal mortality in developing countries remains unacceptably high.[11] In order to begin to make real progress, health systems in developing countries must be strengthened, and EmOC must be made available and accessible to all women. Only with additional resources and increased political attention to the issue will these changes be possible.

2.6 Emergency obstetric care is necessary to prevent maternal deaths

EmOC is a standard set of medical interventions which treat obstetric complications and, accordingly, prevent maternal deaths. The importance of EmOC has been endorsed by most international health organisations, including WHO, UNICEF, UNFPA and DFID. Basic EmOC comprises the following interventions, or "signal functions": 1) parenteral administration of antibiotics, for the prevention or treatment of sepsis, 2) administration of oxytocic drugs, which induce contraction of the uterus, to control bleeding, 3) administration of anticonvulsants (eg magnesium sulphate), for the treatment of pre-eclampsia and eclampsia, 4) manual removal of placenta, to control bleeding, 5) removal of retained products (eg, manual vacuum aspiration), to control bleeding and to prevent infection, and 6) assisted vaginal delivery (eg, vacuum), in the case of prolonged labour. Comprehensive EmOC includes all of the above interventions, in addition to surgery, namely caesarean sections, and blood transfusion. To provide the signal functions, facilities must have the requisite medications, supplies and functioning equipment and staff must be trained,

[6] WHO, Unicef, & UNFPA (2004). "Maternal Mortality in 2000: Estimates developed by WHO, Unicef, UNFPA." Geneva.

[7] AbouZahr, C. (2003). "Global burden of maternal death and disability." Br Med Bull. 67: 1–11.

[8] WHO, Unicef, & UNFPA (2004). "Maternal Mortality in 2000: Estimates developed by WHO, Unicef, UNFPA." Geneva.

[9] Bailey, P., A. Paxton, et al. (2006). "Measuring progress towards the MDG for maternal health: including a measure of the health system's capacity to treat obstetric complications." Int J Gynaecol Obstet. 93(3): 292–9. Epub 2006 Mar 6.

[10] UN Millennium Project Task Force on Child Health and Maternal Health. (2005). "Who's got the power? Transforming health systems for women and children." New York, UNDP.

[11] Rosenfield, A., C. J. Min, et al. (2007). "Making motherhood safe in developing countries." N Engl J Med. 356(14): 1395–7.

competent and authorized to provide the intervention. In order to reduce maternal mortality in a real way, high quality EmOC must be available and accessible to all women and utilized by those women who suffer from obstetric complications.[12]

2.7 A set of six process indicators was established in the 1990s to evaluate health services' capacity to provide EmOC. These UN EmOC Process Indicators are: 1) The quantity of EmOC facilities in a region, generally described by the number of functioning basic and comprehensive EmOC facilities available per 500,000 population. The recommendation is for at least four basic facilities and one comprehensive facility per 500,000. 2) The geographic distribution of EmOC facilities, in order to ensure that the minimum standards of availability are met in all regions of a country. 3) The proportion of births which take place in a basic or comprehensive EmOC facility; the recommendation is that this proportion be at least 15%. 4) The met need for EmOC, or the proportion of women who require EmOC services who are treated in an EmOC facility. The goal is 100%. 5) The percentage of births which take place via caesarean section; the recommendation is between 5% and 15%. 6) The case fatality rate, which is the percentage of women admitted for obstetric complications who die as a result of those complications. It is recommended that the case fatality rate of women with obstetric complications be less than 1%.[13]

3. *State of emergency obstetric care*

3.1 The 2007 DFID Annual Report notes that progress toward MDG 5 is lagging. No change or negative progress has been made toward the reduction of maternal mortality in sub-Saharan African and in South Asia. Some or negligible progress has been made toward this goal in Northern Africa, Southeast Asia, West Asia, Latin American and the Caribbean.[14]

3.2 An important component of health systems which must be addressed is human resources. EmOC services cannot be provided without adequate numbers and levels of staff who are appropriately trained, posted and retained. One solution to the problem of insufficient staff, or inappropriate distribution of staff, is the expansion of mid-level providers' capacity and authority to provide EmOC services.

3.3 This strategy of training mid-level providers has been extremely successful in countries such as Mozambique, Tanzania and Malawi. In Mozambique, for example, the lack of physicians was a central factor leading to the training of dozens of surgical technicians to provide a variety of surgical interventions, including caesarean sections, throughout the country. The importance of the surgical technicians is particularly great at rural hospitals. While physician retention in these hospitals is extremely low, 88% of surgical technicians assigned to rural hospitals remained there seven years later. Data from 2002 show that surgical technicians performed more than half (57%) of major obstetric surgeries in the country, including nearly all such surgeries (92%) in rural hospitals. The case fatality ratio for surgeries performed by surgical technicians is only 0.4% and 0.1% for emergency and elective procedures respectively. Data showed that the only difference between outcomes of caesarean sections performed by surgical technicians compared to those performed by physicians was a slightly higher occurrence of superficial wound separations. The training of surgical technicians has also proven cost-effective; one recent study found that the cost of major obstetric procedures performed by a surgical technician is, on average, 27% of the cost of such a procedure when performed by a physician.[15, 16, 17, 18, 19]

3.4 The UN EmOC Process Indicators have been used in some 50 countries to assess the status of and to monitor progress in the provision of emergency obstetric services. Findings from needs assessments using these indicators are described below in paragraphs 3.5–3.7. It is clear from analysis of the assessments which have been conducted that availability, quality and utilisation of EmOC services at all levels need to be improved.

3.5 National assessments of health centres and hospitals in Africa, Asia and Latin America have shown that many countries have inadequate numbers of EmOC facilities for their population size; most facilities providing delivery care only provide some of the signal functions that would qualify them as EmOC

[12] Paxton, A., D. Maine, et al. (2005). "The evidence for emergency obstetric care." Int J Gynaecol Obstet. 88(2): 181–93. Epub 2005 Jan 8.

[13] Unicef, WHO, & UNFPA (1997). "Guidelines for Monitoring the Availability and Use of Obstetric Services. " New York, Unicef.

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[16] Chilopora, G., C. Pereira, et al. (2007). "Postoperative outcome of caesarean sections and other major emergency obstetric surgery by clinical officers and medical officers in Malawi." Ibid. 5: 17.

[17] Vaz, F., S. Bergstrom, et al. (1999). "Training medical assistants for surgery." Bull World Health Organ. 77(8): 688–91.

[18] Pereira, C., A. Cumbi, et al. (2007). "Meeting the need for emergency obstetric care in Mozambique: work performance and histories of medical doctors and assistant medical officers." Br J Obstet Gynaecol. In Press (DOI:10.1111/j.1471–0528.2007.01489.x).

[19] Kruk, M. E., C. Pereira, et al. (2007). "Economic evaluation of surgically trained assistant medical officers in performing major obstetric surgery in Mozambique." Br J Obstet Gynaecol 114: 1253–1260.

facilities. This means that even women who live near health facilities may not find the medical services needed to treat life-threatening complications.[20] Assessments of health facilities serving forcibly displaced populations in Africa show similarly poor capacity to deliver EmOC.

3.6 Most assessments showed that few health facilities delivered the full range of EmOC signal functions they were expected to provide. Administration of oxytocics, antibiotics and anticonvulsants were available more frequently than procedures such as manual removal of the placenta and removal of retained products. Assisted vaginal delivery was reported to be the basic EmOC signal function least likely to be performed. In terms of comprehensive EmOC, the capacity to perform caesarean deliveries varied widely, ranging from 100% of hospitals in Nicaragua and the Sofala province in Mozambique to 33% of hospitals in one region of India.[21]

3.7 Geographic distribution of EmOC facilities remains a problem, especially in rural areas. While many countries have the minimum recommended number of comprehensive EmOC facilities per 500,000 population, these facilities tend to be very poorly distributed. Many sub-national regions are lacking comprehensive EmOC. Of a sample of nine developing countries, for example, only Benin had the minimum number of comprehensive EmOC facilities in every sub-national region.[22, 23]

3.8 Met need for EmOC is quite low. National needs assessments in nine countries in sub-Saharan Africa showed that met need was on average 28% (ranging from 12% in Mali to 48% in Benin), far below the UN recommended level of 100%. Such low met need indicates that too many women in those countries are not receiving treatment for their obstetric complications.[24]

3.9 Health care is not only a service provided to individuals, but also a basic human right. National governments are obligated under international human rights law to progressively realize the highest attainable standard of health, which includes ensuring that all women have access to good-quality pregnancy-related care.

4. *Case Study: Chad*

4.1 A woman born in Chad has a one in 11 chance of dying as a result of complications of pregnancy or childbirth, compared with one in 3,800 in the UK. A 2002 study evaluating the six EmOC process indicators in Chad found that few targets were being met. According to the process indicator recommendations, Chad should have a minimum of 63 facilities with the capacity to provide basic EmOC in addition to a minimum of 16 facilities with the capacity to provide comprehensive EmOC. Study authors, however, found that Chad had only 40% of the EmOC facilities recommended for its population size. Distribution is also a problem; no region had the minimum number of recommended basic facilities, and the northern region had no EmOC facilities at all. The met need for EmOC was only 12%, diverging sharply from the recommended 100%, and the CFR was 3.9%, four times the recommended maximum of 1%.[25, 26]

4.2 Nearly one-quarter (23%) of maternal deaths in Chad in 2002 were attributable to pre-eclampsia and eclampsia, hypertensive disorders experienced during pregnancy. Both of these conditions can be easily treated with magnesium sulphate, an inexpensive anticonvulsant medication common in the developed world. Unfortunately, the same medication is nearly impossible for health providers to obtain in many developing countries.[27, 28, 29]

4.3 Dead Mums Don't Cry

In 2005, a programme aired on BBC as part of the Panorama Series. This programme, Dead Mums Don't Cry, chronicled the unflagging work of Dr. Grace Kodindo, an obstetrician fighting to save women's lives daily in Chad's major referral hospital, the Hôpital Général de Référence, located in the capital city of N'Djamena. At the time of filming, there was no magnesium sulphate in the entire country of Chad. As Dr Kodindo notes of her native country, "Everything is lacking here."[30]

[20] Paxton, A., P. Bailey, et al. (2006). "Global patterns in availability of emergency obstetric care." Int J Gynaecol Obstet. 93(3): 300–7. Epub 2006 Mar 6.

[21] Bailey, P., A. Paxton, et al. (2006)."The availability of life-saving obstetric services in developing countries: an in-depth look at the signal functions for emergency obstetric care." 285–91. Epub 2006 Mar 6.

[22] Paxton, A., P. Bailey, et al. (2006)."Global patterns in availability of emergency obstetric care." 93(3): 300–7. Epub 2006 Mar 6.

[23] Paxton, A., P. Bailey, et al. (2006)."The United Nations Process Indicators for emergency obstetric care: Reflections based on a decade of experience." 95(2): 192–208.

[24] Ibid.

[25] AMDD Working Group on Indicators. (2004). "Program note: using UN process indicators to assess needs in emergency obstetric services: Benin and Chad." Ibid. 86(1): 110–20; discussion 109.

[26] Unicef. "United Kingdom." Retrieved 12 September, 2007, from http://www.unicef.org/infobycountry/uk—statistics.html.

[27] AMDD Working Group on Indicators. (2004). "Program note: using UN process indicators to assess needs in emergency obstetric services: Benin and Chad." Ibid. 86(1): 110–20; discussion 109.

[28] Sevene, E., S. Lewin, et al. (2005). "System and market failures: the unavailability of magnesium sulphate for the treatment of eclampsia and pre-eclampsia in Mozambique and Zimbabwe." BMJ. 331(7519): 765–9.

[29] Quinn, T. (2006). "Dead Mums Don't Cry." BBC's "Panorama" Series. M. Robinson, Bullfrog Films: 49 minutes.

[30] Ibid.

4.4 The response to the account of Dr Kodindo's struggle and the situation in Chad has been remarkable. A UK-based non-profit organisation created in response to the programme, "Hope for Grace Kodindo,"† has sent medications, baby clothes, and other vital supplies to the Hôpital Général de Référence. One accomplishment has been the provision of magnesium sulphate: as a result of these donations, over 1,100 women's lives have been saved.[31]

4.5 While such efforts are inspiring, and important, they are not sustainable. Other crucial steps must be taken to improve women's health. The national essential drug list of all countries must be updated to include such vital drugs as magnesium sulphate, and staff must be trained in their use. Drug and equipment procurement systems must be strengthened. National protocols on EmOC must be updated, and medical staff must be trained and supported in the use of new medications.[32]

5. *Required actions*

5.1 The single most important task of organisations seeking to decrease death and disability due to pregnancy and childbirth is to strengthen health systems at all levels to deliver EmOC—especially at sub-national levels. A crucial component of this task will be to focus on the systematic implementation of EmOC services, with equitable distribution to all women. Only when this is achieved will the reduction of maternal mortality become a reality. Columbia University's Averting Maternal Death and Disability Program (AMDD), for example, was able to help upgrade hundreds of existing facilities in 18 developing countries to increase met need for EmOC by at least 100%, and to significantly reduce case fatality rates, often by 50% or more, over the course of only a few years, through effective partnerships and a systematic focus on improving facility, district and national systems.[33, 34, 35, 36, 37]

5.2 Organisations must ensure that refugee and internally displaced women are not excluded from the prioritisation of EmOC and other reproductive health services for women in developing countries. DFID is an important donor to UN agencies and to humanitarian relief organisations, and as such should encourage these organisations to include comprehensive reproductive health services, including EmOC, in their programmes.

5.3 Needs assessments have shown that in many places facilities exist but lack the trained staff, essential drugs, equipment and supplies to make them function as EmOC facilities. In order to effectively strengthen health systems, donor agencies must encourage the systematic upgrading of existing health centres and hospitals to provide the full range of life-saving signal functions.[38]

5.4 Donors should encourage national governments, implementing organisations and policy-making bodies to expand the role of mid-level providers to provide good quality EmOC, with requisite training and support, and within strengthened health systems.

5.5 DFID's maternal health strategy appropriately focuses on the most critical elements of maternal mortality reduction, notably EmOC. Moreover, DFID is a global leader in this field, together with its partners in the International Health Partnership. It is crucial that DFID maintain this evidence-based focus on what is needed to reduce maternal mortality. It is also crucial that DFID maintain and expand its global leadership in maternal health.

5.6 Funding

The charge to strengthen health systems and all its components necessitates additional funding; donors such as DFID will be crucial to the success of the process of strengthening health systems. There are several ways in which donor agencies can be most efficient. First, they can make commitments to long-term investments. Second, they can provide funding which complements national health programmes and ensures donor harmonisation. Finally, stakeholders at every level should be included in plans for funding.[39] DFID's participation in the International Health Partnership will help to accomplish these goals, and DFID should continue to pursue such collaborations.

[31] "Hope for Grace Kodindo." Retrieved 12 September, 2007, from http://www.hopeforgracekodindo.org.

[32] Fortney, J. A. (2004). "Averting maternal death and disability: Editor's comment." Int J Gynaecol Obstet. 86: 109.

[33] AMDD (2006). "Averting Maternal Death and Disability Program Report 1999–2005." New York.

[34] UN Millennium Project Task Force on Child Health and Maternal Health. (2005). "Who's got the power? Transforming health systems for women and children." New York, UNDP.

[35] Rana, T. G., B. D. Chataut, et al. (2007). "Strengthening emergency obstetric care in Nepal: The Women's Right to Life and Health Project (WRLHP)." Int J Gynaecol Obstet. 98(3): 271–7. Epub 2007 Jun 29.

[36] Santos, C., D. Diante, Jr., et al. (2006). "Improving emergency obstetric care in Mozambique: the story of Sofala." Ibid. 94(2): 190–201. Epub 2006 Jul 18.

[37] Kayongo, M., E. Esquiche, et al. (2006). "Strengthening emergency obstetric care in Ayacucho, Peru." 92(3): 299–307. Epub 2006 Jan 25.

[38] Rosenfield, A, C J Min, et al. (2007). "Making motherhood safe in developing countries." N Engl J Med. 356(14): 1395–7.

[39] UN Millennium Project Task Force on Child Health and Maternal Health. (2005). "Who's got the power? Transforming health systems for women and children." New York, UNDP.

5.7 In the 2005-2006 fiscal year, DFID spent over £2.5 billion on its Bilateral Programme. Over £200 million, or 17%, of this was spent on the health sector, representing an increase in funding from the previous four fiscal years.[40] However, the health sector requires additional support. In addition, of the health spending only £16 million was spent on maternal and newborn health (excluding Poverty Reduction Budget Support).[41] Given DFID's strong strategy and leadership position, further spending is called for. In addition, allowing for explicit funding for maternal health, including EmOC, family planning and safe abortion services, can help to ensure that these effective interventions are prioritised. Without additional funding and attention from DFID and other donors, little, if any, progress will be made toward MDG 5.

5.8 Donors have the obligation to challenge governments of countries suffering from high maternal mortality to redouble their efforts to improve maternal health and reduce maternal deaths. International organisations must work in concert with national and sub-national actors in order to effect real change in maternal mortality.

5.9 Health is a basic human right, and as such, donors must support national governments in their progressive realisation of this right.

5.10 Donors must also promote increased accountability at all levels of the health care system, from health workers to donor agencies, in order to reach the common goal of maternal mortality reduction. As noted in the Task Force on Child Health and Maternal Health's progress report, "Accountability should lie at the heart of the MDG initiative."[42]

September 2007

Memorandum submitted by Immpact[43]

1. Key Messages

- The burden of maternal mortality is borne disproportionately by the poor;
- Financial barriers to skilled delivery and emergency care are major reasons for this inequity;
- A window of opportunity has opened for reducing these barriers by abolishing user fees;
- Enabling governments to reduce these barriers is an evidence-based way to catalyse progress towards MDG5.

What needs to be done is clear: the poorest women must have access to timely and effective care, particularly in the event of obstetric emergencies. A focus on the poor and on the reduction of financial barriers to skilled care can act as a hub for efforts, but with many wider spin-offs and benefits.

We set out below further material from Immpact in support of our key messages, and in response to specific questions posed by the Select Committee.

2. Background

Our "key messages" emerge from Immpact research and are also supported by other sources of evidence.

Immpact is an international research initiative for maternal mortality programme assessment. It was set up in 2002 to improve the evidence-base for decision makers on cost-effective strategies to reduce maternal mortality.
Immpact developed innovative means to conduct programme evaluations; used these to assess maternal mortality reduction strategies in Burkina Faso, Ghana and Indonesia; and built capacity in these countries to gather and use evidence for decision-making.

Investment in Immpact was in direct response to donor and country concern about slow progress towards MDG5. There was recognition that gaps in evidence on effective strategies were significant bottlenecks. DFID played a crucial role in catalysing and sustaining Immpact. Many other research and programme initiatives in recent years have also contributed to strengthening the evidence base.

In our view, the bottlenecks have now shifted to communicating and acting upon the evidence, at country and international levels. In particular, the four[44] new major global enterprises relevant to MDG5 must make use of the available evidence in order to progress towards action.

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[40] DFID (2007). "DFID Annual Report 2007: Development on the Record." London.

[41] The International Development Committee. (2007). "Press Notice 34, Session 2006–07. New Inquiry: Maternal Health."

[42] UN Millennium Project Task Force on Child Health and Maternal Health. (2005). "Who's got the power? Transforming health systems for women and children." New York, UNDP.

[43] Professor Wendy J Graham, Mr David Braunholtz, Mr Alec Cumming, Dr Tim Ensor, Ms Sue Fairburn, Dr Julia Hussein (all of University of Aberdeen), Dr Eddie Addai, Ghana Ministry of Health and Dr Sam Adjei, Ghana Health Service

[44] International Health Partnership; Women and Children First; Catalytic Initiative to Save a Million Lives; Innovative Result-based Finance.

3. *Question: How can donors—and DFID specifically—catalyse progress towards MDG-5?*

We urge DFID and other donors to champion explicitly the needs of the poorest women by focusing on the removal of financial barriers to delivery and emergency care, and so catalyse wider improvements in the demand and supply side of health systems in low-income countries.

We base our case around 4 key messages.

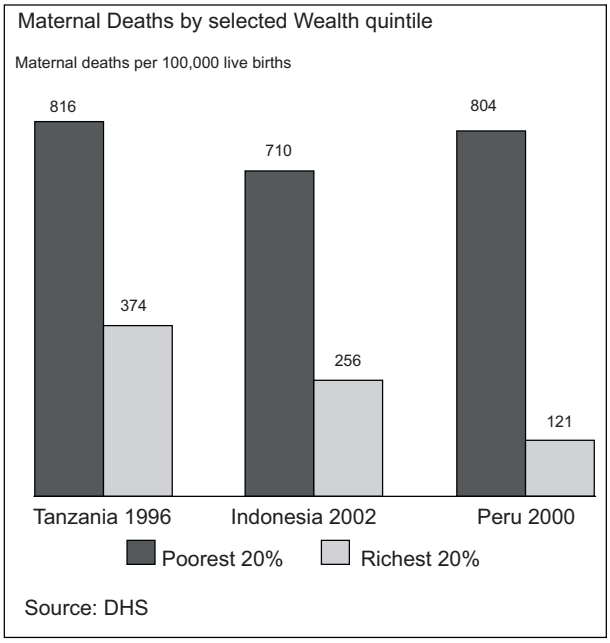
3.1 *Message 1: The burden of maternal mortality is borne disproportionately by the poor.*

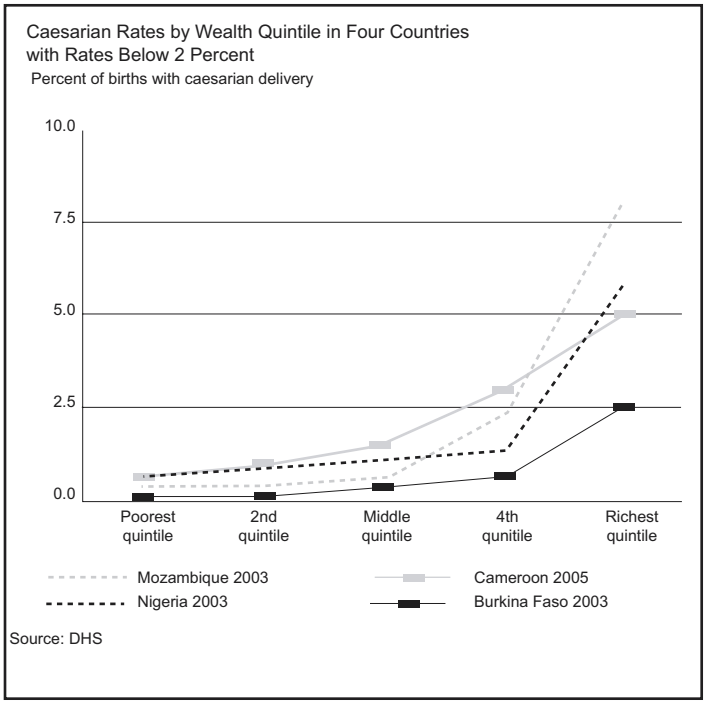
An equity lens is essential to monitoring all indicators relevant to maternal health.

The poor-rich gap has been clearly demonstrated in many studies (Figure 1).

In relation to maternal mortality the gap is a reflection of wider inequities: in education, gender, and nutrition, for instance, and particularly in access to care. Poor women have limited access to care, especially for obstetric emergencies.

The lifetime risk of maternal death for poor women is further increased by the markedly higher fertility rates for women in the lowest income quintile in developing countries—these rates are typically 2-3 times higher than for women in the highest income quintile.





The disproportionate burden on the poor has not been adequately revealed or communicated, in part owing to data constraints and use of insensitive indicators.

We know, for example, that uptake of antenatal and delivery care with a health professional shows 2-6 fold differences between the rich and the poor. It is only recently that the gap for caesarean sections—a life-saving surgical intervention, was shown to be substantially greater in many low-income countries (Figure 2).

The burden does not stop at the death of a mother.

Young children lose the parent who makes the biggest difference to their survival and well-being (Figure 3).

Figure 3

A study in Indonesia of over 2,500 children aged 6–10 showed that maternally orphaned children are approximately four times more likely to die compared to non-bereaved children, and twice as likely to drop out of school.

Source: id21 Insights 2007: 11:4

Families disintegrate with the loss of the key person who feeds and cares for members. Societies and economies lose women in their prime of life and when most productive.

Better indicators are needed to quantify and communicate these broader aspects of the burden of mortality. Immpact, for example, is working on ways to estimate the number of children who lose their mothers during childbirth or whilst they are still young (Motherhood Method).

3.2 *Message 2: Financial barriers to skilled delivery and emergency care are major reasons for the disproportionate burden of maternal mortality borne by the poor.*

Even with existing knowledge gaps regarding the true burden from maternal mortality, it is clear that the costs of care help explain the wide and widening poor-rich gap.

Surgical interventions related to pregnancy and childbirth, especially caesarean sections, are amongst the most common and expensive operative procedures that families face. The costs of complicated deliveries are often "catastrophic""—a term used where costs are in excess of 10% of yearly household income. The consequences for the poorest groups are particularly devastating (Figure 4), plunging them further into irrecoverable debt.

Figure 4

In Burkina Faso on average, a normal delivery costs US$ 124 for a caesarean section, and with transport costs to reach health facilities in addition. Delivery costs are estimated to constitute 43% of per capita income in the poorest households and as much as 138% for a caesarian section.

Source: Immpact

For women who survived obstetric complications, Immpact's anthropological research in Burkina Faso and Indonesia also found adverse social consequences (Figure 5) arising from the costs of care.

Figure 5

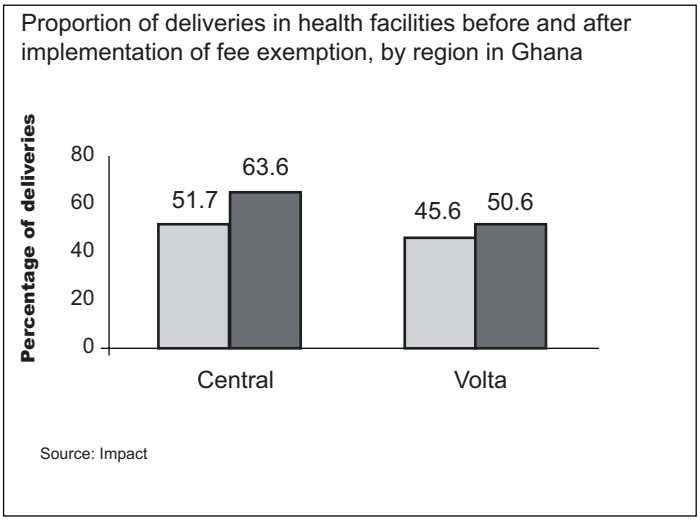
Social tensions arising from catastrophic payments were felt very strongly in women's daily lives according to research in Burkina Faso and Indonesia. These tensions were reflected in women's efforts to cut back on their own spending to avoid being blamed for being "too expensive", increased work activities 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.

3.3 *Message 3: A window of opportunity has opened for reducing these barriers by abolishing user fees.*

The universally adverse effect of user fees on the poor is now widely accepted. Many countries, particularly in sub-Saharan Africa, are taking the bold move to abolish fees. There is now a "head of steam" behind such a move, and many agencies—including DFID, are endorsing this. Advocates for maternal health should take special advantage of such an opportunity.

Our research provides evidence to support removal of fees for delivery and emergency obstetric care. But benefits in terms of reduced mortality will not be realised unless two further barriers are addressed—out of pocket expenses and poor quality of care.

Figure 6



Care made "free"" at the point of service may still not reach the poorest women. Out-of-pocket expenses are still significant obstacles, including costs of transport, food, drugs and supplies, and informal charges. In Ghana, for example, although the Government's fee exemption policy was shown by Immpact to have increased overall uptake of delivery care in health facilities (Figure 6), the fall in out-of-pocket payments was only 14% for the poorest households but almost double this for the richest. In other words, special consideration needs to be given to the equity dimension of free care.

It is often assumed that financing schemes to reduce barriers to care will automatically be of greatest benefit to the poor.

Our research shows that, particularly for obstetric emergencies, free care without transport subsidies (as in Ghana) or social insurance for the poor without tackling referral costs (as in Indonesia), will undermine prospects for reducing maternal mortality (Figure 7).

Figure 7

In Indonesia, women covered by the Government's social insurance for the poor still had the lowest uptake of delivery with a health professional (<21%) and the highest level of mortality (630 maternal deaths per 100,000 live births). This compares with the equivalent figures of 31% and 410 for women without any insurance, and 81% and 235 for those with other insurance.

Source: Immpact

The second additional barrier is poor quality of care.

Increased workload facing health professionals is a threat to the effectiveness of fee removal, with implications for staff motivation and quality of care.

These problems are particularly acute where there is already a massive shortage of skilled health professionals and functioning facilities (Figure 8).

Figure 8

In Burkina Faso, for example, the community mobilisation component of an intervention to increase uptake of institutional delivery helped to explain the increase in uptake observed by Immpact, over time and in comparison with a control district. However, improvement sin the supply of care were constrained by the lack of facilities: 77% of births within 1 km of the health centre took place in a facility, compared to just 19% for births further than 10 km from the health centre. Access to life-saving interventions remained extremely low in the intervention area, with only 0.4% of all births being delivered by caesarean section. It is generally accepted that caesarean section rates of less than 1% indicate an unmet need for life-saving care.Source: Immpact.

3.4 *Message 4: Enabling Governments to reduce financial barriers to delivery and emergency care is an evidence-based way to catalyse progress towards MDG5.*

There is now an enabling international environment to push forward a concerted effort to do what needs to be done: the poorest women must have access to timely and effective care, particularly in the event of obstetric emergencies.

A focus on the poor and on the reduction of financial barriers to care can act as a hub for efforts, but with many wider spin-offs and benefits for the health system and for other health problems in low-income settings.

The way to achieve this cannot be a "one-size-fits-all" approach. The options and phasing for removing financial barriers need to be context-specific, and built into national plans. These plans are now being called for by the four[45] new major global actions relevant to MDG5. The Innovative Result-based Financing, for example, can provide a stimulus for tackling financial barriers to delivery and emergency obstetric care, with equity-sensitive indicators used to track progress.

It is important that these plans also mobilise interim funds whilst Governments seek to establish mechanisms for replenishing income lost from the abolition of user fees.

Immpact is now using evidence to help design strategic alternatives for reducing financial barriers in specific country contexts. We refer to these as FreeD strategies—a term which captures the primary aim—for women to be freed from the financial barriers to delivery and emergency care.

We urge DFID and other donors to prioritise FreeD strategies within and through the new international initiatives to catalyse progress towards MDG5.

4. *Question: How effectively DFID is working with recipient countries to resolve EmOC and HR issues?*

We sought a view on this from a senior colleague who was attached to the project for a year but who previously had been Deputy Director-General of the Ghana Health Service. The response is based in part on Immpact experience and in part on his and colleagues experience within the Ghana Health Service and Ghana Ministry of Health. The full report is included as an appendix, but the key messages in response to this question are:-

1) DFID has contributed about £7-10m annually to the programmes of work agreed with the Ghana Ministry of Health through flexible funding arrangements for the sector. However the release of funds has been unpredictable and erratic in recent times.

2) DFID closed its health office in Ghana without discussion. This has created a vacuum in the policy dialogue in Ghana. It has also deprived the health sector of good quality technical support in health as a whole and in dealing with MDG5 in particular.

3) DFID and other donors can support Ghana's effort at achieving MDG5 by:

(i) Providing more flexible funding especially as they move into multi-donor support.

(ii) Providing technical support for policy, human resource development, evaluation and research.

(iii) DFID especially can assist in exchange programs with NHS UK in service delivery support and training of skilled personnel.

(iv) DFID needs to revisit its policy of closing down its country office for health.

[45] International Health Partnership; Women and Children First; Catalytic Initiative to Save a Million Lives; Innovative Result-based Finance.

5. *Question: How achieving MDG5 is being prioritised and integrated into countries' overall health provision?*

Achievement of MDG5 is not simply a matter for Ministries of Health and health provision. The findings of our project are that education, nutrition, employment and transport all have major impacts on maternal health. The Public Services Agreement (PSA) approach by DFID in sub-Saharan Africa provides flexible funding where this is feasible, but the temptation to target resource through vertical initiatives, experienced by our Ghanaian colleagues, needs to be resisted by DFID and as far as DFID can influence them, by other donors.

6. *Question: How effectively DFID works with bilateral and multilateral donors, NGOs and other stakeholders to promote maternal health?*

DFID have provided very effective leadership through the substantial contribution of Dr Stewart Tyson as Chair of the group of Funders for this project which is an example of donors (the Bill and Melinda Gates Foundation, USAID and DFID) working together for maternal health.

We do observe, however, in working with DFID colleagues both in the UK and in developing countries that they are frequently overstretched by the volume and range of work they must undertake, so that their potential for providing leadership and influence cannot always be realised. The experience of our colleagues in Ghana where DFID interests are looked after by another national agency, demonstrates the dangers of this overstretch.

7. *Question: What leadership the UN is providing and how well{coordinated its agencies are?*

In our experience and opinion this has, and continues to be, a problematic issue for maternal health. The absence of a clear and unequivocal technical lead agency for this important target group has resulted in tensions and duplication of efforts at country and international levels. By comparison, the example of UNICEF's lead for child health shows what can be gained within and beyond the UN family by such clarity of mandate. The recent creation of the Partnership for Maternal, Newborn and Child health (PMNCH), on which the Immpact Principal Investigator sits as a Board Member, cannot be expected to provide leadership on maternal health, since its remit is the MNCH continuum. We understand that three agencies—WHO, UNICEF and UNFPA—are now being regarded as the triad of leaders within the UN. Our hope is that this succeeds, though history would suggest otherwise.

Appendices

1) Stopping Women dying during childbirth; how are the Commonwealth countries doing? (submission to Commonwealth govt conference, O. Campbell, W. Graham, Aug 07)

2) "Dear Minister"—an open letter to developing country ministers urging action on maternal health—Wendy 1graham and others, Reproductive Health Matters 2007; 15 (30)

3) Dying Mothers—from the evidence to political will—news article in Real Health News May 2007

4) Delivering Safer Motherhood—Sharing the Evidence—Policy Brief from Immpact February 2007.

5) Comments for the Committee from Dr Sam Adjei, former Deputy Director-General of the Ghana health Service and Dr Eddie Addai, Director of Policy, Planning, Monitoring and Evaluation for the Ministry of Health, Ghana

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Memorandum submitted by the Institute of Development Studies (IDS)

The Contribution of Unsafe Abortion to Maternal Mortality and Morbidity in Developing Countries

Context

Unsafe abortion is a particularly serious problem in many developing countries where abortion laws remain very restricted. While levels of morbidity and mortality due to unsafe abortion have fallen dramatically in developed countries, abortion-related mortality and morbidity are a major public health challenge in much of the world.[46] The WHO defines unsafe abortion as a: "procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both".[47] The abortion mortality rate is 0.2–1.2 per 100,000 abortions in countries where abortion is legal. The mortality rate in countries where abortion is penalized is 330 per 100,000.[48]

[46] Guttmacher Institute "Sharing Responsibility: Women Society and Abortion Worldwide" Michael Vlassoff "Economic Impact of Abortion Related Morbidity and Mortality: Modeling Worldwide Estimates"" Unpublished report for the Hewlett Foundation, 30 April 2006

[47] RJ Cook, BM Dickens and M Horga (2004). Safe abortion: WHO technical and policy guidance, International Journal of Gynecology and Obstetrics 86, p 80.

[48] Warriner IK and Shah IH, eds. (2006). Preventing Unsafe Abortions and its Consequences Priorities for Action and Research, New York: Guttmacher Institute, p vii.

Of the estimated 600,000 women who die each year from pregnancy-related causes, possibly one in eight is due to abortion related complications. Out of an estimated 46 million induced abortions that take place globally every year, around 19 million are considered unsafe in that they take place outside of the legal framework and are carried out by unregistered practitioners. About 5.2 million of these women are hospitalised for serious complications, while an unknown but possibly equal number of women suffer similarly serious complications but cannot obtain treatment. As a result, around 70,000 women die each year, making unsafe abortion the second leading cause of maternal mortality (at around 14% worldwide). This number has remained unchanged since 1990.

In 2000, the rate of unsafe abortion was higher in Africa and Latin America than in Asia. In Africa, 709 women die per 100,000 unsafe abortions, compared to 324 in Asia and 100 in Latin America. 5,000 women die each year as a result of complications from unsafe abortions in Latin America and the Caribbean.—more than 1/5 of all maternal deaths.[49] Nearly half of all deaths due to unsafe abortion occur in Africa, although Africa accounts for only 13% of all women of reproductive age in developing countries. The most impoverished women are the ones who have the least access to networks providing safe abortions in addition to not being able to afford them;[50] Though more and more unmarried women of adolescent age are getting abortions, the highest percentage of women seeking abortions are married women who already have several children.[51]

It is thought that about one-third of women undergoing unsafe abortions experience serious medical complications, yet fewer than half of these women receive hospital treatment. In Latin America, where abortion laws are highly restrictive but safe services are available in the major urban areas of some countries, four out of 10 women having abortions are estimated to experience complications.but only about two-thirds are believed to receive hospital treatment. In South and Southeast Asia, one-third of women having abortions are believed to experience complications, and more than half do not receive hospital treatment. Despite this, in some countries where abortion is illegal, as many as two out of every three maternity beds in large urban public hospitals are taken up by women hospitalized for the treatment of abortion complications. The problem is exacerbated by inequalities in access to services within countries. Even where abortion is generally against the law, better off urban women can often obtain safe abortions, whereas poor, rural women invariably use unskilled practitioners. Of these cases, many suffer long-term effects, including an estimated 1.5 million women who annually suffer secondary infertility as a result of induced abortion.

Unsafe abortion-related morbidity and mortality has effects on human welfare and productivity at the level of individuals, households, communities and the nation and particularly affects poorer and socially vulnerable populations. It is therefore a matter of importance for public policy. Some low income countries (eg Ghana and Nepal) have liberalised their laws in the recent past. There are indications that in a number of countries with highly restricted abortion legislation, there is growing openness to considering the public health arguments for liberalising laws. Part of the context for this is the Millennium Development Goal on maternal health. This is a very good moment for pressing home the public health arguments for liberalising abortion laws, for improving access to contraception to prevent unwanted pregnancies and for providing high quality post abortion care services.

There are also very strong economic arguments for preventing unsafe abortion. A meeting held at the Institute of Development Studies (UK) on 18–19 April 2007. and funded by the Hewlett Foundation, brought together experts on unsafe abortion and economists specialising in costing methods. The meeting reviewed recent work estimating the cost of unsafe abortion to the health sector. Two different methods were used to estimate the global costs to the health sector of unsafe abortions Participants also discussed the costs to individuals, households and the economy, and the links between unsafe abortion and poverty. Millions of women with serious post-abortion complications do not get treatment. This means that the costs to households and national economies of lost productivity due to abortion-related injury and death are considerable. There are also substantial costs in terms of orphaning of other children.

Key findings on global economic costs were:

— From cost-per-case surveys, the mean per-patient cost for post-abortion care lies between US$96 and US$131 (2005 US dollars). The global cost to health systems ranges from US$509 million to US$676 million.

— Using the "bottom up" costing method, global health system costs lie between US$677 million and US$1.08 billion.

— Regionally, Africa and Asia each have a 42% share of the total global cost, while Latin America and the Caribbean's share is around 14%.

— Per-patient treatment costs are substantially higher in southern Africa, eastern Africa and northern Africa.

[49] Olukoya, Peju (2004) Reducing Maternal Mortality from Unsafe Abortion among Adolescents in Africa African Journal of Reproductive Health, Volume 8,{Number 1, 1 April, pp 57–62(6)

[50] *Ibid*, p 6.

[51] WHO (2004). Unsafe abortion, Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000, Geneva: World Health Organization, p 5.

— These studies offer a conservative estimate of total costs to already overburdened developing country health systems. The economic impact of unsafe abortion is several times larger than estimated health system costs.

It can be concluded that unsafe abortion is diverting scarce health resources when safe, cost effective alternatives are available

In recent years, countries such as Nepal, have responded by liberalising abortion law. When accompanied by expanded access to safe services, such as in South Africa, this greatly reduces complications and deaths from unsafe abortion. Another promising trend is the increased use of new medical technologies such as mifepristone and misoprostel—the "abortion pill""—in very early pregnancy. These are an effective alternative to surgery and further reduce the risk of complications.

Key policy implications that emerged from the IDS meeting were:

— Health systems in low-income countries spend large sums treating complications from unsafe abortion despite the existence of cost-effective alternatives.

— Women need better access to contraceptive information and services to reduce unintended pregnancies and abortion (unsafe and safe).

— Where the law broadly permits abortion, safe services need to be expanded to further reduce women resorting to unsafe methods.

— Where the law is highly restricted, access to services for permitted criteria should be effective. Advocacy should highlight the unacceptable cost of unsafe abortion and the benefits of expanding the criteria for legal abortion.

— The quality and coverage of post-abortion care in developing countries need urgent improvement.

Memorandum submitted by the International Planned Parenthood Federation (IPPF)

Introduction

IPPF is a global service provider and a leading advocate of sexual and reproductive health and rights. We are a worldwide movement of national organizations working with and for communities and individuals in approximately 180 countries to deliver health care services and campaign for individual rights. From our "56,000 service delivery points, our Member Associations provided over 20 million contraceptive services and over 18 million other sexual and reproductive health services in 2006."[52]

IPPF works closely with DFID to advance sexual and reproductive health and rights around the world and we welcome this inquiry into the state of maternal health around the globe. While still insufficient, the increased international spotlight and consensus on addressing maternal health, partly as a consequence of the maternal health MDG, means that this is an opportune time to review and revise DFID's existing maternal health policy.

Our strategic relationship with DFID is mutually beneficial and based on a shared vision. We work together at this strategic level to try to help deliver the goals of the International Conference on Population and Development (ICPD) and the Millennium Development Goals (MDGs), particularly those related to poverty reduction and those relating to women's status and health. IPPF translates this shared strategic vision into action at the grassroots level.

Safe pregnancy and safe births are still pipe dreams for hundreds of thousands of women each year. Maternal deaths and ill-health, easily prevented in developed countries, continue to kill and harm women, undermining families, communities and societies, in some of the poorest countries in the world. Despite the fact that we know how to prevent these deaths we have failed to make significant progress in reducing maternal mortality and morbidity, especially in Africa and much of Asia. This failure is despite numerous international attempts to address these issues, including: the Safe Motherhood Initiative, the1995 Fourth World Conference on Women (Beijing), The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), United Nations General Assembly Special Session (UNGASS 2001 and 2006) and the World Summit outcome document of 2005.

In 1997 DFID launched a White Paper on "Eliminating World Poverty: A Challenge for the 21st Century".[53] Since 2000, DFID's determination to combat poverty has been closely aligned to the MDGs. This has included a special focus on MDG 5—"Improve Maternal Health"—which is essential to combating poverty. We applaud this determination to address women's health and combat poverty, and it is our hope that the new reproductive health target will provide a further incentive for reaching this goal.

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[52] IPPF, "At A Glance", p3 August 2007t

[53] See Eliminating World Poverty: A Challenge for the 21st Century, White Paper on International Development, Presented to Parliament by the Secretary of State for International Development by Command of Her Majesty November 1997, at www.dfid.gov.uk/Pubs/files/whitepaper1997.pdf [accessed 10 September 2007]

DFID's bilateral expenditure on programmes which contribute towards maternal health has increased from £172 million in 2002–03 to £243 million in 2004–05.[54] This has been used to tackle the "three delays" in maternal health, "the time taken to decide to get help, to get the help and for the help to actually be provided can make all the difference between life and death."[55]

However, it is also important to link these "three delays" to family planning and the ability to choose the number and spacing of children in order to save the lives and ensure the well-being of women and children. The important role of family planning in reaching MDG 5 is demonstrated through the proposed adoption of the new indicator on "Unmet need for Family Planning".

The role of bilateral donors in helping reach MDG 5 is crucial. This is because bilateral donors can:

- Influence regional donors.
- Help meet existing demand through supporting increases in supply; achieved through the funding of both recipient countries and multilateral agencies (such as the World Bank).
- Help stimulate new demand by supporting civil society interventions in terms of grassroots advocacy including Behaviour Change Communication (BCC), service delivery and supporting the development of new modalities of delivery.
- Influence recipient governments some of whom place a low priority on maternal health, evidenced by the fact that and do not even collect data.

Increasing international consensus on strategies to reduce rates of maternal mortality, including emergency obstetric care, care by skilled birth attendants and unmet obstetric need are timely and welcome. This consensus acknowledges that "without the ability to treat women with obstetric complications, maternal mortality cannot be substantially reduced."[56]

Each year over 529,000 women die in pregnancy or childbirth and for every woman who dies, roughly 20 more suffer serious injury or disability—between eight million and 20 million a year.[57] "Four out of five maternal deaths are the direct result of obstetric complications, most of which could be averted through delivery with a skilled birth attendant and access to emergency obstetric care."[58] The main causes of maternal death include: "severe bleeding, infection, consequences of unsafe abortions, hypertensive disorders such as pre-eclampsia and eclampsia, and obstructed labor (sic)". Other causes which contribute to maternal death include Sexually Transmitted Infections, "poverty, race, ethnic or tribal affiliation, or lack of education is also underlying causes of maternal death or disability."[59]

"In sub-Saharan Africa where maternal deaths are highest, fewer than 40% of women receive skilled assistance during childbirth."[60] Concurrent with this is the need to strengthen national health systems and human resource crisis.

Maternal mortality is also exacerbated by the lack of access to comprehensive sexual and reproductive health services, particularly family planning services, commodities and information. The WHO has stated that sexual and reproductive ill-health accounts for 17.8% of all Disability Adjusted Life | Years (DALYs). "But for women in their reproductive years (15–44), the burden of sexual and reproductive health conditions is far higher than any other category of illness, a full 31.8% of DALYs lost, of which sexually transmitted infections, including HIV, account for 16%. Maternal health conditions (death and disability resulting from pregnancy and childbirth) account for 12.4%. For women in Sub-Saharan Africa, the burden of sexual and reproductive health conditions is particularly alarming"[61] In some countries high rates of uterine prolapse (1:10) and fistula are a direct result early marriage and early childbirth.

If the unmet need for contraception were filled and women had only the pregnancies they wanted at intervals they choose, maternal mortality would reduce by up to 35% (Maine 1991; Daulaire and others 2002p 73).[62]

Currently, the unmet need for sexual and reproductive health, care, education, information and services is enormous. "One in three deaths related to pregnancy and childbirth could be avoided if women who wanted effective contraception had access to it."[63] Indeed, "it is notable that contraceptive prevalence is low in

[54] DFID, Factsheet, Maternal Health, November 2006

[55] DFID, Millennium Development Goals, Maternal Health, Improving healthcare for mothers and pregnant women at http://www.dfid.gov.uk/mdg/health.asp [accessed 11 September 2007]

[56] Lancet (2006) Meeting MDG 5: An impossible dream? Lancet 358, September 28 2006: 1133-1134.

[57] World Health Organization/United Nations Children's Fund, Maternal Mortality in 2000: Estimates developed by WHO, UNICEF, UNFPA. See UNFPA, Reproductive Health Fact Sheet at http://www.unfpa.org/swp/2005/presskit/factsheets/facts_rh.htm [accessed 10 September 2007]

[58] Facts about Safe Motherhood, UNFPA at http://www.unfpa.org/mothers/facts.htm [accessed 07 August 2007]

[59] WHO. 1999. "Reduction of maternal mortality. A joint WHO/UNFPA/UNICEF/World Bank statement." Cited at USAID Maternal and Child Health at http://www.usaid.gov/our—work/global—health/mch/mh/faqs.html£neonatal [accessed 12 September 2007]

[60] Facts about Safe Motherhood, UNFPA at http://www.unfpa.org/mothers/facts.htm [accessed 07 August 2007

[61] Millennium Project, Task Force on Child and Maternal Health, Who's got the power? Transforming health systems for women and children, Earthscan (2005) at http://www.unmillenniumproject.org/documents/maternalchild-complete.pdf [accessed 11 September 2007]

[62] Who's got the power? Transforming health systems for women and children, Millennium Project, 2005

[63] Facts about Safe Motherhood, UNFPA at http://www.unfpa.org/mothers/facts.htm [accessed 07 August 2007]

countries with high maternal mortality".[64] Without access to family planning and modern contraceptive services women will continue to die as a result of unwanted pregnancies. UNFPA estimates "that meeting the existing demand for family planning services would reduce maternal mortality and morbidity alone by at least 20%."[65] "Globally, coverage of contraception is 61%, whereas unmet need for contraception ranges from 6% in Europe to 23% in sub-Saharan Africa. Forty one per cent of pregnancies globally are unwanted, with 22% resulting in induced abortion. These data suggest that between a quarter and two-fifths of maternal deaths could be eliminated if unplanned and unwanted pregnancies were prevented."[66] As a result, there is a strong need to invest in comprehensive sexual and reproductive health programmes and commodity services if MDG 5 is to be reached.

IPPF believe that DFID is in an ideal position to advocate on maternal health at the country, regional and global levels. This is because DFID is recognised as a leading proponent of maternal health by the international community. Indeed, DFID is "the only major bilateral donor to have a strategy specific to improving maternal health".[67] DFID's leadership in this field can be used to galvanize other donors and recipient governments to prioritise sexual and reproductive health in national health plans and international policy commitments to achieve MDG 5.

Q1 *How donors—and DFID specifically—can catalyze progress towards MDG 5*

1.01 The latest progress report by the United Nations shows that Millennium Development Goal 5 (MDG 5)—to "improve maternal health" by 2015—is unlikely to be reached.[68] The report shows that the Goal's target of "reducing maternal mortality by three quarters" is classified as "no progress, or a deterioration or reversal"[69] in progress in the regions where maternal mortality is most acute; those of Southern Asia and Sub-Saharan Africa.

1.02 The adoption in 2006 of a new target under Millennium Development Goal 5 (MDG) was welcomed by those of us that understand the role and importance of sexual and reproductive health and rights for reducing poverty. The new target—"universal access to reproductive health" should be seen by the international community as an acknowledgement of the fact that access to reproductive health care and services saves lives and reduces poverty. In addition, reproductive health's centrality to development is evidenced by the fact that it impacts on each of the eight MDGs—as well as the overall goal of reducing poverty by half by 2015.[70]

1.03 However, the apparent lack of acknowledgement of the new target by many governments, despite the 2005 outcome document, the Millennium Project Report and the previous Secretary General's recommendation, the failure by the international community to agree on the target's indicators, and the failure to reach the political consensus required to prioritize reproductive health at the global level remain a serious concern.

1.04 Progress towards MDG 5 will only be catalyzed when countries see health as a priority and integrate sexual and reproductive health into national health plans and budgets. In Abuja in 2001, African countries committed themselves to allocating fifteen per cent of their expenditure to the health sector—only two have achieved this. DFID is in a position to encourage recipient countries to recognize the value of such investment. And when, women, men and young people have control over their own bodies, and therefore their destinies; are free to choose parenthood or not; are free to decide how many children they'll have and when; are free to pursue healthy sexual lives without fear of unwanted pregnancies and sexually transmitted infections, including HIV; and where gender or sexuality are no longer a source of inequality or stigma"[71].

1.05 In addition, action at the local, national, regional and global levels needs to be taken. In order for women to safeguard their health, women need access to comprehensive sexual and reproductive health care and services. These services need to be supported by rights giving access to such services that are enshrined in national laws. At present, however, this appears a long way off. This is because unsafe abortion still

[64] Annex 9.6, The important issues in developing a national plan on maternal mortality reduction, Dr Pang Ruyan, Regional Adviser, MCH/FP/WPRO, at http://www.who.int/reproductive-health/publications/RHR_02_2/ax6.pdf [accessed 06 September 2007]

[65] Women's Health and Empowerment: A Key to a Better World, Statement by Thoraya Ahmed Obaid, Executive Director, UNFPA, Monterey, California, USA, 12 May 2003, at http://www.unfpa.org/news/news.cfm?ID=343&Language=1 [accessed 06 August 2007]

[66] Strategies for reducing maternal mortality: getting on with what works, Oona MR Campbell, Wendy J Graham, on behalf of The Lancet Maternal Survival Series steering group, The Lancet—Vol. 368, Issue 9543, 7 October 2006, Pages 1284-1299 at www.thelancet.com/journals/lancet/article/PIIS014067360669853X/fulltext [accessed 08 September 2007]

[67] DFID's Maternal Health Strategy Reducing maternal deaths: evidence and action Second Progress Report, point 16, April 2007

[68] Millennium Development Goals: 2007 Progress Chart at www.un.org/millenniumgoals/pdf/mdg2007-progress.pdf [accessed 01 August 2007]

[69] Millennium Development Goals: 2007 Progress Chart at www.un.org/millenniumgoals/pdf/mdg2007-progress.pdf [accessed 01 August 2007]

[70] See MDGs and Reproductive Health at http://www.unfpa.org/icpd/mdgs-rh.htm [accessed 06 August 2007]

[71] IPPF Strategic Framework, 2005–15, at http://www.ippf.org/en/Resources/Reports-reviews/Strategic+Framework+2005-2015.htm

accounts for 13% of all maternal deaths,[72] while four out of five maternal deaths are the direct result of obstetric complications, most of which could be averted through delivery with a skilled birth attendant and access to emergency obstetric care. It is estimated that accessible and effective family planning and contraceptive services would avert up to 35% of maternal deaths.[73]

1.06 It is also important to invest in women's education and empowerment and to eliminate gender based violence (GBV) and violence against women (VAW). High levels of such violence lead to unplanned pregnancy, abortion and maternal mortality. Likewise, violence during pregnancy can lead to maternal mortality.

1.07 Therefore, maternal health needs:

— to be prioritised as a development concern at the global, regional and national levels by the international community, including both donor and recipient countries.

— The political will for addressing maternal health at the national, regional and global levels needs to be increased. This will only happen through sustained high level advocacy that involves the participation of donors, recipient countries and civil society organizations.

— Political will needs to be translated into increased financial commitments by donors and targeted specifically at tackling maternal ill-health. According to the World Health Organisation (WHO) the amount needed to be spent on child and maternal healthcare needs to increase to US$9 billion US dollars annually if the Millennium Goals are to be realized by the 75 countries with the highest mortality rates."[74]

1.08 Despite the best efforts of DFID and a number of donor and recipient countries to improve maternal health, intensive political advocacy and an increase in funding will be necessary to attain this goal. For example, additional funding and / or advocacy will be required to:

— Strengthen health systems. DFID already supports the strengthening of developing country health systems as is witnessed in its health strategy.[75] However, if for example, DFID worked in collaboration with the European Commisison or the World Bank to ensure that infrastructure projects met with the health and education needs of a country as well as economic needs, the investment would have a much broader impact. In many developing countries, years of under investment "have rendered local hospitals, clinics, laboratories, medical schools, and health talent dangerously deficient."[76] If maternal health is to be given the priority it deserves there needs to be a dramatic increase in the number of trained and retained health care providers with midwifery and emergency obstetric skills. This will only occur once health systems are strengthened and receive greater investment.

— Ensure access to client centred rights based services. Ensuring rights-based approaches are integrated into services is essential if maternal health is to be improved.

— Advocate for an end to child marriage—which has a high impact on maternal mortality and maternal morbidity. Likewise, increase funding for adolescent health.

— Provide / increase training for health professionals including NGO staff and volunteers distributors.

— Encourage and/or fund community and school education that includes information on comprehensive sexuality education or life skills. In Uganda, the total fertility rate (TFR) is 7.1.[77] Large families are seen as a benefit to the community but often leave women too exhausted to be productive. Uganda also has very high maternal and infant mortality rates.

— Increase access to sexual and reproductive health commodities. IPPF Member Associations play a key role in these areas by providing sexual and reproductive health information, contraceptives, safe delivery services and where they are unable to provide safe delivery services, referrals to hospitals and medical centres with skilled health care personnel.

— Increase the number of deliveries attended by skilled health care personnel. Skilled attendance at births is considered to be the single most critical intervention for ensuring safe motherhood.[78]

— Continue to Fund specific health interventions in countries where access to certain health services is limited or denied. This can include for example, access to safe and legal abortion services.

[72] IPPF, Advocating for the right to safe abortion services, at http://www.ippf.org/en/What-we-do/Advocacy/Advocating+for+the+right+to+safe+abortion+services.htm accessed 11 September 2007]

[73] IPPF, Advocating for the right to safe abortion services, at http://www.ippf.org/en/What-we-do/Advocacy/Advocating+for+the+right+to+safe+abortion+services.htm accessed 11 September 2007]

[74] NORAD, "Saving the lives of mothers and children" at http://www.norad.no/default.asp?V—ITEM—ID=7824 [accessed 03 August 2007]

[75] DFID, Working together for better health,

[76] "The Challenge of Global Health", Foreign Affairs, Laurie Garrett, January/February 2007 at http://www.foreignaffairs.org/20070101faessay86103/laurie-garrett/the-challenge-of-global-health.html [accessed 30 July 2007]

[77] UNICEF, Uganda, Statistics at http://www.unicef.org/infobycountry/uganda_statistics.html [accessed September 2007]

[78] UNFPA, Skilled Attendance at Birth at http://www.unfpa.org/mothers/skilled_att.htm [accessed 11 September 2007]

— Increase Investment in non-governmental organizations. This is because NGOs often have considerable expertise and reach and are able to work in areas that governments cannot.

— Increase funding for emergency support, such as in crisis and conflict settings. Syria, for example, is currently home to 1.4 million refugees from Iraq[79], while the conflict in northern Uganda has resulted in 1.6 million internally displaced people. In these circumstances, meeting the needs of refugee and IDP communities strains existing services and impacts upon the ability of service providers to continue to meet the needs of clients.

1.09 DFID is in an ideal position to advocate on maternal health at the country, regional and global levels and is seen as a leader in this field, being "the only major bilateral donor to have a strategy specific to improving maternal health".[80] DFID can and should galvanize other donors and recipient governments to prioritise sexual and reproductive health including family planning in national health plans so that MDG 5 can be achieved.

1.10 The new aid architecture and "country ownership" raises specific issues and problems for recipient countries. This is because funding is not targeted at specific (usually high-profile) health interventions; this could result in less visibility for donors with a result that some donors may consider investing less in lower profile activities such as family planning.

1.11 DFID's support for MDG 5 is apparent. It supports the Global Campaign on Health MDGs which includes the International Health Partnership, and other initiatives such as that by the Norwegian Government on MDG 4 and 5. It also supports the Partnership for Maternal, Newborn, Child Health etc which prioritises advocacy for maternal health. In addition, DFID has increased its bilateral expenditure on programmes that contribute towards maternal health by 34% between 2002 and 2005.[81]

Q2 *How effectively DFID is working with recipient countries to make emergency obstetric care available and to ensure that adequate numbers of skilled birth attendants and other staff are being trained to meet MDG 5, and are integrated within a robust health system*

2.01 "Four out of five maternal deaths are the direct result of obstetric complications, most of which could be averted through delivery with a skilled birth attendant and access to emergency obstetric care."[82] "In sub-Saharan Africa where maternal deaths are highest, fewer than 40% of women receive skilled assistance during childbirth."[83] It should be noted that age can be an important factor in maternal mortality. Pregnancy is the leading cause of death for young women aged between 15 and 19.[84] This age group is twice as likely to die during pregnancy or child birth as those over 20. In Afghanistan 40% of girls are married before they reach the age of 18.[85] Girls under the age of 15 meanwhile are five times as likely to die.[86]

2.02 Maternal mortality can be said to be rooted in a combination of three factors: a lack of access to family planning services and information, a lack of access to skilled health care personnel during pregnancy and a lack of access to emergency obstetric care in case of complications. Each of these is prevalent in health systems that are weak. However, other considerations must be taken into account. These include: a shortage of funds for the purchase of reproductive health supplies (including family planning commodities); weak distribution, supply chain and management processes in many developing countries.[87] In addition, there are a range of social and cultural considerations that prevent women from attending hospitals (transportation issues and distance to health service facilities etc), gender bias that curtail or limit a woman's capacity to seek health care when complications arise. Likewise, consideration must be given to the impact of: Stockouts: due often to funding shortages for supplies; Procurement/Logistics problems: including getting supplies from central warehouses to districts, forecasting challenges; Unmet Need: political/socio-cultural and economic challenges, supplies not being included as a part of budget lines, a reduction in donor funding, increased demand for services.[88]

2.03 There are a number of reasons why health systems are weak. These include chronic underinvestment and a lack of priority being afforded to health by national governments. Likewise the number of skilled health care providers may be low because of a variety of factors such as: conflict; HIV and AIDS; low salaries; poor working conditions—each of which can lead to health sector workers migration weakening

[79] Syria assures UN it will not forcibly deport Iraqi refugees under new visa system, 14 September 2007, UN News Centre at http://www.un.org/apps/news/story.asp?NewsID=23683&Cr=Iraq&Cr1= [accessed 14 September 2007]

[80] DFID's Maternal Health Strategy Reducing maternal deaths: evidence and action Second Progress Report, point 16, April 2007

[81] DFID, Maternal Health, Improving healthcare for mothers and pregnant women at www.dfid.gov.uk/mdg/health.asp [accessed 05 Sept 2007]

[82] Facts about Safe Motherhood, UNFPA at http://www.unfpa.org/mothers/facts.htm [accessed 07 August 2007]

[83] Facts about Safe Motherhood, UNFPA at http://www.unfpa.org/mothers/facts.htm [accessed 07 August 2007

[84] UNFPA (2004). State of World Population, 2004; http://www.unfpa.org/swp/2004/english/ch9/page5.htm; accessed 14 September 2007.

[85] UNFPA Ibid

[86] Advocates for Youth: Adolescent Maternal Mortality: An Overlooked Crisis at www.advocatesforyouth.org/PUBLICATIONS/factsheet/fsmaternal.pdf [accessed 14 Sept 2007]

[87] For further information see the T2 Initiative—Interpreting the Total Market Approach, ICON

[88] For further information see the T2 Initiative—Interpreting the Total Market Approach, ICON

health systems even further. However, under investment and a lack of priority is not confined to the health sector alone. In many developing countries health systems, transport, housing, sanitation, education and other basic social infrastructure has been neglected meaning that governments often face a number of competing priorities.

2.04 The migration of Malawian health workers had a major impact on its health system as can be seen from the table below.[89] Migration here led to a near doubling of its maternal mortality ratio between 1992 and 2000.[90] Indeed, Malawi which has a population of 12 million has only 250 doctors.[91]

Table 2

TOTAL OUTPUT AND NUMBER OF CADRES EMIGRATING, MALAWI, 1993–2002[17]

Cadre	*Total Graduates*	*Number emigrating*	*% of total*
Obstetrcian—gynaecologists	5	1	20
General practitioners, medical officers	164	14	9
Registered nurse—midwives	209	166	79
Registered nurses	445	167	38
Enrolled nurses	1,200	19	2

2.05 IPPF welcomes DFID's renewed focus on health system strengthening as is illustrated in DFID's health strategy. To help strengthen the health system and reduce maternal mortality in Malawi, DFID is providing £100 million over a period of six years (2005–11) to deliver an Emergency Human Resources Programme (£55 million)[92], this has three main elements:

— improving incentives for recruitment and retention of Malawian staff through salary increases for 11 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.[93]

2.06 As a result, there has been a significant decline in the number of nurses leaving the country to work abroad. Meanwhile in Uganda, DFID funding has helped train 3,000 health workers.[94] DFID also supports increased emergency obstetric care in a number of countries including Nigeria, Zimbabwe, India and Bangladesh.[95] DFID has also been present at a number of key international meetings and conferences to discuss ways forward on sexual and reproductive health care including emergency obstetric care, such as in Mozambique for the Maputo Plan of Action for the operationalisation of the continental policy framework for sexual and reproductive health and rights 2007–10. It is also a member of the Nordic plus countries who are working to enhance aid effectiveness.

2.07 In addition, the UK government's policy of not actively recruiting healthcare workers from the developing world for the National Health Service (NHS) should be applauded. "A list of countries, including all those in sub-Saharan African, has been drawn up by DFID and the Department of Health, to ensure the NHS does not "poach" doctors and nurses that are needed elsewhere. In addition, the Department of Health has secured a groundbreaking agreement for this code to apply to many private healthcare providers so they too do not recruit staff from the world's poorest countries."[96] Advocacy for the implementation of such a policy needs to be directed at other wealthy countries whose health systems use skilled health workers from developing countries. The practice of poaching skilled staff is also a problem for many NGOs, when staff, often trained by the NGO, are poached by better funded agencies, such as those of the United Nations or large donor initiatives such as PEPFAR.

2.08 A much greater emphasis needs to be placed on promoting maternal health. Health promotion and prevention programmes can be promoted through schools, the media, NGOs, and the primary health care system. Programmes that provide education, family planning services, and pre-and postnatal care among young women must be developed.

[89] Table from: Malawi Institute of Management. The Migration of Health Workers in the African Region: the Malawi Scenario. Lilongwe7 University of Malawi, 2003.cited in The Implications of Shortages of Health Professionals for Maternal Health in Sub-Saharan Africa by Nancy Gerein, Andrew Green and Stephen Pearson, 2006 Reproductive Health Matters

[90] See DFID's Maternal Health Strategy Reducing maternal deaths: evidence and action Second Progress Report April 2007

[91] PM Gordon Brown speech to the United Nations, New York, 31 July 2007 at www.number-10.gov.uk/output/Page12755.asp

[92] See DFID's Maternal Health Strategy Reducing maternal deaths: evidence and action Second Progress Report April 2007

[93] See DFID's Maternal Health Strategy Reducing maternal deaths: evidence and action Second Progress Report April 2007

[94] DFID Uganda, Health, August 2007 at www.dfid.gov.uk/pubs/files/uganda-factsheet.pdf [accessed 07 September 2007]

[95] See DFID's Maternal Health Strategy Reducing maternal deaths: evidence and action Second Progress Report April 2007

[96] UK helping to slow down "brain drain" that costs African lives at "News" http://www.dfid.gov.uk/news/files/world-health-day-2006.asp [accessed 05 September 2007]

2.09 However, health system strengthening should not be reliant on donors alone. Recipient countries need to prioritise the strengthening of their own public health care systems. This can be achieved through prioritising expenditure on health within national budgets.

2.10 Despite weak health systems, greater encouragement needs to given for women to give birth in hospitals where medical interventions can save their own and their child's life if complications arise. Outside hospitals, many women rely on Traditional Birth Attendants (TBAs), but they are not a substitute for skilled health care personnel. A project paying TBAs to refer women to hospital, implemented by DFID in Malawi, has proven successful in addressing this issue, with the hospital reporting a "30% increase in antenatal visits, and a 44% increase in deliveries."[97]

2.11 Donor financing also needs to become more sustainable and predictable. Often donor government priorities will change according to which political party is in power. Thus elections thousands of miles away can have a serious impact on the provision of maternal health care in a recipient country. This can only be avoided through a commitment by donors to long term predictable investment. This will assist recipient countries in their planning and allocation of funds for health system strengthening and allow them to budget over the long term. Without such predictability, long term planning will be constantly interrupted in the quest for short term solutions by donors and governments' alike and maternal health will continue to remain a distant priority. Likewise, longer-term and predictable funding for NGOs is also required.

Q3 *The steps DFID is taking to mainstream maternal health across related policies*

3.1 DFID has taken a number of steps to mainstream maternal health and works effectively and in partnership with a number of donors and civil society organizations. DFID supports the advocacy focussed Partnership for Maternal, Newborn and Child Health (PMNCH) and has given its support, along with that of the Gates Foundation, to the Norwegian government's 2006 initiative to accelerate progress on MDGs 4 and 5. This initiative seeks to advance gender equality and improve the health of women and children by increasing focus on maternal health at a high level politically. It does this through forming "partnerships with other political leaders and to build global alliances to ensure a marked reduction in child and maternal mortality by 2015".[98] Global alliances created through partnerships help highlight and raise awareness about an issue and help prioritize and focus attention at the national level.

3.2 DFID also supports the Safe Motherhood Initiative (SMI), now in its 20th year. The SMI works at the community level to build "demand for maternity services, encouraging local women to use the safer option of hospital births, as well as providing quality nursing care, medical equipment and all-important transportation to the hospitals."[99] Following on from the SMI was the creation of an Inter-Agency Group (IAG) for Safe Motherhood, which was joined and supported by IPPF amongst others. Under the SMI, programmes have been developed to reduce the number of maternal deaths. "The strategies adopted to make motherhood safe vary among countries and include: providing family planning services; providing post-abortion care; promoting antenatal care; ensuring skilled assistance during childbirth; improving essential obstetric care and; addressing the reproductive health needs of adolescents."[100]

3.3 The UK government has also co-launched the Global Campaign for the Health Millennium Development Goals and will be taking the lead on the International Health Partnership which will help agencies work together more effectively to deliver aid to reach MDGs 4, 5 and 6. Likewise DFID is also supporting the Women and Children First initiative (previously called the Global Business Plan) under the Global Campaign.

3.4 DFID has also attempted to mainstream maternal health across other related policies such as HIV and AIDS. AIDS is, according to the Lancet, "the largest cause of maternal death in some parts of Sub-Saharan Africa"[101] and thus mainstreaming maternal health is essential if we are to address preventable maternal deaths. Likewise, DFID is mainstreaming SRHR and gender equality with maternal health—seen in their health strategy "Working together for better health".

Q4 *How achieving MDG 5 is being prioritized and integrated into countries' overall healthcare provision*

4.1 It is hoped that the recently launched Global Campaign for the Health MDGs will provide a significant step forward in tackling MDG 5 which at present is unlikely to be reached by 2015. The campaign commits to addressing problems that are preventing progress being made strengthening healthcare systems

[97] DFID, Giving birth the safer way in Malawi, July 10 2007, at http://www.dfid.gov.uk/casestudies/files/africa/malawi-birth.asp [accessed 11 September 2007],

[98] NORAD, "Saving the lives of mothers and children" at http://www.norad.no/default.asp?V_ITEM_ID=7824 [accessed 03 August 2007]

[99] DFID, Saving mothers' lives in Northern Nigeria, 09 May 2007, at http://www.dfid.gov.uk/casestudies/files/africa/nigeria-saving-mothers-lives.asp [accessed 07 August 2007]

[100] RHO Archives, Safe Motherhood, Overview and Lessons Learned at http://www.rho.org/html/sm_overview.htm [accessed 07 August 2007]

[101] Lancet (2006) cited in DFID's Maternal Health Strategy, Reducing Maternal Deaths: evidence and action, Second progress report, DFID, (April 2007)

and simplifying existing systems at the national level for planning and coordinating activities for tackling this goal. The Campaign has been signed up to by eight bilateral donors, seven developing countries and nine international organisations amongst others.

4.2 The global campaign is comprised of four separate, yet inter-related initiatives—1) the "Women and Children First" initiative (being led by Norway, driven by civil society and coordinated by the PMNCH). This initiative seeks through increased advocacy to strengthen political commitment for health focussed reforms designed to assist women and children, 2) the "catalytic initiative to save a million lives" (being led by Canada). This initiative seeks to tackle weaknesses in local health services by facilitating access to services integrated into national health plans, 3) the "Innovative results based finance" initiative (being led by Norway) which will focus attention on evaluating the most cost-effective approaches for achieving the health MDGs, and 4) The international health partnership (being led by the UK).[102] This initiative is supported by major health agencies and foundations as well as numerous donor governments. The aim of the IHP is to "to make health cooperation work better for developing countries by: focusing on improving health systems as a whole, not just on individual diseases or issues; providing better coordination among donors; and developing and supporting countries' own health plans."[103]

4.3 The integration of the IHP into the overall global campaign is an attempt to put the Paris Declaration on aid effectiveness into practice in the health sector. One potential problem of the IHP is that coordination, as envisaged in the Paris Declaration, has not been the easiest of agendas to adopt. This is because some donors while agreeing in principle to coordination and harmonization still like to fund their own health priorities. Thus, coordination of funding and priorities could be difficult to achieve. Another potential problem lies in the fact that the two largest donors (the United States and Japan) are yet to sign up to this initiative.

Q5 *How DFID is supporting the 2006 recommendation by the UN General Assembly for an MDG target for universal access to reproductive health*

5.1 DFID has fully supported the 2006 recommendation of the UN General Assembly for the new target and has spoken out at the UN, the EU and other important arenas. While DFID has been vociferous in its support of the new target, and is seen by many as one of the target's leading proponents, further political advocacy is required to ensure the UK and other member states in favour of the target gain the support of other influential member states. The support of progressive member states such as the Nordic countries are welcome but a wider support base will be required.

Q6 *The progress being made in reducing maternal deaths from unsafe abortion (which account for 13% of all maternal deaths)*

6.1 An estimated 46 million abortions take place globally every year and of these, 19 million are considered unsafe[104]; every year over 67,000 women die from unsafe abortion[105] and nearly all of these occur in the developing world. Unsafe abortion is "one of the most neglected health care issues in Africa"[106] and approximately 90% of global abortion-related deaths and disabilities could be avoided if women who wanted effective contraception had access to it."[107]

6.2 The causes and consequences of unsafe abortion are some of the most neglected global public health and human rights issues.[108] This is because it is deemed controversial by many donors and recipient governments, including the largest donor the United States which refuses to support reproductive health policies that include abortion. It does this through the Global Gag Rule which prohibits U.S. family planning assistance from being provided to foreign non-governmental organizations that use funding from other sources to counsel, refer or perform abortions in cases other than a threat to the woman's life, rape or incest. Since 2001 the current US administration has refused to fund international sexual and reproductive health NGOs that advocate for a woman's right to access safe, legal abortion or who work to address unsafe abortion . This has seen a significant cut in family planning provision and sexual and reproductive health services in some of the neediest countries. DFID and other donors have attempted to breech this funding gap and to increase funding for NGOs working on reducing maternal mortality from unsafe abortion.

[102] For further information see DFID: The International Health Partnership Launched Today,5 September 2007, www.dfid.gov.uk/news/files/ihp/default.asp [accessed 12 September 2007]

[103] See: The Global Campaign for the Health Millennium Development Goals, Sept 2007, at www.dfid.gov.uk/news/files/ihp/compact.pdf [accessed 11 September 2007]

[104] World Health Organization (2005) "World Health Report 2005: Make Every Mother And Child Count" Geneva: WHO (pp xxi) available at www.who.int/whr/2005/whr2005_en.pdf [accessed 07 August 2007]

[105] World Health Organization (WHO), Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2000, 4th ed. (2004) cited on Population reference Bureau Unsafe Abortion: Facts & Figures 2006 at http://www.prb.org/Reports/2006/UnsafeAbortionFactsandFigures2006.aspx [accessed 07 August 2007]

[106] The Magnitude of Abortion complications in Kenya, International Journal of Obstetrics and Gynaecology cited in and Denial: Unsafe Abortion and Poverty, IPPF (2006)

[107] Facts about Safe Motherhood, UNFPA at http://www.unfpa.org/mothers/facts.htm [accessed 07 August 2007]

[108] The UK, Nordic countries and Dutch are strong on the issue of unsafe abortion

6.3 It should be noted that while some donor nations such as the UK, Denmark, Norway, Sweden, and Switzerland are committed to reducing maternal deaths from unsafe abortion through targeted initiatives, others are not. This is due in part to abortion being regarded as a controversial issue. DFID is committed to and funds organizations that work on abortion related issues, including IPPF.

6.4 DFID's determination to halt unsafe abortion is most clearly seen through its support of the Safe Abortion Action Fund (SAAF) administered by IPPF. We administer the SAAF on behalf of donors to support civil society groups and non-governmental organizations and have to date awarded $11.1m in grants to non-governmental organizations in 32 different countries to fund 45 two-year projects dedicated to advocacy, operations research and/or service delivery.[109]

6.5 DFID has advocated for other donor governments to commit towards the SAAF and should continue to do so by highlighting the role that access to safe abortion plays in reducing maternal death. DFID should continue to fund and increase its funding for the SAAF given the fact that we received in excess of 130 proposals—testament to the size of the need.

Q7 *How effective family planning is being promoted as a way to improve maternal health*

7.01 Family planning prevents unintended pregnancies, many of which are unwanted. Unwanted pregnancies lead to abortion, many of which are unsafe in the developing world. Unsafe abortion is a leading cause of maternal death and ill-health. Family planning is critical to improving maternal health and needs to be a key strategy at the national and international levels to reduce unsafe abortion and maternal mortality. DFID is a key supporter of family planning.

> "I well recognise that it is important to keep family planning at the heart of development policy".[110]

7.02 DFID is working with key governments, decision-makers and agencies to promote family planning. It is doing this through a variety of actions:

(1) advocacy initiatives such as the Partnership for Maternal, Newborn and Child Health (PMNCH) and the recently launched Global Campaign for the Health MDGs.

(2) DFID advocates with UN agencies and other key donors and advocates on individual advocacy actions (see below)

(3) DFID has increased its funding for a number of NGOs including IPPF that provide reproductive health care services and commodities.

(4) There are many examples of DFID's work on family planning around the globe. For example, In Pakistan, DFID has contributed £90 million to a project where the aim is to save the lives of 30,000 women. It will do this through the training of community based midwives, the provision of better family planning services and training of skilled staff to deliver babies safely in an emergency.[111]

(5) Likewise, DFID is a member of the Reproductive Health Supplies Coalition (RHSC) which was set up to "provide global leadership in making essential reproductive health products available to developing and transitional countries." Established in 2004 it brings together diverse agencies and groups that play a critical role in providing contraceptives and other RH Supplies. Its members include: multilateral organizations; institutional donors; foundations and non-governmental organizations.[112]

7.03 Despite an increase in funding from DFID for IPPF and UNFPA (the two key agencies working to promote family planning) the current "unmet need" for sexual and reproductive health, care, education, information and services is enormous. "One in three deaths related to pregnancy and childbirth could be avoided if women who wanted effective contraception had access to it."[113] Indeed, "it is notable that contraceptive prevalence is low in countries with high maternal mortality".[114] Without access to family planning and modern contraceptive services women will continue to die as a result of unwanted pregnancies.

7.04 UNFPA estimates "that meeting the existing demand for family planning services would reduce maternal mortality and morbidity alone by at least twenty per cent."[115] As a result, there is a strong need to invest in comprehensive sexual and reproductive health programmes and commodity services if MDG 5 is to be reached.

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[109] IPPF, "Safe Abortion Action Fund awards $11.1 million to reduce unsafe abortion" at http://www.ippf.org/en/What-we-do/Abortion/Safe+Abortion+Action+Fund+awards+111m+to+reduce+unsafe+abortion.htm [accessed 03 August 2007]

[110] Baroness Royall of Blaisdon, House of Lords debates, Monday, 9 July 2007, Africa: Family Planning, at http://www.theyworkforyou.com/lords/?id=2007-07-09a.1225.0&m=100222 [accessed 12 September 2007]

[111] See Gareth Thomas MP, PUS DFID cited on DFID News Press Release "UK promises £90 million to cut deaths of pregnant women and young children in Pakistan" at http://www.dfid.gov.uk/news/files/pressreleases/90million-pakistan.asp [accessed 12 September 2007]

[112] For further information see: Reproductive Health Supplies Coalition at http://www.rhsupplies.org/coalition/about.shtml

[113] Facts about Safe Motherhood, UNFPA at http://www.unfpa.org/mothers/facts.htm [accessed 07 August 2007]

[114] Annex 9.6, The important issues in developing a national plan on maternal mortality reduction, Dr Pang Ruyan, Regional Adviser, MCH/FP/WPRO, at http://www.who.int/reproductive-health/publications/RHR_02_2/ax6.pdf [accessed 06 September 2007]

[115] Women's Health and Empowerment: A Key to a Better World, Statement by Thoraya Ahmed Obaid, Executive Director, UNFPA, Monterey, California, USA, 12 May 2003, at http://www.unfpa.org/news/news.cfm?ID=343&Language=1 [accessed 06 August 2007]

7.05 Clearly, effective family planning needs to be promoted as a key way in which maternal health can be improved. However, it can only be improved once reproductive health commodity security is guaranteed. It should also be noted that the disparity in supply of reproductive health services between rich and poor nations is considerable. The risk of a woman dying as a result of pregnancy or childbirth during her lifetime in the developing world is considerably greater than that of a woman from a wealthy nation. In the United Kingdom one in 3,800 women[116] are likely to die as a result of pregnancy or childbirth. In Afghanistan and Sierra Leone, this figure is one in seven.[117]

7.06 IPPF targets unmet contraceptive need by prioritizing its services for the poorest and most marginalized communities with least access to services and information. From our "56,000 service delivery points, our Member Associations provided over 20 million contraceptive services and over 18 million other sexual and reproductive health services in 2006."[118] B[1]ut there is still much more to be done.

7.07 The effective delivery of sexual and reproductive healthcare requires reliable access to essential products and commodities. Without appropriate choices, agreed upon at the ICPD in 1994 as universal access by 2015 to the widest possible range of safe and effective family planning methods, or the necessary quantity of commodities, sexual and reproductive health programmes will fail. The lack of adequate supplies in many countries is a result of funding and supply shortfalls. However, other problems exist which increases the level of unmet need, including:

1. "Inadequate forecasting of supply needs
2. A lack of adequate distribution systems in-country
3. Regulatory, tariff and tax barriers that hinder the importation and provision of supplies by the public and private sector
4. Inefficient use of public funds
5. Duplication of efforts and/or inadequate coordination among donors, governments, NGOs and other agencies in relation to commodity funding and delivery."[119]

7.08 IPPF, and its subsidiary ICON, provides US$25 million in reproductive health commodities each year to more than 100 countries. IPPF is also a founding member of the Reproductive Health Supplies Coalition (RHSC)[120], "a partnership designed to provide global leadership in making essential reproductive health products available to developing and transitional countries. DFID's initial leadership of the RHSC helped prioritise access to essential supplies in developing and transitional countries. It remains a member of the RHSC. IPPF is also a member of the RHSC Systems Strengthening, Resource Mobilization/ Advocacy, and Market Development Approaches Working Groups, working within the RHSC to:

1. Promote the efficient and effective use of existing, limited resources by improved coordination and harmonization of RH supply programmes;
2. Encourage innovation among the public, private and commercial sectors to develop markets for RH supplies;
3. Build the capacity of supply chain systems in developing countries;
4. Ensure sustained delivery of a choice of quality RH supplies to end-users;
5. Address acute problems of stock-outs; and
6. Advocate for the inclusion of RH supplies in funding for humanitarian crises"[121].

7.09 The international community's failure to meet its funding commitments to family planning denies the SRH needs of millions of women, men and young people, and is likely to have long term impacts across development sectors—such as the ability to invest in education or provide employment opportunities as a population grows. Indeed, the United Nations expect world population to rise by 2.5 billion people from today's 6.7 billion to 9.2 billion in 2050.[122]

7.10 Maternal health will not be improved without reducing unmet need. This can come about only through intensified advocacy at the national, regional and global levels. DFID, its donor counterparts, multilateral agencies and CSOs (including IPPF) are in a prime position to advance this advocacy through increased partnership. Effective family planning, therefore, needs to be promoted to reduce maternal ill health. This can be achieved at both the donor and recipient levels through an increase of advocacy.

[116] See: Save the Children, State of the WORLD'S MOTHERS 2006—Saving the Lives of Mothers and Newborns, at www.savethechildren.org/publications/mothers/2006/SOWM_2006_final.pdf [accessed 12 September 2007]

[117] Facts about Safe Motherhood, UNFPA at http://www.unfpa.org/mothers/facts.htm [accessed 07 August 2007]

[118] IPPF, "At A Glance", p3,,August 2007

[119] ICON: mobilizing business for appropriate and affordable access, (date?),

[120] Members of the RHSC include: multilateral organizations; low-/middle-income country governments; donor governments; private donors; nongovernmental organizations; civil society; and social marketing organizations

[121] ICON: mobilizing business for appropriate and affordable access, (date?),

[122] New population projections "a wake-up call" Posted: 14 Mar 2007, at http://www.peopleandplanet.net/doc.php?id=2972 [accessed 14 September 2007]

7.11 IPPF has recently been engaged with other civil society organizations and progressive governments, such as that of the UK, in a number of advocacy initiatives to help improve maternal health through increasing access and rights to family planning and other sexual and reproductive health services. For example:

1. IPPF helped ensure a key pro-choice report by Glenys Kinnock MEP entitled "Draft Report on the Millennium Development Goals—the midway point" successfully passed through both the Development Committee (DEVE) and full Plenary Session of the European Parliament (EP).
2. IPPF also played a key advocacy role in regard to the World Bank's Health Nutrition and Population Strategy which in its first draft omitted reference to family planning and sexual and reproductive health. Not only did we help lead a concerted and successful advocacy effort to rectify this omission but managed to ensure that the checks and balances to avoid such mistakes in the future would be put in place. The results of our advocacy led to the commitment of many Executive Directors at the World Bank to press for stronger language reflecting the need for family planning and reproductive health within the HNP strategy. UK officials at the World Bank fully supported stronger language within the strategy. Likewise, the Secretary of State for International Development stated that he was very concerned about the lack of references to sexual and reproductive health and rights. Contacts within DFID informed IPPF that they would not support the draft HNP strategy in such a format.
3. IPPF also played a key role at the African Union Ministers of Health Conference in Maputo, Mozambique which passed the Maputo Plan of Action (PoA) for the operationalisation of the continental policy framework for sexual and reproductive health and rights (2007–10). This key document among other issues supports the following: the repositioning of family planning as an essential part of attaining the health related MDGs; addressing the SRH needs of adolescents and youth as a key SRH component; addressing unsafe abortion; delivering quality cost effective services to promote safe motherhood, child survival, maternal, newborn and child health, and; creating south/south cooperation for the attainment of the MDG and ICPD goals in Africa. This PoA was also supported by DFID which was in attendance at the conference.

7.12 Family Planning is being promoted as one way in which to improve maternal health. However, increased advocacy at the donor and recipient levels for the prioritization of reproductive health services within national budgets and action to address reproductive health commodity security is still required. DFID can and should play a key role here. Core investment in IPPF and its Member Associations is essential if family planning is to be promoted effectively.

Q8 *How effectively DFID works with bilateral and multilateral donors, NGOs and other stakeholders to promote maternal health*

8.01 Increasingly bilateral donors are channeling their funds into the coordinated aid mechanisms such as the Sector Wide Approaches (SWAps), the Poverty Reduction Strategies and General Budget Support that supports national governments ownership of national development. The declaration on aid harmonization signed in Paris in 2005 institutionalized and standardized this approach for bilateral agencies and recipient countries. DFID has been a key actor in developing and endorsing the Paris Declaration on Aid Effectiveness and the EU Harmonization Plan.

8.02 In recent years, the structure of official development assistance has begun to shift dramatically across all areas of international aid. Donors and recipient countries are reforming the aid system by putting in place measurable objectives and a new management framework. These changes were spearheaded at a number of international conferences, notably: a) The Millennium Summit, 2000; b) The International Conference on Financing for Development, Monterrey, 2002; and c) The High Level Forum on Aid Effectiveness, Paris, 2005.

8.03 The change in aid architecture was a response to the realization that the existing funding mechanisms for ODA were not working effectively. Indeed, a "2006 World Bank report estimated that about half of all funds donated for health efforts in sub-Saharan Africa never reach the clinics and hospitals at the end of the line."[123] Thus, donor countries have made a concerted effort to reform ODA in order to address these problems. As a result of the Monterrey Consensus, ODA has started to increase.

8.04 Despite the best efforts of a number of donors, a major obstacle to improving maternal health in many countries continues to be the low priority afforded to improving maternal health in particular by many developing country governments. Regrettably this may become an even greater obstacle to overcome with the developments described in paragraphs 2.01–2.04. Intensified advocacy is required to ensure that maternal health is given the priority it deserves within national budgets by recipient countries. Until maternal health is prioritized in policies and programmes and awarded sufficient budgetary support by developing country governments, high levels of maternal mortality and morbidity will prevail; and despite the best efforts of DFID to prioritize maternal health within policies and funding "maternal mortality

[123] The Challenge of Global Health, Laurie Garrett, Foreign Affairs, January/February 2007 at http://www.foreignaffairs.org/20070101faessay86103/laurie-garrett/the-challenge-of-global-health.html [accessed 01 August 07]

remains unacceptably high in DFID-supported countries"[124] Increased advocacy highlighting the wider economic and social benefits of maternal health is still required. This needs to be directed at the political leadership, civil servants, bureaucrats and Ministers of Finance and Health of developing countries emphasizing the costs, benefits and productivity of a healthy population.

8.05 It also needs to be recognized that funding for most basic health care services is deficient in many developing countries, with health often given a low priority within national budgets—and maternal health within the health budget a lower priority still.

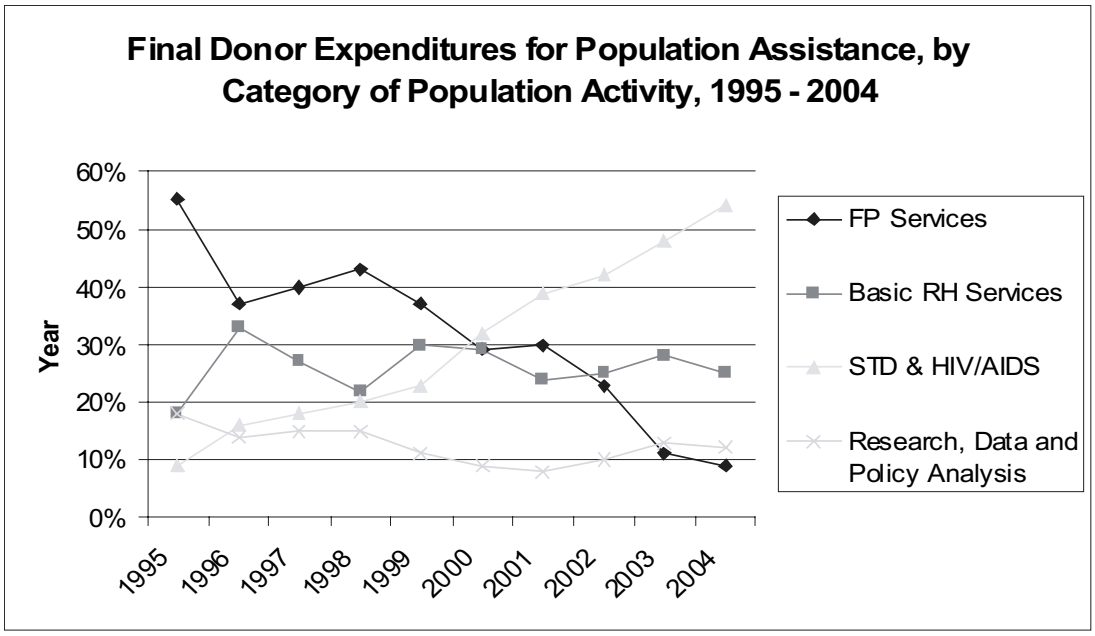
> "There are several reasons why maternal mortality remains high in some countries. One is the lack of commitment to make motherhood safe. Many governments allocate too small a portion of the national budget to health care, and within that budget, not enough is spent towards addressing preventable and avoidable deaths. Political commitment to reduce maternal and neonatal mortality is often not translated into increased resource allocation (ie in terms of finances, skilled personnel, adequate health facilities and available drugs)."[125]

8.06 Much of the reason for this can be attributed to the politicization of reproduction, gender inequity (including gender disparities in parliaments), and a lack of gender responsive policies.

8.07 Another issue that needs to be addressed is that many donors direct funding at specific high profile health interventions. This type of funding is used when there are gaps in budgetary support. Although such specific interventions can impact negatively of the amount of funding available for maternal health, the continuation of specific health intervention funding is necessary; and while it should be continued, the need for it could be reduced if DFID and other agencies worked with developing country governments to raise the awareness of the importance of SRH in reducing maternal mortality and its contribution towards wider-economic and social development.

8.08 At the present time, however, there is still a strong need for DFID to support specific interventions especially in the many poor countries where SRH is not prioritized. For example, in country's where abortion is legal, but difficult and costly to access for reasons such as few service providers or transport limitations and distance required to travel, or due to social and cultural attitudes that stigmatize abortion despite high levels of maternal death. DFID's support of the Safe Abortion Action Fund being administered by IPPF is a clear example of this need for specific health interventions. Likewise, DFID's support of specific maternal health interventions can be seen in Cambodia, where it leads on ensuring that progressive abortion legislation is operationalized through their participation in the health SWAp.

8.09 Funding for family planning and reproductive health has suffered despite their being large increases in funding for other SRH services, most notably HIV and AIDS. The graph below shows how funding for reproductive health and family planning has fallen as donor priority has shifted towards HIV and AIDS.



8.10 Another complication is that because funding is often channeled towards specific health interventions funding for health infrastructure is neglected (this is why DFID's focus on health system strengthening is important). In addition, although some recipient governments receive funding for specific

[124] DFID's Maternal Health Strategy, Reducing Maternal Deaths: evidence and action, Second progress report, DFID, (April 2007)

[125] Annex 9.6, The important issues in developing a national plan on maternal mortality reduction Dr Pang Ruyan Regional Adviser, MCH/FP/WPRO at http://www.who.int/reproductive-health/publications/RHR_02_2/ax6.pdf [accessed 06 September 2007]

health initiatives, many do not have the financial capacity to support more basic services. In Rwanda, for example, funds for HIV and AIDS account for by far the largest proportion of external funding, yet it has a relatively low level of HIV compared to child mortality from other causes. It is hoped that the International Health Partnership will address some of these issues as it seeks to coordinate and harmonize ODA.

8.11 Therefore, despite a reduction in the levels of international support for SRH, it is often a consequence of the funding priorities of the donors rather than the broad public health based needs of the countries themselves that determine where funding is channelled. Thus donor priorities have led to skewed funding patterns which has ultimately led to a reduction in support of SRH through the inequitable distribution of aid within the health sector.

8.12 It is important that developing countries are empowered and supported to set their own health priorities and produce their own national health plans to achieve them. Likewise, it is also important that donors coordinate their efforts to help achieve these developing country determined priorities. At present, coordination of funding is a major obstacle that impacts negatively on the health sector of many developing countries. This is because there are "more than 40 bilateral donors, 26 UN agencies, 20 global and regional funds and 90 global health initiatives".[126]

8.13 Complicating the matter further for many developing countries is the fact that many developing country governments are forced to respond to the countless reporting mechanisms of the many different donors. At present there are in excess of one hundred health partnerships[127] that are supported by donors and UN agencies through multiple funding streams. Such a large number of partnerships help create conditions that make the coordination of activities difficult. For example, "in Cambodia there are 22 different donors providing support for health through 109 separate projects".[128] This additional bureaucracy has stifled the ability of many developing country governments to implement projects due to the increased demands of donor bureaucracy, meaning that key staff within the health sector has to spend vital time reporting back on projects rather than implementing them.

Q9 *What leadership the UN is providing and how well co-ordinated its agencies are*

9.1 The UN has provided mixed leadership on the MDGs. Its initial failure to include reproductive health as a goal in 2000 was seen by the development community as a major and deliberate omission, (the ICPD was the only major conference whose outcome was not included in the original MDG framework). This has been partially addressed by the "noting" of the new reproductive health target in 2006 which occurred as a result of sustained advocacy by many member states, including the UK, and civil society organizations such as IPPF. It also came about despite the opposition of a number of influential member states including the United States. However, despite support for the reproductive health target by the former UN Secretary General, Kofi Annan, the present incumbent Ban Ki Moon and a number of progressive member states, political unease at highlighting "controversial issues" has helped hinder any real progress towards attaining MDG 5. This brings into question fundamental issues related to gender, women's rights and traditional social structures—as can be found in the Convention for the Elimination of all forms of Discrimination Against Women (CEDAW).

9.2 The lack of acknowledgement in any official UN reports about the new reproductive health target, since the recommendation of the target's inclusion into the MDG framework by the Secretary General, has not given confidence to those of us working in the field of sexual and reproductive health and rights concerning the true priority being attached to MDG5 by some member states. Despite the recommendation that all four new targets[129] including the new reproductive health target be incorporated into the MDG process in August 2006, little progress has been made to date.

9.3In addition, the politically motivated delay on the selection of indicators to measure the new target has also delayed progress and threatens to relegate the priority of the MDGs within the international development framework.

9.4It would also appear that a lack of coordination at the country level between different UN Agencies (and a lack of focus on SRH by key agencies such as UNICEF) is hindering progress on MDG 5. DFID's 2006 White Paper flagged the need for reform to deliver a UN system better able to support poor countries to achieve their development goals. It identifies as key issues the proliferation of agencies with multiple, sometimes overlapping mandates, and the need to improve in-country co-ordination. DFID strongly

[126] DFID, The International Health Partnership Launched Today, at http://www.dfid.gov.uk/news/files/ihp/default.asp [accessed 07 September 2007]

[127] These high profile health interventions include, for example, The Global Fund on AIDS, TB and Malaria, WHO's 3 by 5 initiative, Roll Back Malaria, Measles Initiative, Malaria Vaccine Initiative, Stop TB, Diabetes Action Now etc.

[128] DFID, Millennium Development Goals, Improving healthcare for mothers and pregnant women, at www.dfid.gov.uk/mdg/health.asp [accessed 07 September 2007]

[129] The new targets are: "a new target under Millennium Development Goal 1: to make the goals of full and productive employment and decent work for all, including for women and young people, a central objective of our relevant national and international policies and our national development strategies; a new target under Goal 5: to achieve universal access to reproductive health by 2015; a new target under Goal 6: to come as close as possible to universal access to treatment for HIV/AIDS by 2010 for all those who need it; and a new target under Goal 7: to significantly reduce the rate of loss of biodiversity by 2010."—See: Report of the Secretary-General, on the work of the Organization, General Assembly, Official Records, Sixty-first Session, Supplement No. 1 (A/61/1) at http://daccess-ods.un.org/TMP/2273176.html [accessed 13 September 2007]

supports the One UN initiative recommended by the UN Secretary General's High Level Panel on system-wide coherence (at the end of 2006). The eight pilot countries have agreed to work towards a common UN presence in country, testing different models, while capitalizing on the strengths and comparative advantages of the different members of the UN family.

9.5Advocacy is being undertaken to strengthen the role of women within the UN reform process. Within the framework of United Nations Reform, there is currently a discussion being held in New York on the Report issued by the High-Level Panel on United Nations System-wide Coherence, in November 2006. Leading to this report, women's rights organizations around the world gathered to advocate for the inclusion of a specific recommendation that called for strengthening the Gender Equality Architecture (GEA) within the United Nations. The report included this recommendation, consisting of consolidating the three main existing bodies (The Secretary General's Special Advisor on Gender Issues OSAGI, The Division for the Advancement of Women: DAW, and the United Nations Development Fund for Women: UNIFEM), and establishing a new Under-Secretary General position at the highest level, in order to guarantee that women have a place at the decision-making process and that there is a necessary driver for meeting women's needs on the ground.[130]

9.6 Clearly, the agencies involved need to communicate more effectively and develop a coordinated strategy that uses each of them to their best ability for effective delivery of the maternal health initiatives. Without effective coordination between these agencies, MDG 5 will become increasingly difficult to reach.

9.7 It is important for DFID to recognize that NGOs can often go where UN agencies cannot in regard to advocacy and service delivery. As a consequence DFID should increase its core funding for NGOs such as IPPF.

Q10 *How DFID is addressing socio-economic barriers to women's empowerment and the low status of women in relation to maternal health*[131]

10.1 High levels of maternal death and disability reflects a woman's lack of rights and social, economic and political status. Lack of rights, decision making, education, access to services and the low priority afforded to women's health contributes significantly to high maternal mortality. In many countries overcoming such barriers often means advocating against social and cultural norms. "Gender discrimination against women leaves them powerless to make decisions about when to have sex, and whether to use contraception or to seek health care. Discrimination based on gender continues to be one of the major risk factors to women's vulnerability to sexual and reproductive ill health."[132]

10.2 DFID needs to reinforce the value of investing in the training of midwives with recipient countries.

10.3 It is vital that DFID continues to develop a Rights Based Approach (RBA) to maternal health. DFID already attempts to address the socio-economic barriers to women's empowerment and the low status of women in many countries. For example, DFID is supporting a four year initiative (2004–08) entitled Working Towards Safe Motherhood in South Asia: Combating gender based violence during pregnancy in Bangladesh and Nepal under its Civil Society Challenge Fund.

10.4 Although the high incidence of gender based violence (GBV) in Bangladesh and Nepal is widely acknowledged, the project has enabled IPPF Member Associations to address GBV during pregnancy for the first time in a comprehensive and effective manner. The project aims to protect the rights of women who are at risk of or who are experiencing GBV with a specific focus on pregnant women. The project increases awareness of frontline service providers to the SRH dangers and the violation of human rights of GBV during pregnancy, and offers skills to support survivors or those at risk of GBV. The project has also adopted a multi-sectoral approach by working in partnership with key agencies to provide additional / specialized support services (eg counselling, emergency shelter, legal advice). A range of activities have supported the economic and social empowerment of survivors to escape violence and to become advocates against GBV. Finally, strong engagement with key community gatekeepers and national level advocacy has helped strengthen civil society groups to advocate against GBV.

10.5 DFID's support has enabled IPPF in the South Asia Region to improve the maternal health of women through this targeted initiative in the following ways:

1. Created institutional mechanisms (screening and referral) of two large NGO SRH providers to integrate support for survivors of GBV within a SRH setting and strengthened partnership working;
2. Raised awareness of entitlements and rights and strengthened the capacity of survivors of GBV to demand their rights to a life free from of all forms of coercion and violence;
3. Supported the self determination of survivors through improved social, economic, political and civil status (from micro credit fund, community level Information Education and Communication activities and national level advocacy).

[130] Update on UN Reform: Strengthening the Gender Equality Architecture in the United Nations, Alejandra Garita, IPPF WHR, September 2007

[131] Answer to Question 10 based on email from IPPF South Asia Region 03 August 2007

[132] IPPF commitment to family planning—http://www.ippf.org/en/What-we-do/Access/

4. Survivors' testimonies have confirmed an increase in self esteem and community respect as a result of improved economic status through the micro credit fund.
5. Strengthened the capacity of southern civil society groups to engage with and influence governments to address policy reform eg enforcement of anti dowry laws/ legal age of marriage/ polygamy.
6. Brought the issue of GBV during pregnancy into the public arena.

10.6 The project directly reflects DFID's overall strategic country priorities for poverty eradication and human development by addressing gender inequality and discrimination. It rests on the premise that women's inequality is a key obstacle to development and a major cause of social injustice and that gender discrimination is the most widespread form of social exclusion. The economic cost of GBV which directly impacts on women's productivity and economic status is also widely accepted. Women in Nepal and Bangladesh, as in many other developing countries around the world, are poorly represented in positions of power and opportunities for independent action are often severely limited. When women have a voice, they are able to participate directly in governance processes. As a result they can advocate for issues of particular importance to women. However, there is not a single country in the world where women outnumber men in parliament. DFID can help advocate for the greater representation of women's power through global and regional advocacy using bodies such as regional All Party Parliamentary Groups to push for the greater representation of women in parliaments.

10.7 DFID's Country Assistance Plan for Bangladesh 2003–06 identifies gender inequality as a key constraint to poverty reduction in Bangladesh where issues such as dowry, inheritance, access to health services and physical security, all need to be addressed in order to improve the lives of women and girls and reduce overall poverty in Bangladesh. The Nepal Country Strategic Plan 1998 (currently under review) also makes clear the need for a project such as this. It notes the cause and effect relationship between Nepal's entrenched patriarchal society and the low status and limited decision-making power of women as the underlying factors leading to their poor health status reflected in the fact that Nepal has some of the highest maternal and infant mortality rates in South Asia.

10.8 Overall, the project adopts a rights-based approach to promote gender equality and women's empowerment by developing practical and strategic interventions to eradicate gender based violence within a SRH/R framework. By promoting gender equality and reducing maternal and infant mortality within a safe motherhood framework, the project specifically contributes to the achievement of the Millennium Development Goals (Numbers 3, 4 and 5), to which DFID is committed.

10.9 DFID needs to encourage governments to develop a comprehensive and integrated, joined up approach across government, and across local government with NGOs, schools etc.

Q11 *How the international community can improve maternal health in crisis and conflict settings*[133]

11.1 Maternal health can be improved through the safeguarding of rights in crisis and conflict affected settings. Programmes that address the sexual and reproductive health and rights of communities that have been affected by conflict have a significant impact upon the emergence of democratic decision-making, empowerment and wider economic development. Programmes that empower internally displaced people to make informed decisions about their sexual and reproductive health and bodies also have important repercussions for people exercising and acting on their right to take an active role in wider decision making processes that affect their lives and communities.

11.2 The empowerment of internally displaced people to demand sexual and reproductive health and rights is an important first stage in ensuring that people who have been affected by conflict feel that they are empowered and have the right to engage in wider discussions and activities that focus upon human rights, community-led democratic decision-making and conflict resolution.

11.3 While entire communities suffer the consequences of armed conflict and terrorism, women and girls suffer disproportionately—the United Nations High Commission for Refugees has estimated that 65% of all internally displaced people and refugees are women. This is because existing social inequalities are aggravated by war and conflict situations. With the breakdown of social structures, women and girls are subject to gender-based violence, rape and sexual abuse. It is within this context that programmes that address sexual and reproductive health and rights are crucially important.

11.4 The UNHCR (United Nations High Commission for Refugees) reported in its 1999 Inter-agency Field manual that "reproductive health is central to the health and welfare of refugees. It should be available in all situations and be based on the expressed demands of refugees, particularly women . . . an increase in sexual violence in insecure refugee situations is well recognised. Displacement, uprootedness, the loss of community structures, the need to exchange sex for material goods or protection leads to distinct forms of violence, particularly sexual violence against women".

[133] Answer to Question 11 based on IPPF funding proposal (2004) "Conflict Resolution and Recovery"—"Improving the Sexual and Reproductive Health of Displaced Women and Young People in Sudan"

11.5 The UNHCR has recorded high levels of rape, domestic violence, gender-based violence and assault amongst women that are internally displaced or refugees. In areas where there are large numbers of refugees and internally displaced people, not having basic sanitary equipment for childbirth, access to emergency obstetric care or trained midwives leads to large increases in maternal mortality, whilst lack of access to modern methods of contraception—particularly condoms also results in major increases in the transmission of STIs (including HIV/AIDS) and increases in unplanned pregnancies.

12. *IPPF Recommendations*

IPPF's recommendations:

1. Intensify advocacy to ensure that maternal health becomes a development priority at the global, regional and national levels by donor and recipient countries alike. DFID is seen as a leading proponent of maternal health and should, therefore, use its position and influence to advocate at these levels.

2. Ensure health system strengthening is prioritised by the donor community and that the wider social, economic and political barriers to improving maternal health are addressed.

3. DFID should encourage a joined up approach to development which links maternal health with education, health and adolescent development.

4. DFID should encourage recipient governments to involve and include civil society in all discussions, consultations and plans related to development.

5. IPPF recommends that DFID advocate for recipient governments to support national budget lines to increase reproductive health supplies around the following three major preventatives of maternal mortality—emergency obstetric care, unsafe abortion and family planning. DFID-funded sexual and reproductive health interventions should take a country-specific approach, recognizing the numerous and complex factors that combine to result in a given health and market situation in each country.

6. DFID should encourage recipient governments to prioritise women's education, literacy, and rights including the elimination of gender based violence.

7. DFID should encourage an emphasis in recipient countries on a public health and primary health care approach (as per the Ottawa Charter).

8. DFID should recognize the importance of investing in comprehensive sexual and reproductive health, not only family planning, including the integration of sexual and reproductive health, family planning and HIV and AIDS prevention and Voluntary Counselling and Testing (VCT) which also impacts on maternal health of HIV positive women.

9. Increase advocacy around the issue of wealthy countries "poaching" health sector workers from developing countries—including Commonwealth protocols.

10. Ensure that the political will for improving maternal health is translated into increased financial commitments by donors.

11. Ensure that all relevant UN agencies work together effectively to improve maternal health.

12. DFID should advocate for developing country governments to prioritise maternal health within their health plans and budgets and take into account health system reform.

13. DFID should encourage other donors nations to contribute towards the Safe Abortion Action Fund and commit itself to the ongoing funding of the SAAF.

14. Ensure that a rights-based approach to maternal health is incorporated into national health plans.

15. Ensure the effective coordination and harmonization of aid by donors.

16. Simplify and make more transparent the reporting mechanisms for recipient countries.

17. Invest in family planning, advocacy, health and women's education and sexual and reproductive health including STI prevention.

18. Advocate against child marriage.

19. Invest in the elimination of gender based violence.

20. Develop similar principles of trust, harmonization and ownership with civil society organizations.

21. Recognize the role of civil society.

22. DFID should continue to focus on SRHR and maintain or increase its current staffing levels so as to ensure that SRHR is maintained as a DFID priority.

23. DFID should ensure that within negotiations with PSA countries that the following components are included within Country Strategy Papers: Emergency Obstetric Care; Unsafe Abortion and Family Planning.

Memorandum submitted by the International Rescue Committee

Maternal Health—How the international community can improve maternal health in crisis and conflict settings

1. Given the prevalence of conflict and natural disaster in many least-developed countries, MDG 5 will not be met without concerted efforts by donors to find ways of providing effective reproductive healthcare to disaster- and conflict-affected women and their families.

2. This is a highly complex, but vital, challenge. Tens of millions of people are currently either displaced by disaster or conflict or are living in highly volatile conflict-affected regions. Moreover, while on average residents of refugee camps can expect to enjoy relatively good access to care, internally displaced and non-displaced persons in conflict zones generally receive very little in the way of services.

3. Ensuring adequate reproductive health provision in conditions of conflict or displacement can not be done cheaply or casually. Donors such as DFID need to invest significantly in supporting effective sexual and reproductive health programmes as part of their engagement with "humanitarian" and "fragile" contexts, as well as in more stable "development" contexts.

4. A large gap exists between recommended practice and the reality in the field. As an influential donor, DFID should aim to address this by ensuring the following:

4.1. that staff with the necessary clinical qualifications and experience to address obstetrics are included in any emergency response team;

4.2. that the availability of emergency obstetric care is integrated into all assessments conducted by all humanitarian assistance providers;

4.3. that support is provided to fill identified gaps, either reinforcing existing referral facilities or establishing new services as needed to meet the needs of conflict- or disaster-affected women;

4.4. that data is collected on the six UN Process Indicators in all humanitarian relief programs providing Emergency Obstetric Care to measure progress in reducing maternal mortality and morbidity, to support advocacy efforts and to leverage resources;

4.5. that standard protocols for emergency obstetric procedures based upon WHO, UNFPA, UNICEF and the World Bank's Managing Complications in Pregnancy and Childbirth: A guide for midwives and doctors are widely disseminated;

4.6. that regional training centres are identified and supported;

4.7. that funds to cover the additional costs of emergency obstetric care are included in grants made to humanitarian relief programmes.

5. At the community-level, DFID can have a rapid impact on maternal health outcomes by ensuring that clean delivery kits are distributed to visibly pregnant women among displaced populations and by supporting programmes to educate community-level decision-makers about the signs of pregnancy complications and the importance of quick transfer to save the life of a woman and her baby.

14 September 2007

Memorandum submitted by the DFID Funded Research Programme Consortium on Maternal and Neonatal health at the London School of Hygiene and Tropical Medicine and Institute of Child Health (Towards 4 + 5)[134]

Introduction

(i1) This document is written from the perspective of the academic communities at the London School of Hygiene and Tropical Medicine (LSHTM) and the Institute of Child Health (ICH), and their collaborators in Nepal, Ghana, Malawi, Burkina, and Bangladesh, and the UK. We provide evidence only where we have good insight from our experience and respond directly to the questions raised in the International Development Committee News Release. We emphasize research reflecting our role in finding or assessing solutions to improve maternal health, but also discuss other issues, and in particular donor financing for which we have new information.

(i2) From a research perspective, we believe that DFID is generally very effective in its application of its maternal and neonatal health strategy compared to other national aid agencies. For example, DFID support to the research activities in the Kintampo Health Research Centre in Ghana (KHRC) (a Ministry of Health research unit which works mostly on maternal and neonatal health in collaboration with LSHTM), has been

[134] Contributors: Dr Véronique Filippi, Professor Simon Cousens, Professor Betty Kirkwood, Dr Dharma Mandandhar, Ms Giulia Greco, Professor Anthony Costello, Dr Charles Mwansambo, Dr David Osrin, Dr Carine Ronsmans, Ms Annemarie Terveen, Dr Dominique Behague, Mr Tom Marshall, Mr Timothy Powell-Jackson, Dr Daniel Chandramohan, Dr Oona Campbell and Dr Matthias Borchert (section 7).

outstanding in terms of level of funding, the keen interest of staff in DFID headquarters and the accompanying measures supported by DFID. In addition to research funds, DFID sponsored the development of a business plan to encourage the sustainability of the institution. In the UK, DFID's long term support to the Maternal and Neonatal Health Group at LSHTM since 1989 and to the Perinatal Health Unit at ICH since 1998 has enabled both institutions to nurture and retain staff who have become recognised experts in the field.

(i3) One concern, however, relates to the downsizing in the number of staff at head quarters. If health advisors and other associated staff become over-stretched this will adversely affect the depth and quality of the interactions between DFID and the academic community in developing countries and in the UK. A second concern is the informality and lack of systematic links between DFID country programmes and advisers and DFID research programme consortia. We believe that DFID country work for maternal health would benefit greatly if the evaluation skills of researchers were applied routinely to DFID's large scale country work.

1. *How donors can catalyse progress towards MDG 5?*

The following catalysts will be discussed in our answer to this question:

— Research
— Finance
— Policy

a. Research

(1a1) From our perspective, donors can catalyse progress towards MDG 5 in the short and medium term by supporting robustly designed research which can disentangle (a) which interventions work and do not work in very poor countries in Africa (including Francophone Africa) and South East Asia, (b) how interventions which work on their own can be combined together more effectively to reduce maternal mortality, and (c) how to promote the implementation of evidence-based interventions and policies. While it is often said, that "we know what works" in maternal health, this is true in terms of therapeutic interventions and in relation to the central role played by midwives, obstetricians and emergency obstetric services in the reduction of maternal mortality. There are implementation questions for which we do not have good answers (Sanders and Haines, 2006), for example in relation to the most conducive policy environment to ensure changes, the financing strategies to ensure equitable access, the best methods to promote good quality of care, the policies which work best to retain health staff in remote areas, the relative cost-effectiveness of interventions and how to package safe motherhood and neonatal health interventions into a coherent and efficient programme. There is also a need for donors to finance long term efforts to develop new, innovative interventions to reach women in need, especially those in remote populations whose access to services is extremely limited.

(1a2) Where it concerns the question of integration with child and neonatal health, and of health systems approaches to maternal health, there is also a need for donors to recognise, actively support and reward researchers for engaging with interdisciplinary methods, non-experimental observational epidemiology, and operations research. This is particularly important because, for researchers, generating credible scientific evidence for evaluation of horizontal initiatives is a major challenge, since these require different research models than those used to assess the efficacy and effectiveness of vertical initiatives (Behague and Storeng, 2007).

(1a3) DFID is one of the biggest bilateral donors (in terms of funds and visibility) for research activities in maternal and neonatal health. Major research priorities for DFID concern the effectiveness of current safe motherhood activities, the scaling up of effective maternal health interventions within existing health systems, and the integration of safe motherhood with neonatal health interventions. A key concern of DFID is to demonstrate that the research they have supported has influenced policy, and there is a push to show changes. We believe that the focus of DFID should not always be on change. Sometimes the current policy is appropriate, and the focus should be on how research has helped to produce rational policy decisions even if it does not involve change.

(1a4) Nevertheless, DFID is also willing to take risks with research, by financing research on innovative interventions, which take longer to impact policy, for example, with the Vitamin A trial in Ghana and the women's group trials in Nepal, Malawi, Bangladesh and India. DFID is also one of the few donors supporting research on induced abortion.

b. Finance

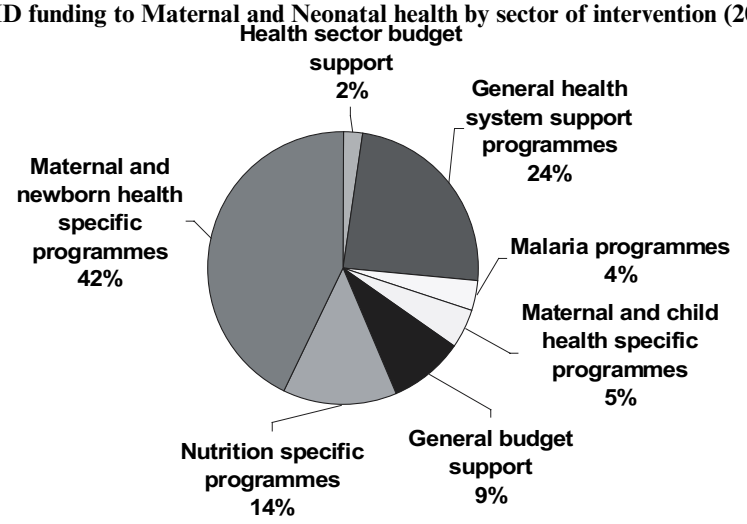
(1b1) Worldwide Overseas Development Assistance (ODA) for maternal, newborn and child health represented approximately 16 percent of ODA to health, and approximately 2.5 percent of total ODA in 2004. The amount pales into insignificance when compared against projected resources required to achieve MDGs 4 & 5. It is also far less than resources committed to HIV/AIDS, which accounts for a smaller burden

of disease in many developing countries. The majority of funds are provided by a small group of donors. Fourteen donors contributed 90 percent of total ODA to maternal, newborn and child health in 2004, and just four donors account for 51 percent—World Bank, USAID, DFID and UNFPA.

(1b2) According to our study on tracking donor assistance (Powell-Jackson 2006), DFID spent US$56 million on maternal and neonatal health (equivalent to 8 percent of all-donor expenditure) in 2003, and increased its contribution to US$62 million (12 percent of all-donor expenditure) the following year. The following pie chart gives details on the distribution of DfID funding to maternal and newborn health:

Figure 1

DFID funding to Maternal and Neonatal health by sector of intervention (2004)



(1b3) Some attention has been paid to estimating the amount of funds required to scale up maternal and neonatal health to reach MDG 5 and comparing this against projected trends in available resources (ie. to estimate the financing gap). Even if donor countries fulfil their commitments to increase external aid to developing countries, and developing countries' governments implement their commitment to increase health expenditure, low income countries will still lack adequate financial resources to scale up maternal and newborn health interventions. We have estimated that US$ 1 per capita additional to committed resources would be required in 2015 to extend coverage of life-saving interventions for mothers and children in Sub Saharan Africa (Greco et al, 2007). If domestic and external health expenditures increase only in line with past trends, the financing gap is estimated to be more than US$ 4 per person. Lower and upper middle income groups are likely to have sufficient funds to reach the MDG 5. Their domestic policies for maternal and neonatal health fund allocation will be therefore paramount. The implication is clear: donors, including DFID, must focus on low-income countries first and foremost.

(1b4) Insufficient time has been spent on how to raise additional resources and, equally importantly, how to channel additional resources in the most efficient way possible. As DFID is fully aware (more than any other donor), the aid architecture for health is overly complex. A study on the health sector in Rwanda (Foster 2006) illustrates this point well at the country level.

c. Policy

(1c1) DFID is one of the more innovative funders where it concerns efforts to promote horizontal policy-making and implementation—that is, to integrate interventions from different subfields (such as maternal/child health), to promote sector-wide approaches, and to strengthen health systems. A recent research on evidence-based policy-making has demonstrated how important support for a horizontal approach to maternal health issues is for long-term sustainability of programs developed to reduce maternal mortality and for improved, cohesive policy-development (Behague and Storeng, 2007).

(1c2). Nevertheless, a number of social and political factors, including most importantly the competition for funds and international recognition between subgroups (eg maternal, child, reproductive and neonatal health), operate to persuade policy-makers and donors of the greater relative importance of vertical interventions. The inclination to favour vertical approaches also ensues from the demands of political and economic accountability of professional activities at the international level. Because vertical approaches tend to be more universally applicable and standardized, and less context-specific, than horizontal approaches, they lend themselves to becoming tools for monitoring professional accountability (Béhague and Storeng, 2007).

(1c3) For international policy-makers and donors, a major challenge in contributing to vertical-horizontal collaboration lies in finding ways to make horizontal initiatives a priority without losing the focus on the more immediate needs of vertical initiatives and on achieving a direct, measurable, and easily monitored impact on health outcomes. We feel DFID should continue to embrace this challenge head-on. Rather than solely support disease- and subfield- specific approaches, donors such as DFID, together with researchers and policy-makers, urgently need to engage in open dialogue regarding the larger international, academic, and donor-driven forces that drive the public health community towards a predominant interest in vertical programs.

2. *How effectively DFID is working with recipient countries to make emergency obstetric care available, ensure adequate numbers of skilled birth attendants, and integration in health system?*

(2.1) Nepal (Dr Dharma Manandhar): DFID made substantial contributions to the provision of emergency obstetric care, training and making available skilled birth attendants, and integrating safe motherhood policy with the national health programme. Initially in 1997, it helped through the Nepal Safer Motherhood Project by developing infrastructure, training of health personnel and providing equipment in 10 district and zonal hospitals and some primary health care units in Nepal for providing quality emergency obstetric care. In 2005, this project was converted to the Support to Safe Motherhood Program (SSMP) so as to integrate safe motherhood policy into the national health programme. SSMP has substantially helped by providing training for skilled birth attendants and starting maternity financial incentive scheme to promote delivery in a health facility and to promote the presence of a skilled birth attendant at home delivery. DFID's support to SSMP has also helped in other activities related to improving women's health particularly in reducing maternal mortality eg legalisation of abortion, family planning, gender equity etc. The latest maternal mortality ratio according to DHS 2006 is 281/100000 live births which is substantially less compared to 539/100000 live births as reported by NFHS 1996.

(2.2) Malawi (Dr Charles Mwamsambo): DFID is a major contributor to the Sector Wide Approach (SWAp) funds in Malawi. These funds are being used to fund, among other things, the Human Resource Emergency Plan which involves supporting training institutions to train health workers such as midwives, and enrolled nurse/midwife technicians. SWAp funds are also being used to strengthen the health system where these health workers will be deployed after training. The support is in the form of drugs, equipment and infrastructural development with the ultimate goal of achieving MDG 5 by 2015. Unfortunately we can not see the direct impact of this now. It will take another 2 to 3 years before we can see the results. Previously, DFID supported the Safe Motherhood project for 6 years. When I visit the supported facilities I can see the obvious difference in organization, emergency handling and also the attitude of the staff: generally they are better organized and better prepared to handle emergency obstetric cases

3. *The steps DFID is taking to mainstreaming maternal health across related policies?*

(a) Maternal health and health systems

(3a1) Health systems include anything related to infrastructure and equipment, human resources, financing and the various processes which enable staff to work with a system, such as communication (Sanders and Haines, 2006). DFID has been instrumental in putting the strengthening of health systems on the international agenda, and in making the case for maternal health as a health system issue.

(3a2) Health system issues which are particularly significant for maternal health all relate to how the coverage of skilled birth attendance at delivery and emergency obstetric care can be best improved. There are areas where services are available but underused, and where most of the problems relate to poor quality of care and women's or families reluctance to use services. But the most difficult issues relate to increasing the availability of human resources in areas where services are unavailable, as midwives are trained in insufficient numbers, their willingness to live in remote areas is limited and many leave their home countries for rich nations. In the Lancet maternal health series, we argue that, in the context of integration of maternal and neonatal health, the current lack of human resources should not be a reason for encouraging quick fix solutions, for example by financing programmes using community health workers at the expense of training more midwives or mid-level workers when there is insufficient doctors. It is important that every effort is made for women to receive care from providers working in pairs (as a minimum) in health services settings, and that the international community understand that this is a long term effort. We think that staff at DFID can play a key role in promoting this message, and we would like to encourage DFID as well, to continue supporting action towards the abolition or reduction of user fees for pregnant women. As user fees often represent a sizeable proportion of facility budgets, governments must be supported and encouraged to make the substantial commitment of replenishing the lost revenue through additional tax, donor contributions and/or cross-subsidies. The effectiveness of methods of reducing transport costs (such as vouchers and cash transfers) must also be explored, especially in rural areas where these can be substantial.

(3a3) We would like to add however, that while without a doubt, maternal health would greatly benefit from a general improvement in health systems, it is as much as health system issue as other conditions or public health problems such as HIV or Malaria. There are other broader particularities which make maternal health difficult to improve including those embedded in gender issues.

(b) Integration of maternal health with neonatal and child health

(3b1) Newborn survival interventions are potentially the most cost-effective approach to achieving the Millennium Development Goal 4 given the failure in reducing the neonatal deaths and the increasing proportion of child deaths occurring in the newborn period. Newborn interventions depend heavily upon functional maternal care services and the dual benefits need to be emphasised. There is encouraging progress at international level to create partnerships and data collection systems which monitor both maternal and newborn care coverage and mortality outcomes. At national and district level there remains greater separation, and a high priority for health systems is to emphasise the importance of integration of prenatal, delivery and postnatal care interventions which will benefit BOTH mothers and newborn infants.

(3b2) DFID has also been instrumental in promoting the integration at international level of implementation agendas for maternal, neonatal, and child health, in order to facilitate work at country level. With respect to research, this translated into an RPC on maternal and neonatal health, whose main focus is to look at integration.

(c) Maternal health and infectious diseases (HIV, malaria)

(3c1) There is a real need in countries and at programme level (but also possibly at international level) for better integration of the activities for the prevention of mother to child transmission (PMTCT) of HIV and malaria programmes into antenatal, delivery and postnatal services, and this has been a key concern for DFID. For example, PMTCT programmes often act in parallel to existing maternity services and do not address the family planning needs of women, or their antenatal care needs. There are examples of settings in which HIV programmes take money out of maternal health and the best midwives are taken from maternity care to do PMTCT, for example South Africa. On the other hand, we know from our work in Ivory Coast, that integration can be beneficial for both programmes. A national programme in Cote d'Ivoire integrating PMTCT programmes into regular maternity services has shown that the strengthening of maternity services that accompanied the PMTCT (including additional equipment and drugs and staff training) has resulted in notable improvements in the quality of antenatal and delivery care. While HIV testing and PMTCT uptake increased dramatically after implementation of PMTCT, many quality indicators of maternity care services also improved. The most dramatic changes were seen in the areas of communication and health promotion, but effects were also seen at the technical level (eg staff were more likely to monitor foetal heart sounds or to measure blood pressure).

(3c2) Intermittent Preventive Treatment in pregnancy (IPTp) is less likely to be implemented as a separate vertical programme in the same way as PMTCT. However, there are issues of drug safety in pregnancy which are not being addressed by the research community. Chloroquine and sulphadoxine-pyrimethamine (SP) that commonly used drugs for treatment of malaria in pregancy and IPTp need to be replaced with other antimalarials because of wide spread resistance. Although there are several new antimalarials available there is no or very limited data on the safety of these drugs during pregnancy because pregnant women are systematically excluded from clinical trials due to fear of fetal toxicity. The consequence of this situation is that pregnant women are either getting ineffective or drugs of unknown safety records for treatment of malaria.

(d) Maternal health and human rights

(3d1) DFID headquarters has been particularly active in encouraging mainstreaming of maternal health on the human rights agenda, by preparing for example a document on human rights approaches to maternal health.

(3d2) It may be important to write here than there is more to maternal health than mortality only. There are many women who survive in extremis severe obstetric complications and who suffer long term economic, health and other consequences and are not looked after suitably by health services in the postpartum. A paper is forthcoming in the Lancet, but we would be happy to provide evidence on this to the committee.

4. *How effectively DFID works with others*

(a) Research community in developing countries and the UK

(4a1) Our experience in working with DFID headquarters has been excellent, but interaction with country offices has sometimes been less satisfactory. Feedback from some country offices on what are identified as important research topics in their country could be improved. Sometimes it is hard to engage DFID country offices in following the progress of DFID funded maternal health research in the country they are working in. DFID headquarters has tried to facilitate these links, but even when forged, the links can be hard to maintain. For example, links were first forged in 2002 between the Ghana DFID country office and KHRC with repect to the Vitamin A trial to reduce maternal mortality, and a country office representative accompanied the Parliamentary Select Committee visit to KHRC in March 2002. At the suggestion of HQ staff, a representative attended the 2004 annual technical steering committee meeting of the trial. It was intended that this should be a regular occurrence. However, this person was then replaced

by a new staff member, who did not have a particular interest in health or in research, and who did not see this as a priority amongst the wide range of ongoing development projects within Ghana. The wide remit and high turnover of staff in DFID country offices make forging long term links difficult. The number of health advisors at central level has been greatly reduced, and it might be beneficial to have additional health advisors, with expertise in maternal health.

(4a2) That said, as mentioned previously, the long term support of DFID for research institutions in developing countries is greatly appreciated. MIRA in Nepal is an organisation which now employs 800 research staff. It was started in 1992 in collaboration between Professor Dharma Manandhar and Professor Anthony Costello with seed money from DFID (formerly ODA) to start research activity in perinatal health in Nepal. This seed money enabled Mira to start its first study on perinatal health. Mira got another grant in 1993 (ODA) for a trial on postnatal health education for mothers on infant care and family planning. DFID was also the major funder for the Makwanpur study on women's groups. Their evaluation of women's groups in improving demand for better care suggests that the neonatal survival benefits will be substantial, and the possibility of a direct effect on maternal survival. Replication and scalability trials of a women's group intervention are being conducted in Bangladesh, India, Pakistan, Nepal and Malawi. The MIRA studies continue with an emphasis shifting to the links between demand and improved quality of care, and how to increase skilled birth attendance in remote areas.

(4a3) DFID support has been instrumental in the capacity building of individuals and other organizations in Nepal. Many from Nepal have completed postgraduate studies and received a Master's degree or PhD or MD from the UK. Many were supported for short courses and to participate and to present papers in international conferences. The Perinatal Society of Nepal was established in 1997 following the DFID sponsorship of a leading Nepalese paediatrician and obstetrician (Dr D. S. Mandandhar and Dr Malla) to a conference. In 1997 MIRA in collaboration with ICH conducted an international workshop on improving newborn infant health in developing countries. This was attended by a large number of leading perinatologists from other countries. Proceedings of this workshop were published as a book. This workshop as well as post conference workshops which were held during each PESON conference (so far five conferences have been held) has been supported by DFID through ICH.

(4a4) Although DFID has been generous in its repeated support for research work by the ICH-MIRA collaboration, there has been something of a disconnection between funding and dialogue. Given DFID's appetite for communication and linking research with policy, there is sometimes a perceived lack of ownership of DFID-funded projects by country offices, a limited interest within some parts of DFID about project progress and findings (related in part to staff shortages), and insufficient dialogue about the rigor, and policy relevance of research findings.

(b) Partnership and Global funds

(4b1) There appears to be a tension between the need to raise new, additional funds for MNCH and the reluctance to create a new fund (whether it be a global fund for maternal, newborn and child health or a fund in an alternative guise). This was apparent at a meeting in Norway (March 2007) on the Global Business Plan. More resources are needed but how do we find them without creating a new fund or a new initiative that will potentially complicate the aid architecture further? Many donors who would like to support maternal and child health need a way to channel their funds to districts and communities in developing countries. For the moment, the modalities for an effective channelling of the funding are unclear. The Global Business Plan for MDGs 4 and 5 will develop details of how additional funding can be raised and channelled, the Fast Track Initiative Catalytic Fund could serve as example. Aid coordination is an area where DFID is a leader and well respected. It is hoped even greater focus is given to this issue by DFID, particularly at the country level where ultimately the effects of poor coordination and duplication are felt. Basket funding may have long term benefits but there is a paucity of evidence to show that a sector wide approach has actually led to increased expenditure on maternal and newborn care.

5. *What leadership the UN is providing and how well coordinated its agencies are*

(5.1) Multiple UN agencies have remits which include maternal health (WHO, UNFPA, UNICEF). In recent years, staff at WHO have worked very hard to bring maternal, neonatal and child health together. Nevertheless, WHO has two departments with a focus on maternal health: Reproductive Health and Research (HRP) and Making Pregnancy Safer. HRP has experienced financial problems recently which have been detrimental to the ranges of research activities which could be funded in maternal health and reproductive health. The recent formation of the Partnership for Maternal, Newborn and Child Health (PMNCH) represents an attempt to improve co-ordination across various agencies involved in maternal and child health work at country level. However, PMNCH does not disburse funds and has very limited financial support itself. The latter is probably appropriate as PMNCH should not be competing with other international institutions such as WHO and Unicef. Nevertheless, if substantially increased funds for maternal (and neonatal/child) health are generated, there must be mechanisms to ensure that some of these are used to reinforce WHO and other UN agencies in their efforts to reduce maternal mortality and that they are disbursed in a co-ordinated and rational way.

6. *Socio economic barriers to women's empowerment and the low status of women*

(6.1) DFID funding has been central to the development of a new international discussion on the effectiveness of community mobilization activities for maternal and newborn health. Specifically, DFID support for research in Nepal has allowed us to test the effectiveness, potential scalability and sustainability, and possibilities for integration of community women's groups as a lever for demand-led improvements in maternity care. This work is now going forward into areas that cross research disciplines: the evaluation of empowerment, the relationships between economic status and health vulnerability, and the creation and maintenance of poverty.

7. *How the international community can improve maternal health in crisis and conflict settings*[135]

(7.1) To improve maternal health in crisis and conflict settings a comprehensive approach to sexual and reproductive health services is required. The critical importance of sexual and reproductive health (SRH) care to reducing maternal mortality and morbidity is well documented and recognized by the international community. Yet, lack of access to comprehensive reproductive health services, in particular family planning, skilled birth attendance and emergency obstetric care continue to lead to many unnecessary deaths, in particular in conflict settings in the developing world.

(7.2) Experience from Afghanistan, 5 years on from the start of the contracting out of health services, has shown that it is of crucial importance to start investing in training of female health services providers at a very early phase of health services rehabilitation and/or reform. This is true especially for countries where cultural barriers do not allow male health staff to provide care to female patients. Wherever possible, the provision of technical assistance to an (interim) health ministry with the specific aim of developing a strategy for human resources development for the maternal health sector—with a focus on recruitment and training of staff from rural areas—could prove to be a valuable foundation for the improvement of maternal health in countries emerging from periods of instability and conflict. Technical assistance for the development of appropriate curriculums for female doctors, midwives and nurses is another potential area of early investment.

(7.3) As a global leader in women's health and gender issues and a major humanitarian actor, DFID is best placed to draw attention to the pressing comprehensive sexual and reproductive health services needs of affected populations in crisis and conflict settings, and to use its influence at both national and international levels to ensure the incorporation of SRH as integral part of humanitarian policy and action. DFID is well placed to use its influence to pressure UN agencies (such as WHO, UNAIDS, UNHCR, OCHA, UNICEF, UNFPA) to include SRH (including emergency obstetrics) as an integral part of humanitarian policies and guidelines developed by the Inter-Agency Standing Committee (IASC). In particular, DFID should work with the humanitarian coordination system to ensure more attention is devoted to SRH needs, including by ensuring there is an appointed comprehensive RH sub-cluster coordinator under the Humanitarian Coordinator and the WHO-led Health Cluster. DFID should encourage humanitarian agencies, including the UN and NGOs, to develop the human resources necessary to set up and run effective comprehensive SRH programmes in emergency settings. We understand that DFID is particularly well placed to do this, because the approach it has taken for the fragile states is admired on the global stage.

(7.4) DFID could also work towards a better acknowledgement of skills and expertise that exist in the community afflicted by crisis and conflict. Before the "international community' is ready to intervene, the conflict-affected communities may well have developed their own coping strategies. The international community should look for those strategies, acknowledge locally available skills and experience, and help members of the local community who have initiated and fostered these coping mechanisms{to use them even more effectively. This could happen by officially acknowledging the important role they have played, and by ensuring that they benefit adequately from the financial and technical resources the international community will mobilise.

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[135] With inputs from Samantha Guy (Marie Stopes) and Anna Von Roenne (GTZ).

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12 September 2007

Memorandum submitted by Marie Stopes International

Marie Stopes International works through a partnership of agencies in 40 different countries working to improve sexual and reproductive health. Together, the partnership has almost thirty years experience of providing maternal health services in developing countries across four continents. We welcome this inquiry as an important opportunity to highlight the urgent need to address both lack of progress on MDG5 and also the ongoing neglect of essential, life saving health services for women that affects many poor regions throughout the globe.

1. Introduction

1.1 Globally, complications that arise during pregnancy and childbirth kill one woman every minute.[136]1 Numbers who suffer severe or permanent injury are unknown, but it is estimated that every year brings 100,000 new cases of obstetric fistula alone—a condition causing chronic incontinence and hence tragic social consequences for the women and girls affected.[137]

1.2 These deaths and injuries are concentrated in low-income countries. Pregnancy and childbirth causes a lifetime risk of death of one in sixteen for women in sub-Saharan Africa—a level of mortality that would be considered cataclysmic in any developed nation. Yet the issue is not just that globally so many women die from pregnancy but that so many die from a pregnancy they did not want. In Latin America and the Caribbean, for example, 35 to 52% of adolescent pregnancies are unplanned.[138]

1.3 The means of addressing high maternal mortality is well known. The five "big killers", together responsible for over 75% of maternal deaths, are haemorrhage, infection, unsafe abortion, eclampsia, and obstructed labour, all of which are treatable or preventable by skilled attendance at birth and emergency obstetric care (EmOC).

1.4 Furthermore, it is estimated that 25–35% of all maternal deaths could be prevented simply by providing contraception to women who want it.[139] Effective family planning programmes tend to halve average birth rates, so it follows that such interventions could in fact have an even greater impact on maternal mortality for areas currently without access to contraception.[140] This, together with its low cost and capacity to reduce the need for more expensive medical services, makes contraception the most cost-effective maternal health intervention.

1.5 Despite global recognition of these means of reducing maternal mortality, MDG5 has remained the most stagnant of the MDGs. Maternal mortality has not fallen since 2000 in much of sub-Saharan Africa, South Asia, West Asia, Latin America and the Caribbean, with some countries and areas even experiencing negative change.[141] Why has progress been so poor? The answer is twofold:

1. Funding for family planning had fallen since 1995.
2. The basic infrastructure for healthcare systems has long been marginalised from aid finance.

2. Maternal Health and Family Planning

2.1 Family planning is unique in its capacity to reduce demand on health systems to provide much more expensive and resource intensive services including post-abortion care, pre- and post-natal care, EmOC and assisted deliveries. For example, one study across several Latin American countries estimated the cost to the state of preventing one unwanted pregnancy through contraception at US$133 but also estimated the savings from services prevented at US$1,600.[142]

2.2 As Jeffrey Sachs highlighted in his plan to achieve the MDGs, providing access to family planning commodities and information also offers means of:

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[136] UNICEF, UNFPA, WHO (2004) *Maternal Mortality in 2000*.

[137] UNFPA (2004) *State of the World Population*.

[138] de Bruyn, M, and S Packer. 2004. *Adolescents, Unwanted Pregnancy and Abortion: Policies, Counseling and Clinical Care*. Chapel Hill, North Carolina: Ipas.

[139] Global Health Council (2002) *Promises to Keep: The Toll of Unintended Pregnancies on Women's Lives in the Developing World*.

[140] Cleland, John *et al* (2006) "Family planning: the unfinished agenda" in *The Lancet, Sexual and Reproductive Health, October 2006*.

[141] DFID Annual Report 2007.

[142] Cochrane S and Sai F (1993) "Excess Fertility" in Jamison DT *et al Disease Control priorities in Developing Countries* 1993.

— Reducing infant and child mortality,

— Reducing income poverty,

— Empowering women to participate in economic and political spheres,

— Improving access to education for girls and women,

— Reducing environmental damage caused by loss of natural habitat and soil erosion.[143]

2.3 Yet Donor support for family planning has actually fallen in absolute dollar terms from $723 million in 1995 to $442 million in 2004.[144]

2.4 While financial support for "population assistance" has increased exponentially since the International Conference for Population and Development (ICPD) in 1994, the vast majority of the new money has been for HIV/AIDS. But while family planning constituted 55% of population assistance in 1995, this has dropped to only 9% in 2004.[145]

2.5 We perceive that this decline in support for family planning has significantly undermined efforts for a global reduction in maternal mortality and will continue to do so until rectified. We urge the IDC to impress upon DFID the importance of a central place for family planning in new policies and advocacy for maternal health including in the International Health Partnership and in the Global Business Plan led by Norway.

DFID Support

2.6 There is much to commend in DFID support for maternal health including family planning. Examples such as Nepal (see case study below) and others indicate that, where relations with partner governments are strong, DFID has capacity to push through the maternal health agenda to make a real impact on mortality levels. Ongoing DFID advocacy for the new target under MDG5 for universal access to reproductive health services is also of great value to global ambitions to reduce maternal mortality.

2.7 But DFID financial support is difficult to appraise. Ongoing contributions to the United Nations Population Fund (UNFPA) are commendable, but total DFID spending on family planning is obscured by an amalgamation of the accounts with HIV/AIDS spending.

2.8 Furthermore, direct expenditure for maternal health appears to be quite low. The DFID Annual Report for 2007 lists maternal health expenditure excluding budget support as only £16 million in FY2005/06 of a total health spend of £200 million—in itself quite a low proportion of the total £2.5 billion bilateral spend.[146] This is perhaps best reflected in DFID Programme Partnership Agreement (PPA) allocations, none of which support agencies specialising in maternal health or reproductive health.[147]

2.9 Both the inability to measure trends in DFID support in family planning and also the apparent low level of expenditure on maternal health seem incongruous with DFID policy statements that identify reproductive and maternal health as key strategic priorities.[148] We urge the IDC to impress upon DFID the need to ensure that accounting and spending reflect agreed institutional priorities. We propose a new budget line for maternal health, against which DFID could measure its expenditure on a) family planning, b) EmOC and skilled assistance with delivery and c) safe abortion services.

DFID In-Country Advocacy

2.10 DFID advocacy in-country for health system strengthening, maternal health, sexual reproductive health rights and women's rights can—and does—play a key role in securing high level "political will" to address maternal mortality. It is therefore a matter of concern that DFID is under pressure to reduce its staff headcount.[149]

2.11 The strong and continuing lobbies against safe abortion services and for abstinence intensify the ongoing need for DFID to maintain and strengthen its own health advisory role in countries. We urge the IDC to emphasise the importance of country offices retaining the human resources necessary for effective advocacy at the country level. There is no contradiction between supporting greater government ownership and maintaining an evidence-based advisory role in the formulation of national health plans.

[143] Sachs, Jeffrey (2005) *Investing in development; A practical plan to achieve the MDGs* UN Millennium Project.
[144] UNFPA (2006) *Financial Resource Flows for Population Activities in 2004*.
[145] *ibid*.
[146] DFID (2007). *DFID Annual Report 2007: Development on the Record*. London.
[147] DFID (2007). *Partnership Programme Arrangements; The way ahead*.
[148] Eg DFID (2007) *DFID Health Strategy: Working together for better health*. London.
[149] DFID (2007) *Departmental Report 2006*. London.

Civil Society Advocacy and Campaigning

2.12 Civil society advocacy can create legislative change and a policy environment conducive for improving maternal health and DFID commitment to supporting grass roots advocacy is admirable. The Civil Society Challenge Fund (CSCF) has enabled a number of startlingly effective advocacy projects such as the Marie Stopes Clinic Society "DHARA Programme".

2.13 The DHARA programme is recognised for having used grass roots advocacy methods, including the creation of local civil society groups to monitor delivery of public health services at the local level, to affect both extraordinary qualitative improvements in services and hence also a significant increase in attendance at family welfare centres.[150]

2.14 However, there are serious limitations on what can be sustained with the CSCF £500,000 cap over a fixed maximum five-year period. This effectively prevents the roll out of successful local level programmes to larger scale. We strongly recommend that DFID review its CSCF programmes for examples of best practice. Good results should be rewarded with continued funding beyond the existing five-year limit.

Maternal health in humanitarian emergencies

2.15 Maternal health needs do not diminish in emergency settings. Yet an acceptable response to maternal health needs in emergencies is often obstructed by the misperception that humanitarian efforts can only afford to prioritise low cost and lifesaving interventions. This attitude neglects both the potential of family planning to prevent maternal deaths and also the realistic guidelines that exist for implementing effective maternal health services.

2.16 The Minimum Initial Service Package (MISP) is a SPHERE endorsed standard for humanitarian actors, outlining the reproductive health interventions—including EmOC and skilled assistance at birth—required in the onset phase of emergency. It further details how develop more comprehensive services as the emergency stabilizes.[151]

2.17 The fact that the humanitarian response rarely succeeds in providing adequate maternal health and family planning services is both unacceptable and remediable. Humanitarian agencies need to improve their capacity to deliver reproductive health services in emergencies and humanitarian donors must support and encourage them. The UN humanitarian coordination system must also afford greater priority to reproductive health: The "health cluster", as currently defined by the Inter Agency Standing Committee, must give greater recognition to reproductive health as a core focus area. DFID advocacy could be catalytic here, particularly if employed in its relationship with the World Health Organisation (WHO) which leads the health cluster.

2.18 Furthermore, given the ongoing inadequate support for reproductive health in emergencies, we urge CHASE to track its own grant allocations to programmes which include reproductive health services. There is also a need to ensure that CHASE includes reproductive health issues in the initial needs assessment stage of humanitarian interventions.

3. Health System Strengthening

3.1 While difficult to quantify, it is widely accepted that a significant proportion of donor finance for health is delivered through vertical funding streams. Whether for HIV/AIDS, vaccination programmes or the promotion of abstinence, these mechanisms share a limitation: Having been earmarked by donors for a specific purpose they have limited value in strengthening the essential infrastructure upon which all health services ultimately depend. Such infrastructure includes:

- Adequate numbers of trained and paid health staff.
- A sufficient, reliable and well distributed supply of health commodities and equipment.
- The requisite number of health facilities including hospitals and local clinics and an efficient referral procedures between them.
- Good administrative systems including for providing sanitary conditions.

3.2 It easy to see the link between maternal mortality and weak infrastructure. The provision of good maternal health services relies upon the ability to provide women with access to:

- Skilled birth attendants.
- Contraceptives, magnesium sulphate and other basic commodities.
- Blood transfusion, swiftly when required.
- A sanitary environment and sanitised equipment to prevent infection.

[150] Marie Stopes Clinic Society (2007) *Promoting Health Care Rights of the Poor; the DHARA Experience*. Dhaka.
[151] http://www.rhrc.org/MISP/english/about.html

Commodity supply systems

3.3 Health commodities are an essential part of any health programme and, for reducing maternal mortality, include magnesium sulphate for treating eclampsia and all modern contraceptives. Many of our partners observe that state-run family welfare clinics are often forced to turn away a large proportion of clients simply because they have run out of the basic commodities needed to provide the health service required.

3.4 These shortages occur even in cases where the central government has notionally agreed to provide free commodities equal to demand in all state-run clinics. In practice, the supply of commodities to clinics will be both insufficient in its quantity and erratic in its delivery. This is usually due to a combination of inadequacies in:

— Forecasting, procurement and record keeping.
— Storage depots and their facilities.
— Haulage fleets and transport infrastructure.

3.5 It is important to consider that the inability to provide a client with commodities is not only a problem in itself, but also deters such clients from visiting again—particularly those who have travelled long distances—contributing to under utilised resources during times when commodities are available.

3.6 Non-state health providers also suffer from this deficiency. Without means of obtaining government supplies NGOs have to try and procure their own, but the difficulties in registering generic commodities frequently prove prohibitive. National Drug Authorities, especially in Africa and the Middle East, have a reputation for taking months, sometimes years, to register generic commodities and for requiring incentives to do so. Similarly, port authorities have a reputation for bureaucratic inefficiencies that leave health commodities in warehouses, indefinitely awaiting clearance. These obstacles can and do hinder Ministry of Health efforts to procure commodities as well as those of private sector agents.

3.7 Unless the bottleneck of commodity insecurity is removed, objectives such as; releasing new funds for basic health services, harmonised funding behind single national health plans, and even the recruitment of greater numbers of health workers, will have at best only a limited impact on scaling up service delivery.

3.8 In countries where DFID is supporting SWAps and basket funds, DFID should continue to advocate for the earmarking of sufficient funds for the supply chain and specifically for family planning commodities. Funds for the supply chain often tend to suffer when specific donor support is withdrawn in favour of overall budget support so we further recommend supply systems as a key issue for DFID advocacy.

The International Health Partnership (IHP)

3.9 The recent announcement of the IHP comes as a welcome initiative.[152] Its three aims—to better harmonise donor funding; to better support country-led health plans; and to improve health systems as a whole—would all enable recipient governments to invest more in health infrastructure if realised. We congratulate DFID on the initiative and on having secured the signatures of the Global Fund for AIDS, TB and Malaria and the GAVI Alliance on the IHP Compact.

3.10 The goal of the IHP to encourage vertical donor programmes and financing mechanisms (such as GFTAM) to better support basic health infrastructure is highly relevant to commodity supply systems. Vertical mechanisms focus exclusively on the commodities relevant to their specific diseases and hence tend to contribute to the neglect of the overall commodity supply system. The IHP should be used to encourage vertical funding mechanisms towards giving support for the overall national supply chains for all essential medicines and commodities.

3.11 The IHP proposes a shift towards greater government ownership of national health plans which, while welcome, further intensifies the importance of effective advocacy in-country. We refer again to our recommendations re DFID human resources for advocacy on health and for supporting civil society. We also note that the most effective results are achieved where advocacy at the two levels operate in tandem, as witnessed in the Nepal case study below.

Case Study: Nepal

3.12 In 1996, Nepal was burdened with one of the highest levels of maternal mortality, with an MMR of 539 maternal deaths per 100,000 live births.[153] This can be attributed to the inter-action of several factors including:

— Low access to family planning.
— High incidence of child marriage.
— Abortion illegal.

[152] DFID (2007) Press Release 5 September 2007 *Prime Minister launches new International Health Partnership*.
[153] Nepalese Ministry of Health and Population (2007) *Nepal Demographic Health Survey 2006*. MEASURE DHS.

— Very low access to ante-natal care, skilled assistance during delivery and EmOC.

3.13 Lack of access to contraception leads to demand for abortion despite its illegality. Methods of "back-street" abortion in Nepal—as in other developing countries—include drinking poisonous "remedies", pushing substances such as bleach into the uterus, inserting sticks and other sharp objects and heavy pelvic pummelling, all of which frequently result in life threatening complications.

3.14 In 1997, DFID supported the roll out of the "Nepal Safer Motherhood Initiative" (NSMI). The programme—managed by UK health consultancy "Options"—was successful in supporting the Nepalese government to exponentially expand and improve maternal health services. NSMI focused its activities around:

— Policy development, including "paramedicalisation" where nurses and other mid-level providers are trained to provide EmOC services previously exclusively provided by doctors.

— Service delivery, including staff training courses and improving infrastructure.

— Behaviour change communication for health-users, including use of a wide range of media advertising new services available.

3.15 The creation and implementation of NSMI coincided with a period of high profile and sustained civil society-led campaigning calling on the government to deliver health services for safe motherhood and for the legalisation of abortion. Not only did this compliment NSMI efforts in its policy dialogue with government but it also led, in 2002, to the legalisation of abortion.

3.16 The roll out of safe abortion in Nepal has been efficiently managed. HMGN took the decision to incorporate the capacity of the non-state sector in order to begin delivery of safe abortion services as quickly and as widely as possible. MSI partner, Sunaulo Parivar Nepal (SPN), was well placed having been providing post-abortion care services in country since 1994. Its network of clinics were contracted by HMGN to provide safe-abortion services in 60 of Nepal's 75 districts and services have also been coordinated in ten further districts. This utilisation of non-state sector capacity has enabled safe abortion services to be rolled out rapidly and cost-effectively.

3.17 The Nepal Demographic Health Survey 2006 found MMR to have fallen from 539 in 1996 to 281 ten years later. We congratulate DFID on its strong role in this achievement.

3.18 Events in Nepal suggest that MDG5 is not too ambitious: A 75% reduction in maternal mortality ratios is possible by 2015. We draw the following further conclusions from both Nepal and also the experience of other MSI partners:

Incorporating the Non-state Sector

3.19 Often forgotten or ignored, incorporating the non-state sector into national health strategies can make a significant contribution to scaling up delivery on the health MDGs and building public sector capacity. By contracting out, governments can utilise the facilities, staff and expertise of non-state providers to deliver health services efficiently, cost-effectively and as part of a government led national or district-level strategy.

3.20 In Tanzania, for example, Marie Stopes Tanzania (MST) is contracted to periodically provide family planning services from public health facilities. This arrangement also enables MST to train local public-sector health staff in effective family planning procedures and so improve public sector capacity in this important area.

3.21 We urge the IDC to applaud DFID on including mention of the non-state sector in the IHP Compact and to emphasise the importance of maintaining this focus. However, we feel DFID could do more here at country level. In Pakistan, for example, where 70% of women go to the non-state sector for their health services, only 17% of DFID financial support reached non-state health providers in 2006.[154]

Paramedicalisation

3.22 "Paramedicalisation"—where mid-level health service providers are trained and permitted to perform medical procedures previously confined to doctors—offers a significant means of increasing the capacity of a health system to provide services. Trials by MSI in South Africa and Vietnam of almost 3,000 manual vacuum aspiration procedures found that first trimester abortions performed by appropriately trained health professionals who are not doctors do not suffer from increased incidence of complication.[155]

3.23 We recommend that DFID advocate at both international and national levels for paramedicalisation of procedures such as EmOC, caesarean-section, anaesthesia and safe abortion services as a key policy for health system strengthening.

[154] Figures obtained through private correspondence with DFID Pakistan.

[155] Warriner *et al* "Rates of complication in first-trimester manual vacuum aspiration abortion done by doctors and mid-level providers in South Africa and Vietnam: a randomised controlled equivalence trial" in *The Lancet* 29 November 2006.

4. Summary of Recommendations

4.1 The low proportion of direct DFID expenditure on maternal health points to a need for DFID to better align expenditure with its stated intent to prioritise maternal and reproductive health. We recommend a new maternal health budget line for DFID that would include expenditure on a) family planning, b) EmOC and skilled assistance with delivery, and b) safe abortion. This would facilitate a commitment to annual increases in expenditure in these three key areas for maternal health.

4.2 The global decline in donor support for family planning since 1995 requires urgent attention. We urge the Select Committee to impress upon DFID the importance of making family planning a key priority for advocacy and to use the IHP in support of family planning wherever possible.

4.3 The International Health Partnership is a welcome initiative that has the potential to make significant advances in global health and towards achieving MDG5. For the IHP to succeed it should continue to include focus upon improving commodity supply systems and the incorporation of the non-state sector as key issues for health system strengthening.

4.4 DFID advocacy has a successful track record on winning political will to address maternal mortality in partner governments. We urge the IDC to protect DFID from pressures to reduce staff numbers that may weaken DFID capacity for advocacy.

4.5 Civil society can and should play a powerful role in generating political will. We urge DFID allow greater flexibility in its Civil Society Challenge Fund to support effective programmes beyond the first project cycle.

4.6 The commodity supply system is an essential component of a well functioning health system. In countries where DFID is supporting SWAps and basket funds, DFID should continue to advocate for the earmarking of sufficient funds for the supply chain and specifically for family planning commodities.

4.7 Paramedicalisation offers a significant means of increasing the capacity of health systems. We recommend that DFID advocate for the paramedicalisation of relevant medical procedures at both national and international level.

4.8 Incorporating the non-state sector into national health strategies can contribute significantly to scaling up health service delivery and to building public sector capacity. DFID and the IHP can support health systems by encouraging optimal use of the non-state sector in national health strategies.

4.9 DFID has identified reproductive health as a key priority, but it must extend this policy to its humanitarian portfolio. To address the ongoing neglect of reproductive health (RH) services in humanitarian emergencies, DFID must:

(a) Advocate for greater priority for RH within the health cluster led by WHO,

(b) Monitor its own performance by tracking CHASE grants for RH programmes,

(c) Ensure that RH issues are included in all DFID needs assessment activities.

September 2007

Memorandum submitted by Maternity Worldwide

Maternity Worldwide is a UK based INGO which works in partnership with communities and local organisations (public and NGOs) to support the awareness of, access to and provision of emergency obstetrics care.

Maternity Worldwide welcomes the opportunity provide input into the International Development Select Committee Inquiry on Maternal Health. In order to provide our feedback we have sought the opinion of our staff and our partners and discussed this to ensure that the views we are putting forward are representative and in line with actual experience.

In summary we believe that DFID has played a significant role in helping to address the critical issues associated with improving maternal health in developing countries. We believe that there is scope for further intervention and support to continue to make a real difference in this area. We have outlined some specific responses below and take this opportunity to highlight the need for an emphasis on continued strengthening of health systems and human resource development in all areas of MCH.

1. *How can donors (specifically DFID) catalyze progress towards MDG 5?*

The new DFID new health strategy, the support for the Global Campaign for the Health MDGs and the new International Health Partnership are examples of DFID's potential to help catalyse progress. The evidence based approach to developing capacity and to strengthening health systems is to be encouraged, as is more consultation in the development of initiatives such as the IHP. The move away from utilising NGOs as part of the solution causes some concern and a number of our partners request that DFID and others have a role to play in increasing the funding available to NGOs.

DFID has shown an obvious commitment to funding maternal health however there remain concerns over the actual and perceived decline in funding for this area (as reported in a number of studies and evaluations, including *The Lancet* 2006 series of papers). DFID and other funders can play a real role in helping to address shortfalls.

Additionally there is a role to be played in helping to ensure that policy is appropriate (and adaptable to reflect the actual needs of women in situ) and that policy is translated into action (funding required).

Donors are well placed to fund effective and innovative approaches, including smaller scale approaches, but are on occasion not well enough linked to beneficiaries and local expertise and understanding. There is scope to increase the expertise within DFID and to work in closer collaboration with local health professionals, NGOs and other civil society organisations. In addition there is scope to provide leadership in creating intersectoral and comprehensive approaches which include and reflect a range of different demands and providers.

Continuing to support initiatives to address issues around equity in the access to and uptake of information and services (within the context of broader civil society initiatives and rights based approaches) is a vital role.

2. *How effectively is DFID working to ensure EMOC is available and accessible with adequate numbers of skilled birth attendants?*

The answer to this question varies between stakeholder groups and with the parameter within which it is placed. At a macro level there is recognition that DFID has played a significant role in this area through the development of policies and the provision of funding.

Whether or not this has been effective is less easy to answer. There is a suggestion that more collaboration with local health professionals and local organisations would make the approach more effective. Comments from our local partners reflect that the effectiveness of any donor will be limited by extent to which the agreed health plans are being implemented. In many areas the critical shortages of manpower and skills, particularly the lack of an alternative for TBAs, along with other barriers to access, prevents effective implementation and consequently limits the overall effectiveness. There can be significant variation within and between regions in many countries (particularly with fragile states). In many areas there is limited progress in this area and services are provided by NGOs and/or missionary providers in absence of any (or any effective) public health initiatives.

There is a need for better monitoring of outcomes (both in terms of the provision of services and the other determinants of accessibility) in order to help assess where progress is not being made and to increase accountability at all levels.

3. *How effective is DFID in mainstreaming maternal health across related policies?*

Again the responses to this question vary with the focus of the respondent and the definition of "related policies". There is recognition that DFID has played a significant role in pushing for and supporting the strengthening of health systems and also a recognition that more needs to be done in linking the outcomes of operational research to policy and to supporting the implementation of policies.

4. *How is MDG 5 being supported and prioritised?*

As outlined above there are concerns that whilst prioritisation is clearly demonstrated at policy and planning level, this does not cascade to operational level. Where roadmaps and other plans exist there is inadequate funding, inadequate manpower and other issues that limit the ways in which MDG 5 is supported and prioritised. Additionally it is not always immediately obvious where support (particularly funding) and activities are specific to maternal health or part of more general health initiatives; there needs to be a greater focus on MCH and on monitoring inputs and outputs related to MDG 5.

5. *Is DFID's approach to supporting the 2006 MDG target of universal access to reproductive health effective?*

The UK's involvement in the creation of this new target is welcomed and DFID's role in this is recognised. However there are concerns that the lack of agreed indicators is far from ideal; it potentially negates the credibility of the target and prevents an assessment of progress against the aims and goals of the target. There is a clear role for DFID to play in supporting the development of indicators and of continuing to work towards ensuring that funding is available and that appropriate policies are developed to support universal access.

6. *Are you aware of what progress is being made to reduce the number of women dying from unsafe abortions?*

Progress is being made and specific organisations (NGOs in particular) are recognised as being particularly active in this area: MSI, IPAS and IPPF. However progress remains slow and funding is insufficient to provide the required awareness and access to safe services, including prevention. The role of donors such as DFID in providing funding and in supporting an integrated approach to addressing the demand and supply issues is less clear.

7. *How effective do you think DFID is in working with bilateral and multilateral donors, NGOs and other stakeholders, to improve maternal health (in your country)?*

Internationally it is recognised that strong and productive relationships exist between DFID and other key stakeholders as evidenced by the support to the WHO RH Research Department and the Partnership for Maternal Newborn and Child Health. There is scope for DFID to continue to use its relationship with other governments and stakeholders (notably the US government, the EU, the Global fund and the World Bank) to support and promote positive changes in funding and support policies towards achieving the MDGs.

The relationship with NGOs is variable and appears to be in decline which causes concerns. The range and variety of NGOs is seen by many as a strength which should be incorporated into comprehensive approaches to addressing the MDGs. DFID's approach to reducing the number of "partners" and NGOs in particular is a real concern to many of our partners and stakeholders who welcome a more holistic approach to strengthening health systems and to supporting a CSO-initiated drive for advocating for better health care.

Some concern was expressed over the IHP approach representing a culmination of a policy to remove NGOs (and in absence of evidence for other initiatives to address this, the presumed loss of effective civil society representation) from the equation and as seen by some as a indication of DFID's loss of autonomy and a failure to seek intersectoral initiatives to addressing poverty.

8. *What leadership is the UN providing in addressing maternal health and how well co-ordinated is its agencies?*

UNFPA is widely recognised as providing significant support to addressing maternal health, particularly in Africa where the secondment of expertise and effective individuals is seen as real progress. It is less clear what role UNFPA or other UN agencies have in providing effective leadership on a macro and national level; this has implications on the co-ordination aspect of this question. There is no standard approach and the focus of the different agencies differs across continents and countries. The feedback suggests that the remit of each (and their effectiveness) is linked to individuals in post. There is evidence that the three WHO departments focused on maternal health are duplicating work, which is indicative of a lack of co-ordination and also of the potential for contradiction, interpretation or even lack of action in some areas.

9. *How effective is DFID in addressing the socio-economic barriers to women's empowerment and the low status of women in relation to maternal health?*

We do not have a comment on this question.

10. *How can the international community improve maternal health in crisis and conflict settings?*

There is a need to ensure that RH and maternal health is prioritised within these contexts.

There are a number of suggestions, the majority of which centre on the need for better collaboration and co-ordination of activities (with the need to improve systems for communications, knowledge management etc).

Access to funding is critical as is the need to ensure that longer term financing solutions will be available to support those communities however the situation is resolved (or not).

NGOs are often able to operate in climates that challenge public sector providers and should be included within the solution.

There is now significant operational (and academic) research into ensuring the efficacy and appropriateness of responses and there is a need to help ensure that this evidence informs responses.

Increased collaboration and information provide a platform for appropriate responses where the flexibility to remain responsive and to work in the absence of policy is key. Along side this is the need for improved accountability. A recognition that in many fragile states the architects of the systems into which investment is generally being made may be a substantial part of the problem.

Community involvement is critical to inform responses and as the basis against which to help evaluate the effectiveness and appropriateness of services.

September 2007

Memorandum submitted by Merlin

About Merlin

1. Merlin is the only UK specialist agency, which responds worldwide with vital healthcare and medical relief for vulnerable people caught up in natural disasters, conflict, disease and health system collapse. Merlin's aim is to ensure that vulnerable people who are excluded from exercising their right to health have equitable access to appropriate and effective healthcare.

2. This aim is inspired and underpinned by the World Health Organisation (WHO) declaration[156] that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without discrimination of race, religion, political belief, economic or social condition". In support of this aim, Merlin works in partnership with global, national and local health agencies and communities to strengthen health systems and build community resilience to better prevent, mitigate and respond to health outcomes.

This response focuses on a few key areas highlighted by the Inquiry's Terms of Reference.

Mainstreaming Maternal Health

3. In Merlin's view, DFID is working effectively to mainstreaming its maternal health priorities within the broader health policy framework. The department's focus on strengthening health systems prioritised in the new health policy (2007) as a mechanism for improving maternal health outcomes is welcome. In our view, progress towards the health MDGs can only be achieved by working in support of national health plans aimed at strengthening the effectiveness of the health sector and not through single issue interventions.

4. DFID cites maternal mortality as the best single indicator of the effectiveness of a country's health system. Merlin welcomes this focus on maternal mortality as a key indicator. Maternal mortality impacts significantly on newborn and child health—a child is 2 to 3 times more likely (than other children) to die if its mother dies—however this focus on maternal health is not reflected in the same way by other donors or international institutions. DFID is in a good position to influence other donor priorities in this area and Merlin would welcome their efforts to do so.

5. The priorities set by the maternal health strategy in 2004—to raise the profile of maternal mortality, find ways to scale up interventions address socio-economic barriers to access and develop and apply new knowledge—remain critical areas for development. DFID's second progress report (2007) recognises shortfalls in achieving these and acknowledges that further progress will require significant investment in human resources for heath and support for health services over the long term. Merlin fully endorses this approach; current humanitarian mechanisms are typically short term (12–18 months), and are inappropriate to support long term investment in human resources. While DFID's policy commitment to long term support is welcome this must be supported by appropriate long term funding mechanisms.

6. The challenge (for DFID and all health actors) is to translate these policy commitments at headquarters level to effective programming and financing mechanisms at country level, particularly in fragile states. Engaging with partners, particularly at local level must continue to be a key priority for DFID in the area of maternal health. While the approach of working with Governments has its advantages in terms of political commitment and broad scale of operations, it can lack the depth of partnership, commitment to equity and empowerment that Civil Society Organizations (CSOs) can offer. Failure to secure involvement of these stakeholders, which includes women themselves, will result in slow progress. CSOs can play a pivotal role in addressing the "three delays"; they often have the depth of relation with communities to design and implement strategies around understanding of local context and the issues faced by communities.

Engaging with Bilateral and Multilateral Institutions

7. DFID seeks to, and has been effective in, influencing international partners in accordance with its pro-poor agenda. The challenge for the department will be to maintain this influence in the face of growing multilateral disbursements (eg through the World Bank). DFID has rightly developed a reputation as a strong advocate for the poor and there is some concern that this voice could be diluted. The proposed reductions in staffing levels are also cause for concern as ODA disbursements increase.

8. Merlin welcomes DFID's call for the number of global health initiatives to be rationalised and welcomes the introduction of the new International health Partnership. Global Health Initiatives should support strengthening of health systems that deliver health services more broadly.

[156] As reflected in the WHO constitution (1946), Alma Ata Declaration (1976) and World Health Assembly (1998).

Emergency Obstetric Care

9. In considering the broader determinants of maternal health, DFID's strategy (2004) has a strong focus on the provision and strengthening of emergency obstetric care at BEOC/CEOC[157] level. While this focus is important, it is vital that DFID interventions promote the continuum of care at community/household level, where women are at greatest risk from two of the "three delays": the delay associated with the decision to seek care; the delay in arrival at the point of care and the delay in the provision of adequate care. It is important that mothers are able to recognise danger signs, be aware of the services available and how to reach them. A Knowledge Practise Coverage Survey carried out by Merlin in Ayeyarwaddy Division, Burma in December 2005 (see Annex) showed that only a very small proportion of mothers knew about maternal related (pregnancy, delivery and postpartum) danger signs. This finding is not untypical and a holistic approach is needed to address all of these key delays as one entity, not just a focus on emergency obstetric care.

10. While the first two "delays" require action at the household and community level, addressing the third delay alone—by improving capacity for emergency obstetric care at the health care level—is unlikely to be effective if there is no community demand for services. This emphasis on creating demand for services sits well with DFID's policy objective of promoting good governance and enabling local people to call health service providers to account.

Availability of Trained Staff to Meet MDG 5

11. Merlin welcomes the department's strong commitment to promote and support the development of human resources for health. The lack of human resources for health is one of the most serious constraints to achieving the health MDGs, particularly within the context of fragile or transitional contexts. The rise in the burden of communicable disease combined with chronic under investment in health systems means that many countries face acute health systems collapse.

12. Access to appropriately trained health workers for many women during pregnancy and childbirth is poor. Evidence from Merlin's programmes in Ayeyarwaddy Division, Burma focusing on determinants of maternal health shows that most deliveries—up to 89%—occur in the home, attended by unskilled and untrained birth attendants, most commonly by "traditional birth attendants" (see Annex). There is considerable discourse about the use of unskilled TBAs; the challenge in many fragile states is that human resource development is currently at very low levels. In Merlin's view alternative solutions, such as developing core competencies might be considered and the department could support innovative approaches to training and development.

13. DFID has made clear commitments to supporting 10 year plans for health system support, with particular note to strengthening human resources—including development and training, recruitment and retention. The department has demonstrated a willingness to support existing health staff by providing financing for incentives for health workers in underserved areas or where governments are unable or unwilling to pay salaries. In the absence of predictable financing for the health sector, donor support for incentives payments is a viable way of supporting recruitment and retention of health workers. The difficulty is that DFID's policy approach in this area is not supported by other key donors. Conflicting donor approaches vis-à-vis support for incentives/salaries means that at field level health facilities in one area might receive support for incentives while neighbouring facilities supported by a different donor do not. The tendency for donors to split areas geographically can lead to practical inconsistencies and impact on people's ability to access health care.

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September 2007

Annex

1. Merlin conducted a Knowledge Practice Coverage (KPC) Survey in December 2005, in one of the remote Townships in South Burma. The purpose of the study was to provide further insight into:

- Key determinants of maternal and newborn health such as coverage of knowledge and practices at the community/household level.
- Unmet need for focussing on continuum of care for maternal and newborn health at health facility and community/household levels.

[157] Basic Essential Obstetric Care and Comprehensive Essential Obstetric Care.

2. The study found system failures, namely inadequate Antenatal care (ANC), childbirth and Postpartum care (PPC) services including essential newborn care. The vast majority of the services are provided by midwives (in private) and untrained birth attendants or private practitioners, demonstrating extreme under-utilisation of public health services. The KPC survey found that the vast majority of mothers deliver at home and in most cases are assisted by untrained birth attendants and Traditional Birth Attendants (TBAs). Limited capacity of the public health facilities (including no BEOC services) and long travel distances to the referral hospitals were given as some reasons why skilled workers cannot attend most deliveries.

3. Other survey findings indicate extremely low awareness and knowledge of the population. Women are not consuming enough food during their pregnancies and it is likely that many women suffer from iron deficiency. Respondents' understanding of birth planning and emergency preparedness is also extremely low. It is possible that the strong prevention and promotive work with communities through behaviour change and communication (BCC) as advocated in the Safe Motherhood Initiative and current reproductive health strategies has never been integrated into ANC services. This initiative encompasses education and empowers women, families and communities to prepare for safe delivery and for motherhood. The approach promotes early recognition of complications for mother and baby at any time during pregnancy, delivery or after delivery and maximises the likelihood of timely referral and management (three delays at the community and fourth at the facility level). This involves preparedness within the community and within the formal health care system.

The summary finding of key safe motherhood indicators are shown below in figures and tables:

Figure A

KNOWLEDGE OF MAIN DANGER SIGNS DURING PREGNANCY GIVEN BY MOTHERS

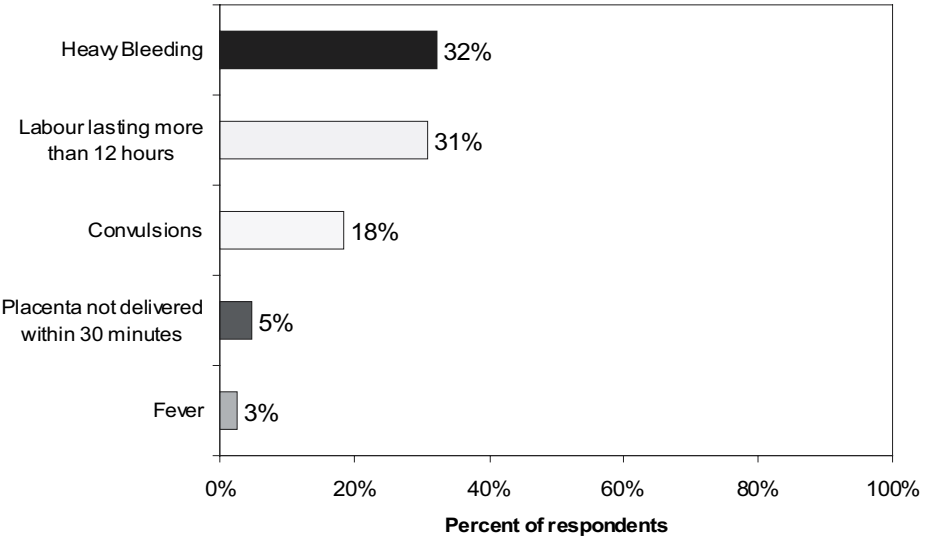

Figure B

PLACE OF MOST RECENT DELIVERY REPORTED BY MOTHERS

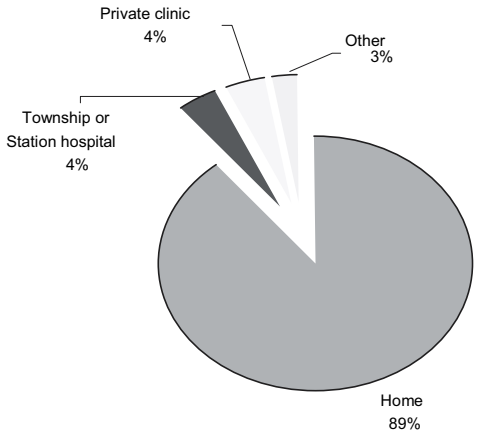

Table 1

ASSISTANT DURING MOST RECENT DELIVERY

Assistant at deliveries	*Frequency*	*Percent*
Untrained attendant		
Untrained TBA	231	48.5
Untrained Relative	9	1.9
Trained Relative	2	0.4
CHW/CHW	1	0.2
Herself	1	0.2
Husband	3	0.6
Mother-in-Law	1	0.2
Neighbour	1	0.2
Subtotal	**249**	**52.1**
Trained and skilled attendant		
Doctor	24	5
Nurse	6	1.3
LHV	21	4.4
Midwife	73	15.3
Subtotal	**124**	**26.0**
Trained but unskilled attendant		
Auxiliary Midwife/TTBA	103	21.6
Total	**476**	**100**

Table 2

CORD CARE AFTER BIRTH AS REPORTED BY MOTHERS

Description of cord care after birth	*Frequency (n=476)*	*Percent*
Timing of cord cutting		
Immediately after birth	269	56.5
After delivery of placenta	132	27.7
Don't know	75	15.8
Instrument used to cut cord		
Razor blade	200	42.0
Scissors	68	14.3
Bamboo	41	8.6
Knife	14	2.9
Other (thread, palm, coin)	21	4.4
Don't know	131	27.5
Sterilisation of instrument		
Boiled	114	23.9
Not boiled	203	42.7
Don't know	159	33.4

Table 3

MATERNAL KNOWLEDGE OF ILLNESS SIGNS IN NEWBORN

Signs of illness in the newborn	*Frequency (N=476)*	*Percent*
Considered correct		
Fever	217	45.5
Not active	157	33.0
Poor feeding	113	23.7
Runny nose (cough and cold)	63	13.2
Redness/discharge from eye	43	9.0
Jaundice	12	2.5

Signs of illness in the newborn	*Frequency (N=476)*	*Percent*
Fast breathing	11	2.3
Irritable	10	2.1
Cold (lips turned blue)	8	1.6
Redness around the cord	5	1.1
Fits	4	0.8
Other responses		
Suck more milk	162	34.0
Chest congestion	21	4.4
Dysentery	16	3.4
Lowering of forehead	8	1.6
Staying too close to the mother	8	1.6
Abdominal pain	4	0.8
Newborns never become sick	2	0.4
Other	54	11.3

Memorandum submitted by Nestlé UK

As you will be aware, Nestlé has a strong legacy of investment and trade in the developing world having built our first factory in Latin America in 1921. Today, 45% of our factories and 48% of our employees are based in developing countries. Nestlé is dedicated to a long-term strategy, putting business development above short-term returns. As a result, we have become fully integrated into the social, cultural, and economic life of the countries in which we operate.

Equally important to our core business is our commitment to sustainability and corporate social responsibility which is reflected through our concept of Creating Shared Value—a belief that in order for a company to create value for its shareholders over the long term, it must bring value to society as a whole. This is reflected across our supply chain and in the many programmes and projects that Nestlé support, including those that work toward attainment of the U.N. Millennium Development Goals (MDGs)

Nestlé regard the MDGs as important objectives for improving the state of the world and in addressing the most pressing needs of people particularly in developing countries. We fully support all 8 Goals and believe by creating international and local partnerships with governments and NGOs, we can measurably improve framework conditions.

In particular we feel, and pertinent to this inquiry, that the issue of improving maternal health is crucial. Women comprise a large percentage of our workforce, are often of child-bearing age and can, in certain circumstances and cultures, be less educated than their male counterparts and with a lower social status.

We believe that if we are successful in our long-term investment approach and our own goal of creating sustained shareholder growth, we can help improve women's health throughout our supply chain. With the inextricable link between mother and child, this can often lead to a brighter future for children and young people—healthy mothers are in the best possible condition to raise healthy babies.

Nestlé are active in working to not only improve mothers' nutrition, but also, in partnership with public health organisations and NGOs, to help them deal with health and hygiene issues. Below we have described a number of initiatives which showcase community programmes that Nestlé support to improve maternal health. These include specific projects which help address the problems of HIV/AIDs and access to clean water—two critical issues known to affect high maternal and infant mortality rates in the developing world.

Senegal

— Nestlé collaborated with NGOs, ENDA Tiers Monde and the International Association for Maternal and Neonatal Health in Senegal, to establish 20 centres to improve nutritional and hygiene status of mothers and their infants under 5 years of age.

— Pregnant women without family support receive counselling, education and medical care in the centres, including information on HIV/AIDS and women's health issues.

— In total, the programme provides health care information to 3,500 families, improves the nutritional status of more than 2,000 infants and young children, and promotes understanding of HIV/AIDS among nearly 15,000 persons.

Venezuela

— More than 1000 Nestlé employees in Venezuela participate in both payroll contributions and volunteer time to support medical and educational institutions in 11 communities.

- Orphanages and special needs schools benefit, as well as Alzheimer's patients and those suffering from cancer or malnutrition.
- In addition, through a new nutrition education programme developed with the nutrition foundation Bengoa and entitled "Santa Cruz de Aragua is learning how to eat well", Nestlé support a specialized team to monitor the nutritional state of children in schools.
- It is hoped that the programme will impact on the community and improve the nutritional knowledge and capacity of school children to detect and correct any problems in their nutritional status.
- Meanwhile, "Project Health and Family"—the construction of dining halls for poor children, feeding programmes, and nutritional assessments—has also benefited more than 6,000 people throughout Venezuela.

Bangladesh

- Nestlé supports the Impact Foundation, a local NGO involved in implementing a series of nutrition education programmes in the Chuandanga District of Bangladesh. As a result, more than 1,500 mothers, government health workers and community leaders have participated in these programmes.
- We also support a series of nutrition workshops in the mountainous Chittagong Hill region.

Kenya

- Nestlé sponsor the Community Nutrition Award, launched in 2004 and given annually to women's groups that have implemented practical programmes to combat hunger and malnutrition using locally available food resources.
- The award seeks to recognise women in unique positions as community health gatekeepers not only in family food preparation and management but also as community food growers and producers.
- In addition, the Nestlé Nutrition Institute Africa supports community nutrition and public health through local scientists and the funding of studies which look at feasible interventions in micronutrient deficiencies and nutrition in ill and low-birth weight babies. More than 300,000 babies benefit annually.

Ethiopia

- In 2003, Nestlé began a partnership with the United Nations High Commissioner for Refugees (UNHGR) to address the water needs of more than 200,000 Somali refugees and local people in Eastern Ethiopia.
- The partnership, based on financial support as well as on-going technical assistance from Nestlé, resulted in a multi-faceted water system including rehabilitated wells, an improved pumping and purification station connected to a 22-km pipeline, new water taps in adjacent villages and a new dam to capture rainfall.
- During 2005, Nestlé began the process of handing over the long-term operation and maintenance of the system to local water authorities.

Philippines

- Water Education for Teachers (WET) is a non-profit organisation and publisher, supported by Nestlé Waters since 1992, that provides education resources to facilitate and promote the awareness, appreciation, knowledge, and stewardship of water resources.
- Project WET workshops and programmes have trained over 400,000 teachers, and reached several million children in over 20 countries worldwide.

Nigeria

- Partnering in 2002 with the International Federation of Red Cross Society CIFRC in Nigeria, where more than five million people are infected with HIV/AIDs, Nestlé has devised a partnership programme which has led to:
  - The provision of anti-retroviral drugs and treatment of employees and their dependents.
  - The training of approximately 2,640 peer educators to provide peer-led awareness raising.
  - 5,000 families reached through the Home Based Care Programme.

Alongside the various programmes and projects outlined above, Nestlé is also respected for its strong focus on infant and child nutrition in the developing world. We recommend exclusive breastfeeding for the first six months, and believe that breastmilk is the best way to start a baby out in life. However, for mothers who either cannot or choose not to breastfeed, Nestlé formula products offer a safe, nutritious alternative.

Underpinning all of our nutrition work is a strict adherence to implementing the World Health Organisation (WHO) Code in developing countries around the world.

In summary, we strongly believe that businesses, alongside other stakeholders, have a key role to play in bringing about positive, sustainable changes in developing countries. Learnings from the past indicate that community based partnership solutions which respond to local needs, and harness local know-how and knowledge have the best chance of impacting on the MDGs.

Memorandum submitted by the Peoples' Health Movement and Global Health Watch Secretariat

SUMMARY

The major challenge to reaching MDG5 is the failure to translate existing recommendations, strategies and policies into effective implementation. The major barriers to effective implementation are:

- poor stewardship and strategic management of the health sector, compounded by the proliferation of external health initiatives, macroeconomic conditions and health sector reforms that have fragmented and weakened public health systems; and
- a lack of basic health care resources in the form of:
  - skilled health workers; and
  - health care facilities that are accessible, equipped to provide a safe delivery environment, including referral to centres with comprehensive emergency obstetric care facilities.

For these reasons, this submission focuses on DfID's need to emphasise the more basic issues of health systems development as a *pre-requisite* for maternal health improvement.

We also emphasise that improving maternal health services extends beyond achieving a reduction in maternal morbidity and mortality:

- it will have a significant positive impact on child health and HIV transmission;
- because it requires "fixing" the health system as a whole, maternal health programmes can act as a catalyst for wider health sector development;
- it can act as a catalyst for female empowerment and improved family planning; and
- it often requires the explicit targeting of the poorest and most marginalised sections of society.

However, too little of the external funding directed at the health sector is allocated to maternal health. The IDC should encourage DfID to take an even more active stance in improving maternal health.

Compared to other donors and global health initiatives, DfID provides important leadership in the health sector. Spearheading the International Health Partnership (IHP) is also a welcome initiative. But the IDC should interrogate DfID's plans for operationalising the IHP and question the wisdom of DfID cutting back on its technical staff at a time its budget is increasing.

Although there is general recognition of the importance of training and retaining health workers in developing countries, there is little in the way of concrete action. One notable exception is Malawi's Emergency Human Resource Programme (EHRP). But this has not been replicated elsewhere. The IDC should ask for a full briefing of the EHRP; and why this approach is not being replicated elsewhere. There is also important HR policy research that needs to be funded.

One of the underlying causes of maternal mortality is poor health sector stewardship and weak health systems management capacity. Governments, donors and external health initiatives continue to fail to address these shortcomings. Initiatives aimed at strengthening public sector stewardship and management capacities have too often been fragmented, piecemeal and short-lived. The failure to develop civil society capacity to hold government and public administrations to account is another concern. DfID should take some leadership in this area. However, this requires a long-term strategy, rather than a quick-fix approach; and it requires strategies that do not involve the export of "new management fads and practices" from developed countries.

Finally, as far as research is concerned, we would like to call for more *implementation research*. This is research that informs policy makers and managers in real-time about what is and isn't working, and why. It focuses on how to promote the uptake and successful implementation of evidence-based interventions and policies that have already been identified.

FULL SUBMISSION

1. *Who we are*

1.1 The *Peoples' Health Movement* (PHM) is a loose but broad network of civil society organisations from many different countries, mostly in the South. It was established in 2000 following the first Peoples Health Assembly held in Bangladesh as a counterpoise to the official World Health Assembly. While it is organised as a fluid network of social movements and civil society constituencies, PHM is guided by a Steering Council of health professionals, many of whom work as senior public health practitioners; academics; and policy analysts. Many of those on the Steering Council have spent many years working in health care delivery institutions in rural and under-resourced settings. The views and policy positions of PHM are based on the core principles of the 1978 Alma Ata Declaration on Health. PHM also works closely with a number of the more established NGOs in the health sector.

1.2 The *Global Health Watch* (GHW) is an initiative billed as an alternative world health report. The first report was launched in 2005, and the next report will be published in May next year. One of the ways in which it is "alternative" is that it reports on the state of global health, as well as on what is and isn't being done about global health. This includes a critique of the policies, programmes and actions of donor organisations and global health institutions.

2. *Preface*

2.1 This submission does not cover all the questions for which evidence was requested. Rather it highlights a number of fundamental issues related to maternal health.

2.2 Three recent publications have also highlighted many of the challenges and recommendations for improving maternal health (listed in the footnote below) and conclude that the major problems are not due to a lack of technology, clinical knowledge or programmatic know-how.[158] The major problem is a failure to translate recommendations, strategies and policies into effective implementation.

2.3 The major barriers to effective implementation are:

- poor stewardship and strategic management of the health sector, compounded by the proliferation of external health initiatives, macroeconomic conditions and health sector reforms that have fragmented and weakened public health systems; and
- a lack of basic health care resources in the form of:
  - nurses, birth attendants and clinicians capable of providing obstetric care, and in particular, emergency obstetric care; and
  - health care facilities that are accessible, equipped and able to provide a safe delivery environment, including referral to health centres with comprehensive emergency obstetric care facilities.

2.4 For these reasons, this submission emphasises the need to address the more basic issues of health systems development as a *pre-requisite for maternal health improvement and the attainment of MDG 5.*

2.5 Having said this, two other important interventions that must be taken on board include:

- Social interventions to improve the status of women and girls.
- Appropriate interventions to reduce high fertility rates in many countries.

3. *But first, does maternal health need to be prioritised and given greater attention?*

3.1 The answer to this question is a resounding Yes.

3.2 The estimated burden of maternal mortality and morbidity caused by poor maternal health services is generally well known. The importance of improving maternal health services also extends beyond that of reducing maternal morbidity and mortality:

- Improved maternal health services will have a significant positive impact on child health (by reducing neonatal mortality and facilitating improved immunisation services and feeding practices), and on HIV transmission (by increasing the uptake of HIV testing and counselling and reducing vertical transmission rates).
- Because there is no quick-fix, technological solution to improving maternal health outcomes and because it requires "fixing" the health system as a whole, maternal health programmes can act as a catalyst for wider health sector development.
- A comprehensive maternal health programme can also act as a catalyst for female empowerment and improved (and appropriate) family planning, both of which would have large, indirect positive impacts on health and development.

[158] The 2005 World Health Report—*Make Every Mother and Child Count*; The Millennium Project (MP) Task Force on MDG 4 and 5 report—*Who's got the power? Transforming health systems for women and children; and The Lancet special issue on maternal health.*

— Unlike some other disease priorities, action to significantly reduce maternal mortality often requires an "explicit strategy" to target the poorest and most marginalised sections of society (disease-based programmes on the other hand have a better chance of achieving MDG targets without always having to be as "pro-poor").

3.3 Too little of the present external funds directed at the health sector is allocated to maternal health service improvement. We hope that the IDC will encourage DfID to take an even more active stance in improving maternal health, and that it does so in a way that promotes the multiple benefits described above. DfID can help generate and encourage more research and development programmes focussed on maternal health and help ensure that they are designed with a strong and coherent "health systems" approach.

3.4 There is also a need for strong leadership at the global level. In our opinion, WHO needs to be strengthened to play this role. WHO is the technical agency best placed to marry the twin objectives of maternal health care improvement and health systems strengthening. Its maternal health programme is currently inadequately staffed and inadequately funded. Its mandate and authority is has also been weakened due to changes to its working environment. This must change.

4. *The broader context of development assistance and global health initiatives*

4.1 Compared to other donors and global health initiatives, DfID provides important leadership in the health sector. Among other things, DfID is recognised for having a strong and progressive position on promoting country-led processes; supporting comprehensive national health planning and appreciating the importance of health systems strengthening, particularly in light of the recent and current focus on vertical, disease-based programmes. DfID is also one of the few donors to demonstrate a clear understanding for the need to repair, rehabilitate and develop the broken public sector health systems of many countries and the weak institutional capabilities of Ministries of Health. It is also helping to advocate for greater attention to be paid to maternal health.

4.2 DfID's spearheading of the recently announced International Health Partnership (IHP) has raised the strategic importance of strengthening health systems and reducing the costly effects of unco-ordinated global and external health initiatives. This is a welcome step in the right direction. The success of efforts to improve maternal health in some recipient countries could depend on the IHP working. However, the principles and aims of the IHP will be hard to implement—especially given the lack of funding and operational guidance directed at managing these partnerships. The IDC should interrogate DfID's operational plans for ensuring that the rhetoric and agreement-in-principle of the IHP will be converted into real and effective change.

4.3 It is also worrying that at a time when DfID is spearheading the IHP and preparing to increase its health spending, it is cutting back on its technical staff. There are serious concerns as to whether DfID will have the capacity to deliver on its strategies and policies for global health. If the increase in DFID spend is to match its principles, policies and strategies (including it promotion of maternal health), a serious re-think about the levels and capacity of DfID staff is required.

4.4 It must be understood that while many other actors may have joined the IHP and/or stated a commitment towards strengthening health systems and promoting equity, the actual policies, programmes and actions of these actors (eg other bilateral donors, the World Bank, the Gates Foundation, the Global Fund) can differ considerably, and not infrequently, demonstrate contradictions. DfID should demonstrate its leadership within the global health landscape by facilitating greater discussion about these contradictions.

5. *Getting the basics right*

5.1 Maternal health improvement is absolutely dependent on the availability of skilled health providers. Countries with a high maternal mortality ratio also suffer from a lack of skilled and motivated health workers. Although there is now international recognition of the importance of training and retaining health workers within developing countries, there is little in the way of concrete action being taken to address this problem.

5.2 One notable exception is Malawi's Emergency Human Resource Programme—a comprehensive six-year programme supported by DfID—that takes a five-pronged approach:

— Improve incentives for recruitment and retention of public sector and not-for-profit mission hospital staff through a 52% salary top-up for 11 professional and technical cadres, coupled with a major initiative to recruit and re-engage qualified Malawian staff.

— Expand domestic training capacity, including doubling the number of nurses and tripling the number of doctors in training.

— Use international volunteer doctors and nurse tutors as a short-term measure to fill critical posts while Malawians are being trained.

— Provide technical assistance to bolster Ministry of Health capacity in human resources planning, management and development.

— Establish robust human resources monitoring and evaluation capacity.

5.3 In addition, the programme explicitly recognises the importance of improving policies on postings and promotions; career development; and incentives for deploying staff to underserved areas. Embedded within this comprehensive HR programme are plans to train, recruit, deploy and support midwives and other cadres of health worker essential to reducing Malawi's MMR which currently stands at about 1,000 per 100,000 births.

5.4 Malawi's EHRP is one of the most positive uses of external donor funding support—and one that goes to the heart of many of the problems witnessed in high-mortality countries. If countries can develop and implement a coherent and comprehensive HR plan for the health sector, many problems will be resolved.

5.5 But the comprehensive approach to the EHRP has not been replicated in other countries. Furthermore, there may be problems related to the implementation of the EHRP due to a lack of operational research and evaluation to identify bottlenecks and problems as they occur; a lack of civil society involvement in monitoring the programme; and the continued "brain drain" of health workers out of the public sector (into the private sector, local NGO projects and to other countries). The IDC should ask for a full briefing of the EHRP in Malawi; and why this approach is not being replicated elsewhere.

5.6 There is important policy research that needs to be funded to improve the human resource crisis. DfID should consider working with the Global Health Workforce Alliance and the Alliance for Health Policy and Systems Research to support this research. This research includes conducting detailed studies of the current number of midwives and birth attendants in countries; the policies and practices for the enrolment of students; the capacity of local training institutions; the structure, content and length of training; the cost and quality of training; and the nature of the labour market for midwives (describing, for example, the pay and income of midwives within the local, national and global market, and how this affects migration and career choices). Similar research on non-physician clinicians, clinical officers and medical assistants would also be useful.

6. *Strengthening maternal health programmes in-country*

6.1 One of the underlying causes of maternal mortality in many countries is poor health sector stewardship and weak health systems management capacity. Governments, donors and external health initiatives continue to fail to address these shortcomings. Initiatives aimed at strengthening public sector stewardship and management capacities have too often been fragmented, piecemeal and short-lived. While some attention has been focussed on training individuals, not enough has been done to help catalyse change at the level of organisational culture and political stewardship. The failure of civil society to develop its capacity to hold government and public administrations to account is another omission. The recent inclination towards vertical programmes and the expansion of the private sector has placed many countries in a vicious cycle: weak public health systems encourage greater use of vertical programmes and NGO projects, which in turn undermine public health systems further.

6.2 While not everything can and should be done by the public sector, public sector failures have to be fixed if maternal health is to improve in the poorest countries. We hope that DfID will take some leadership in this area. However, this requires a long-term strategy, rather than a quick-fix approach; and it requires the adoption of strategies that do not involve the export of "new management fads and practices" from developed countries. Basic public administration skills and the core building blocks of a coherent bureaucracy are desperately needed in many countries.

6.3 DFiD has funded and helped implement a number of country-based safe motherhood programmes in the past. Some of these programmes have been reasonably embedded within a health systems approach. Some have also been funded for relatively long periods of time (up to six years). But not all of these programmes have been as effective as one would have hoped. There are lessons to be learnt about how such programmes can be designed and implemented more effectively in the future. However, the principles of funding and supporting country-based maternal health programmes remain sound. We would like to see DfID making commitments to supporting such programmes in more countries.

6.4 As far as research is concerned, while some traditional forms of research remain valuable to add to the existing evidence base of effective interventions, there is a need for more forms of *implementation research*. Implementation research can be seen as research that informs policy makers and managers in real-time about what is and isn't working, and why. It focuses on *how* to promote the uptake and successful implementation of evidence-based interventions and policies that have already been identified. It is a general term for research that focuses on the question *"what is happening?"* and *"why is it happening as it is?"*, taking into account the specific social, political and health systems characteristics of countries.

6.5 Well-designed 'implementation research' and rigorous evaluation is a vital part of policy development and implementation, health systems strengthening and community development. This is an aspect of global health development that remains under-funded and under-valued. DfID can help close this gap. It is also important to bring together the research and programmatic arms of DfID's work.

7. *Financing*

7.1 Financing for maternal health needs to increase. This is obvious. More skilled birth attendants working in adequately equipped health facilities will require additional funding. Some of this funding will need to come from internal, domestic resources. Much will need to come from external sources. But what is not needed is a new global fund for maternal health. There are already too many streams of uncoordinated funding entering low income countries. Additional funding for the health sector should be, as far as possible, harnessed towards establishing (in an equitable manner) the basic human and physical health care infrastructure within in countries—including the HWs needed for maternal health care and facilities needed to permit safe childbirth. With the basic infrastructure in place, countries might then need some additional programmatic support that would focus on strengthening the organisational, management and professional capacities to deliver effective MCH services. But this could be funded and organised through existing structures.

8. *Development assistance in the broader context of the global political economy*

8.1 Finally, while the focus of this submission has been on development finance, or health sector 'aid', the more fundamental problems associated with the structure and outcomes of the global political economy cannot be ignored. Poverty at the household level is a major underlying determinant of premature and avoidable mortality across the world. And poverty at the country level is a major cause for dysfunctional health systems. Current measures of income poverty (which focus on the $1/day threshold and which use accounting methods that systematically undercount the breadth and depth of poverty) do not reveal the extent to which the structures and systems of the global political economy require radical reform. Development assistance in the context of a massively unjust political economy and in the context of perverse subsidies from poor to rich countries (in the form of skilled human resources, cheap labour, low corporate tax rates or under-priced raw commodities) can be viewed as a distraction from the fundamental business of constructing a fairer global political economy, from which many health benefits would flow.

14 September 2007

Memorandum by Plan UK

This submission has been prepared by the UK division of Plan International, with strong input from Plan's country offices.

Plan welcomes DFID's Maternal Health Strategy and its contributions to multilateral donors and non-governmental organisations but more action is urgently needed to reach the fifth Millennium Development Goal (MDG) target of reducing the maternal mortality ratio by three-quarters by 2015.

INTRODUCTION

1. Plan is an international child centred development organisation committed to promoting the rights of children world-wide. We currently operate in 49 developing countries. Plan's approach to sustainable development takes place through our child centred community development (CCCD) approach based on a rights based approach guided by the UN Convention on the Rights of the Child.

2. Maternal health is the leading cause of death in young women aged 15–19 in the developing world.[159] 70,000 teenage girls in the developing world die from the complications of childbirth and pregnancy each year.[160]

3. The highest proportion of births among young women occurs in Sub-Saharan Africa, where more than one in every four young women has a child by the age of 18.

4. An HIV infected women is four times more likely to die in pregnancy and childbirth than an uninfected woman.

5. Female Genital Cutting (FGC) significantly increases complications for women during childbirth and in Africa results in the death of an additional 10–20 babies per 1,000 births.

6. Maternal newborn and child health (MNCH) are interdependent and inseparable. At least 20% of the burden of disease in children below the age of 5 is related to poor maternal health and nutrition, as well as quality of care at delivery and during the newborn period.

7. Maternal health is also affected by "3 delay":

(a) The delay of taking decision, by women and the whole community to demand high quality maternal care (prenatal, delivery, postnatal care).

(b) The delay of accessing health centres. This is mainly due to the long distance to health facilities.

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[159] UNFPA—Maternal mortality Update (2004).
[160] State of the Worlds Mothers—Children having Children (2004).

(c) The delay of providing high quality health care services at the health centre.

8. This submission highlights the main areas of concern regarding maternal health care as observed by a number of Plan country offices, and puts forward a series of recommendations for DFID to consider, and implement, in their maternal health care policies.

Q1: *How effective Family Planning is being promoted as a way to improve maternal health*

9. Plan promotes effective family planning through a holistic approach to the provision of sexual and reproductive health rights, family planning and AIDS education that incorporates the learning of life-skills. Sexual health education must be inclusive and should be expanded to include often neglected groups, such as disabled children, as ALL children have the right to sex education and to their sexual and reproductive rights.

The introduction of sexual health education, family planning and STI/HIV/AIDS information into the school curriculum

10. All efforts should be made to ensure the active participation of children and young people to enable them to access reproductive health information. Plan Thailand has piloted an adolescent sexual and reproductive health (ASRH) education programme in 21 schools in collaboration with the Ministry of Education and PATH[161] to integrate HIV and related adolescent reproductive and sexual health issues into the mainstream curriculum in both elementary and secondary education.

Youth Clubs

11. Plan is promoting effective family planning through youth clubs and similar spaces where young people can address reproductive health issues as well as gender inequalities. In Togo, communication between children and adults on sexuality is traditionally poor. Plan responded by helping to establish youth clubs in towns and villages in its programme areas, with approximately 20 to 30 members of both sexes in each, ranging from 13 to 19 years old. They developed their own activities, ranging from sports and entertainment to education and other issues of particular concern to them. Sex is no longer a taboo subject and young people note that they can now discuss sexual matters with their parents. Head-teachers report a decrease in the number of pregnancies and abortions among school girls. This case highlights the importance of creating spaces where young people can communicate in which girls can be empowered, as well as the need to involve men as part of such prevention strategies.

Training of Peer Educators

12. In Guinea Plan is implementing the child-to-child methodology and training peer educators to transfer family planning and birth spacing knowledge and positive attitudes gained in the classroom to younger, in-school students and out-of-school peers in the community through activities such as theatre, sports, discussions, video, and song.

Information, Education and Communication activities (IEC)

13. In Zambia, the Ministry of Health in collaboration with Plan Zambia are looking at the production of IEC materials as a way of sensitizing and raising awareness of the various reproductive services available. IEC will provide information to clients to enable them to make informed choices thereby enhancing demand for access to quality reproductive health services, behaviour change among communities and service providers.

Community-Based Events

14. In the Philippines Plan has promoted family planning through a number of community events including developing the guidelines on "Safe Pregnancy Campaign" and supporting the inclusion of a Family Planning Month in the National Health Calendar.

[161] PATH is a non profit organisation with the mandate of improving the health of people throughout the world.

Media

15. Plan promotes effective family planning through children's work with the media and methods chosen by children themselves as ways of disseminating reproductive health messages. Plan Kenya developed a programme using traditional media such as drama, songs, poems and puppet shows to communicate messages on HIV prevention, as these combined together education and entertainment, reaching a broader part of the community.[162]

Enhancing Service Accessibility and Quality

16. Plan is promoting effective family planning through enhancing service accessibility and quality. In the Philippines Plan has done this through the training of professional and volunteer service providers on basic family planning and surgical methods and also through private sector mobilization to set up community-based outlets for family planning methods at an affordable cost.

17. Plan Zambia is promoting effective family planning through supporting community innovations towards community transport and funding systems to address the problem of access to health facilities.

Preventing Early Marriage

18. In Niger Plan began to educate community members about the dangers of early marriage. Plan staff held discussions with religious leaders about reproductive health issues and then trained village leaders in these issues utilising the assistance of the well-respected religious leaders. Plan also reinforced girls' education and school youth programs to keep young people engaged in healthy, stable environments. On the national level, Plan has been working with the Ministry of Social Affairs to implement the Code for the Child, which will discourage the practice of early marriage, by recognising it as a violation of children's rights.

Promoting Birth Registration

19. Universal Birth Registration (UBR) helps girls to access services such as health and education and can protect them from early marriage and abuse. In Nicaragua, Plan works with a local organisation which brings local government authorities and communities together in order to increase the number of children registered at birth. During vaccination campaigns the municipality now accompanies health unit teams on their visits to communities where they set up a mobile registration desk. Mothers bringing their children for vaccination are therefore also able to register the birth of their children.

Ensuring Gender Equality

20. Plan looks more holistically at the underlying causes of women and girls reproductive health, moving away from a medical focus alone to explore the impact of gender power relations and discrimination. The State of the World's Girls report is a series of annual reports published by Plan examining the rights of girls throughout their childhood, adolescence and as young women. The first report, "Because I am a Girl", (published in May 2007) documented the extent of discrimination against girls across the world, in terms of access to education, healthcare and other rights. This series is used as an effective tool in advocating the rights of girls at national and international forum.

21. A "male motivation" project undertaken in Plan Zimbabwe proved the positive impact male involvement can have on improving women's lives and health. The aim of the project was to educate men and women about family planning and so increase the use of family planning methods. Under the campaign theme "Endhla wanuna—longa ndangu wawena (Be a man—plan your family) the project employed a wide range of awareness raising tools to promote joint family planning decision making between men and women. These included talks for men, home visits, community theatre, awareness raising in schools and condom distribution. The result of the project was increased use of contraception and increase in men and women discussing family planning issues and taking family planning decisions as a joint couple responsibility.

22. In programmes designed to promote HIV prevention Plan's experience shows that it is most effective to design programmes to prevent HIV transmission from parents to children, as opposed to referring to mother to child transmission. It is essential that both parents are involved.

[162] Plan International (2005) Children's response to HIV: an examination of how HIV impacts on vulnerable children through the creative arts of children in Homa Bay District, Kenya.

Awareness raising on the risks of Female Genital Cutting (FGC)

23. Plan is promoting effective family planning through our work on Female Genital Cutting (FGC). Plan Ethiopia's family planning project includes a community based FGC component. This project works within the local context utilizing traditional "coffee meetings" to disseminate messages on the dangers of FGC.

Q2: *How DFID can catalyse progress towards MDG 5*

24. We recognise and commend the significant gains made by DFID's assistance to programmes on maternal health and urge for DFID's continued commitment, technical expertise and leadership in achieving the goals of MDG 4 and MDG 5.

25. While recognising the commitments of the Paris Declaration of harmonisation, alignment and management of aid, we call on DFID to continue to remain a leading voice in advocating pro-poor policies within the international donor community.

Strengthening Health Systems

26. DFID should continue supporting health systems strengthening through supporting national governments to increase resource availability in the Health Sector by providing planning and budgetary support. DFID should support programmes to improve health human resource management and provide long-term, predictable funding for salaries in the health sector.

27. DFID should support decentralisation processes within the health system in developing countries in order to provide quality maternal and child health services.

Supporting Community Based Maternal Care

28. DFID should strengthen program support for community based maternal care programmes through scaling-up of behaviour change communication/social marketing approaches in local language highlighting information on antenatal care, danger signs in pregnancy, delivery, newborn care and also through educating the community on women's rights, benefits of health services, nutrition guidelines for pregnant mothers, and other healthy lifestyle practices.

Increased Access

29. DFID should support increasing physical access to comprehensive maternal care through increasing public-private sector collaboration for service delivery, scaling-up the inter-local health system and support community innovations towards community transport. DFID should also support social protection systems to enable local communities to access health care services.

Increased Quality

30. DFID should support the provision of quality health facilities and service providers through strengthening basic and comprehensive emergency obstetric care, increasing the numbers of fully trained health care providers and increasing availability of emergency medicines and equipment. Quality of service can also be achieved through supporting the updating of clinical protocols and guidelines, eg mother-baby friendly indicators for health facilities and ensuring data is disaggregated.

Education

31. DFID should support the introduction of sexual and reproductive health education, family planning, STI/HIV/AIDS information into the school curriculum from as early a stage as possible to then be supported by youth clubs and extra-curricular activities involving the entire community.

32. DFID should continue to support free and compulsory primary education and provide support to secondary education, including scholarships to enable girls to continue their education. Our experience has shown the more educated a girl is the more knowledge she gains in child health, child spacing, nutrition and reproductive health.

Family Planning

33. DFID should support youth friendly Family Planning (FP) health delivery services tailoring to the local social and cultural context to ensure access and utilization of available services and support programmes developed for males mobilising them to take a responsible role in family planning and maternal health decision making.

Legal Issues

34. DFID should support strengthening national and local legislation to ensure the promotion and protection of rights for girls and young women to access comprehensive medical services. DFID should also hold Governments accountable to International Conventions including the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW).

35. DFID can help decrease the early marriage of young girls and promote UBR through supporting governments to improve and implement legislation. This should be complemented by public education campaigns to highlight the rights of girls and should involve the entire community, including children, parents, religious leaders and traditional authorities.[163]

Female Genital Cutting

36. DFID should support local grassroots community awareness raising campaigns to make women, men and children knowledgeable of the risks and dangers of FGC.

Memorandum submitted by the Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative

1. The following contribution to the International Development Committee Inquiry on Maternal Health has been provided by the RAISE Initiative, a collaboration between Marie Stopes International and Columbia University.[164] The document seeks to highlight maternal health challenges in emergency settings, with a particular focus on displaced populations.

2. Overall Emergency Context

2.1 The magnitude and gravity of the world's emergencies today make them impossible to ignore. In 2006, 23 countries were identified as generating displacement and at least 52 countries affected by displacement, with Africa as the region with the highest concentration of internally displaced people (IDPs) worldwide [1].

2.2 According to OCHA, in 2003, 200 million people were affected by natural disaster and 45 million people were in need of life saving assistance due to complex emergencies [2]. Every year, millions of people worldwide flee their homes to escape persecution, conflict and violence. Globally, the estimated number of conflict-induced (IDPs) is hovering around 25 million and the number of refugees is estimated at around 12 million [2]. The majority of these people find themselves unable to access national health services, meaning that donor efforts to support health systems through SWAps and budget support rarely reaches them. Instead they rely on humanitarian relief efforts.

2.3 The United Nations (UN) and humanitarian non-governmental organisations (NGOs) are among the main providers of humanitarian assistance worldwide. The environment in which these agencies operate is complex and often challenges the effective and adequate delivery of service to affected populations. Efforts to address gaps and strengthen effectiveness of humanitarian response have resulted in several reform processes. Most significant is the UN humanitarian reform process, which led to the introduction of a "cluster approach" aimed at enhancing co-ordination and collaboration among different humanitarian actors, as well as strengthening technical capacity and service delivery on the ground. Under the approach, the Inter Agency Standing Committee (IASC) designated "global cluster leads" in nine selected areas of humanitarian activity (clusters). Among these, the World Health Organization (WHO) is lead for the cluster on health [3, 4]. While the approach can be considered an improvement in many respects, it continues to fail to ensure the integration of sexual and reproductive health (SRH) service delivery as an integral part of the humanitarian response; in the current IASC definition of the health cluster SRH receives only scant attention.

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[163] Plan International (2006) Circle of Hope: Children's right in a world of AIDS.

[164] The Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative, is a new initiative led by Marie Stopes International and Columbia University. Launched in July 2006, the initiative seeks to catalyse change in the way RH is addressed by all sectors at all levels. Its main objective is to ensure, as a matter of course, the delivery of a full range of reproductive health services in an emergency or conflict setting. Through its partnerships with major players in the humanitarian and development community, RAISE focuses both on strengthening organisational capacity to deliver SRH services in the field and enabling a supportive global policy and funding environment.

3. Maternal Health Context

3.1 Every year, an estimated 210 million women have life threatening complications of pregnancy, often leading to serious disability, and a further half a million women die in pregnancy, childbirth and the puerperium. More than 99% of these deaths are in developing countries. Moreover, more than 120 million couples have an unmet need for contraception and 80 million women each year have unwanted or unintended pregnancies. 45 million of these pregnancies are terminated, and of these 45 million abortions, 19 million are unsafe [5].

3.2 The critical importance of SRH care to reducing maternal death and morbidity is well documented and recognised by the international community. Yet, lack of access to comprehensive reproductive health services, in particular family planning, skilled birth attendance and emergency obstetric care (EmOC) continue to lead to many unnecessary deaths, in particular in the developing world.

3.3 In its recent report on population issues [6], the World Bank identified lack of access to contraceptives and family planning as among the driving forces behind maternal death and unsafe abortion. "Yet", the report observes, "donor countries and development agencies have shifted toward other issues, and global funds and initiatives have largely bypassed funding for family planning, with less attention being focused on the consequences of high fertility".

4. Maternal Health in Emergency Settings

4.1 Conflict and humanitarian crisis further complicate access to SRH. SRH needs are particularly acute in countries emerging from conflict or natural disaster. Health systems in these countries are often characterised by damaged infrastructure, limited human resources and lack of capacity to provide health services, including SRH. In addition, stewardship of the health system in these countries is often weak and service delivery fragmented as a result of proliferation of NGOs. Moreover, general health NGOs may not have the experience, knowledge or commitment to deliver SRH according to internationally agreed standards. [7, 8, 12].

4.2 Other factors, such as security issues and lack of priority given to SRH by national and international humanitarian players, continue to put refugee and IDP women at risk of death, disease or disability due to pregnancy related causes.

4.3 In sum, major maternal health challenges in emergency settings that require urgent attention from the international community, including DFID, are:

- Ongoing lack of focus or priority given to SRH service delivery within a humanitarian response by key national and international actors, including; host governments, the UN system, donor governments and health focused NGOs.
- Lack of skilled staff, equipment, supplies, means of communication and transportation.
- Lack of access to life-saving EmOC.
- Lack of or limited access to and availability of family planning services.
- Lack of access to post abortion care and safe abortion where legal.

5. Case Study

5.1 For nearly 20 years, parts of northern Uganda have been embroiled in an almost uninterrupted civil conflict centred around the insurgency of a rebel group, the Lord's Resistance Army (LRA), against central government authorities. The conflict has resulted in the displacement of approximately 1.5 million people [9].

5.2 Uganda has one of the fastest growing populations in Eastern Africa and a high maternal death rate. Although the Ministry of Health (MoH) has developed numerous policies and guidelines promoting SRH, resources attributed to this issue are limited, and so is their impact. Clear discrepancies exist regarding the SRH status of urban, rural and conflict affected populations in the north, with a majority of the available resources (both financial and human) funnelled to urban hospitals that are inaccessible to a large part portion of the population.

5.3 The conflict has clearly had a negative impact on basic health services in northern Uganda. The infrastructure has been damaged and many facilities were forced to shut down. Ongoing insecurity has thwarted improvements to SRH services and facilities in the camps. As a result, health care units in the camps are often overwhelmed and largely managed by unqualified staff. Access to better equipped district hospitals is severely limited due to lack of transport, restricted freedom of movement and curfews. Consequently, SRH in northern Uganda has fallen dramatically below national averages [9, 10].

5.4 While antenatal services are fairly well established, emergency obstetric care (EmOC) is nearly non-existent. As a result, the percentage of women delivering in a health facility in the northern districts is the lowest in the country at only 29.9% compared to a national average of 41.1%. Poor family planning coverage (with only 19.1% of the demand for family planning satisfied in northern Uganda compared to a national average of 36.9%) and self-induced abortions compound the critical lack of EmOC and cause additional

mortality and morbidity. Although some training in life-saving EmOC is being provided, critical gaps exist in health worker competence, equipment, means of communication and transportation to support women's access or referral to EmOC [9, 10].

5.5 Further challenging the maternal health and well-being of IDP women in the northern districts is the poor use of family planning. Limited availability of and knowledge about contraceptives, combined with a widely held misconception about family planning, particularly among men, has resulted in the lowest contraceptive prevalence rates in the entire country. The use of any modern method in the north is 8.1% compared to a national average of 17.9%. IDP women however are reportedly desperate for family planning support and this unmet need is clearly reflected in the rates of abortion, which are reportedly the highest in the country [9, 10, 11].

5.6 Major additional problems affecting maternal health in northern Uganda include inadequate SRH co-ordination under the cluster approach and the WHO-led health cluster. Although groups are reportedly established for the health sector in general, gender-based violence (GBV) and HIV, this is not the case for SRH. As a result, SRH co-ordination meetings are not in place, and when they are their output is limited. Moreover, SRH is reportedly "buried" in the general health co-ordination meetings that primarily address infectious disease control [9].

6. Conclusion

6.1 The case of Uganda shows the tremendous SRH challenges faced in an emergency, as well as the consistent need to push for the inclusion of SRH as part of the humanitarian response. Some progress has been made over the years in this area with some policies and guidelines in place. What is now required is a concerted drive to translate policy into action. Ongoing marginalisation of SRH services critical to ensure maternal health within the humanitarian response will result in the unnecessary death and disability of many women and infants. Moreover, not addressing women's SRH will have far reaching implications for the community as a whole, because of the critical role women play in holding families and communities together and in the recovery and rehabilitation of societies [13].

7. Recommendations for DFID

7.1 As a global leader in women's health and gender issues and a major humanitarian actor, DFID is well placed to draw attention to the pressing SRH needs of affected populations in emergencies, and to use its influence at both national and international levels to ensure the incorporation of SRH as an integral part of humanitarian policy and action. In this regard, we welcome the inclusion of language on SRH in the new CHASE Humanitarian Funding Guidelines for NGOs (to be released in October) as an important step in encouraging agencies to include SRH in their humanitarian programmes.

7.2 At UK level DFID should:

- Monitor its own performance in supporting humanitarian SRH programmes by tracking CHASE grant money allocated to programmes that include SRH service delivery.
- DFID should systematically include SRH as part of its needs assessments in emergency settings, as well as use its research budget to commission studies on SRH in emergencies.

7.3 At global level DFID should:

- Use its influence within the IASC to ensure that SRH becomes a core focus area of the Health Cluster.
- Work with the humanitarian co-ordination system to ensure that SRH needs are adequately addressed from the outset of an emergency with the appointment of an SRH co-ordinator under the health cluster.
- Use its position to influence policy decisions on humanitarian issues of the main bodies of the United Nations and the European Union to ensure comprehensive delivery of SRH services from the onset of an emergency.
- Encourage humanitarian health focused agencies operational in emergency settings to develop the necessary human resources to set up and run effective comprehensive RH programmes in emergency settings from the outset of every emergency.

7.4 At host country level DFID should:

- Work with host governments, most notably the Ministries of Health and Finance to prioritise SRH as part of the humanitarian response and ensure its inclusion within national policies, budgets and action plans.
- Work with key partners on the ground (MoH, UN agencies and NGOs) to ensure the availability of skilled SRH health staff, appropriate equipment, supplies, means of communication and transportation, to enable access and quality SRH service delivery, including EmOC and family planning.

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Memorandum submitted by the Royal College of Obstetricians and Gynaecologists

GLOSSARY

SBA	Skilled Birth Attendance
EOC	Essential or Emergency Obstetric Care
BEOC	Basic Essential or Emergency Obstetric Care
CEOC	Comprehensive Essential or Emergency Obstetric Care
QA	Quality of Care
DFID	Department for International Development
SRH	Sexual and Reproductive Health
MNH	Maternal and Newborn Health
SSA	Sub Saharan Africa
NGO	Non Government Organisation
PAC	Post Abortion Car
CAC	Comprehensive Abortion Care
CBD	Community Based Distribution

Reducing maternal and perinatal mortality and morbidity . . .

DAVID died. He was just a day old. This chubby baby, who weighed 5.5kg at birth, bled to death because his umbilical cord had been cut "badly".

In fact, David was named after the shepherd boy in the Bible long after his little heart stopped beating. The Alur culture demanded that either way, he be named.

Every two hours, a baby dies at the Hospital's maternity ward as a result of birth-related complications. Hospital records indicate that on average, nine babies die from birth-related complications every day, nine little souls like David. This means, about 270 babies die every month.

"Some days, over 15 babies die", a hospital source, who spoke on condition of anonymity, says.

David's only day in this world went terribly wrong. "We spent the whole day at the hospital but nobody cared", his father, Clinton, narrates. "The baby was bleeding. The baby really cried. Then a nurse helped us and put him on oxygen but she said we should pray because the machine was not working properly".

Clinton will forever be haunted by the blank face of the doctor to whom he turned in desperation. "He just looked at me and walked away", he says as a slight tremor creeps into his deep voice.

The Maternity ward of the hospital, Sunday 9.00 am: The air in the corridor of the labour ward seems to stand still. Over 20 women in labour are sitting or lying on the floor. "Musawo nyamba, nfaa!" (Doctor, help I am dying), one woman wails.

She is kneeling on all fours. She jerks forward, then crawls rapidly back. Groaning in pain, she puts her elbows on the cold, stained marble floor, rising swiftly. The white blouse she is wearing slides over her shoulder, leaving her naked.

"The baby is coming", another woman, swaying in pain next to her, shouts. A third expecting mother sits calmly next to them, a stream of waterish blood running from under her skirts towards the middle of the corridor. The woman opposite her tries to move away from the blood running towards her. She stands up, looks around, then slowly shakes her head and sits down again as her wrapper gets soaked. There is no other place to sit. The corridor is packed to capacity.

According to the doctor in-charge of the gynaecology and obstetrics department, about 70 mothers are admitted and 60 deliver every day, yet the place was meant to cater for only 20. Some give birth in the corridors. "We are delivering three times the number we are supposed to handle", he says.

"Most of these mothers are referred from other hospitals when their condition is already critical. In fact, many babies are born with the skin already peeling off, meaning that they died 24 hours earlier".

On average, one third of the mothers received at the hospital need to deliver by caesarean section. The operation theatre, which has only one bed, handles an average of 18 mothers a day.
The doctors work day and night but hardly manage to cater for the influx. A proper operation, including preparations, takes two hours. Some have to wait for a day to find a slot.

"Many times we have 21 emergency operations", says the nurse-midwife Rose. "Babies end up being born stressed or dead because the mothers waited too long for the caesarean operation. Imagine you have 15 patients waiting for an emergency operation, all of them in a critical condition. Whom do you operate and whom do you leave out?"

Apart from lack of space and equipment, the maternity wing suffers from acute lack of staff. There are between eight and 12 staff members for the five wards at any one time, according to the doctor in charge. These include nurses, midwives and doctors.

"In the labour suite, there are only three staff to cater for over 60 mothers a day, yet there should be 24", he says.

The hospital serves as a referral hospital. It has become the only place where mothers around the city go to give birth. Most health centres around the city shun women who are about to give birth because they lack the operation facilities in case the delivery goes wrong.

Many private clinics only give antenatal care and refer the mother to the hospital when the labour pain starts.

"Some refer the women when it is too late", explains nurse-midwife Violet. "They don't tell the women what the problem is or even notify us of the condition of the patient and the reason for referral. Many times, the baby is already dead in the womb. And when they come when we have a lot of work, it is difficult to give them the attention they need. So the lives of the mothers are also at risk".

Another problem, she says, is ignorance and poverty.

"Some mothers arrive here after labouring at home for days". "Others don't have transport and are brought in by neighbours when it is very late. Many times we are just helpless".

Executive Summary

The International Office of the Royal College of Obstetricians and Gynaecologists (RCOGIO) received a great many responses from its Members, Fellows and partners working in resource poor countries. Their recommendations are:

1. There is great respect for what DFID is currently doing to catalyse progress towards achieving MDG5, although the priority given to this work should be greater.

2. A continued and sustained focus is needed to ensure all women have real access to Skilled Birth Attendance (SBA) and Essential Obstetric Care (EOC), independent of where they live.

3. The development of a functioning health service is needed for this which is of good quality ie provides evidence based and women friendly care. Providing a continuum of care including antenatal care, postnatal care, safe termination of pregnancy services together with family planning services form an integral part of this process.

4. The introduction of Quality assurance systems with an emphasis on audit processes, already developed in the UK, are vital.

5. Imaginative and innovative human resource strategies, to increase, maintain and sustain the medical and professional workforce, require development and financial support.

6. Evidence based medicine, which is sensitive to the needs of the local community needs encouragement with the introduction of new communication strategies.

7. Appropriate training and educational methodologies will underpin the whole process. The introduction of such processes should be undertaken with appropriate validation.

8. In line with the Crisp report, all such strategies must enjoy local support, accountability and ownership.

9. DFID should work to harmonise relationships and communication between interested and active participants.

10. It is anticipated that the current financial investment in this process is inadequate to realise these aspirations.

Q1 How can donors—especially DFID—catalyse progress towards MDG5?

"Women neglected in labour seem to be the most neglected of all categories of patient and need an emphasis of their own . . ."

1.1 There is a clear recognition among health care providers that MDG5 is "not just a health issue"—it requires a multidisciplinary approach that includes improving roads and transport, sanitation, nutrition, poverty alleviation, changing socio- cultural norms and education. At the same time there is a strong concern that achieving MDG5 requires a functioning and complete health system and that this is very often not available and not accessible especially for women.

> "A health system has many components such as the availability of quality health facility infrastructure, equipment, drugs and supplies, trained personnel, human resource management, free or affordable services, good monitoring systems and community participation."

1.2 The majority of respondents expressed the need to expand and strengthen the existing health facility infrastructure in resource poor countries to ensure Skilled Birth Attendance (SBA) can be provided at all births and Essential (or Emergency) Obstetric Care (EOC) can be provided for those women who need it. With regard to EOC there is a need to strengthen and expand in particular the infrastructure for Basic Essential Obstetric Care (BEOC),[165] but also to have functioning referral facilities higher up ie Comprehensive Essential Obstetric Care (CEOC) centres. In most countries access and availability are not ensured and/or there is non-equitable distribution of such health services. The need for strengthening and provision of blood transfusion services (One of the signal functions of a CEOC) in particular was noted by several respondents as a key issue (Egypt, Nigeria, Nigeria).

[165] As defined by the UN bodies with specific signal functions agreed for BEOC and CEOC and minimal acceptable coverage defined.

> "I have no information from DFID nor from the Ministry of Health but I am aware that there are hospitals especially in the North West that have no doctor, no bed linen and few if any drugs. These hospitals are intended to be providing free healthcare for rural populations".
>
> "Financial support for delivery and referral when needed helps to make hospital care available to the very poor. Usually money is only available at time of discharge from hospital and lack of funds to actually get to hospital and pay for what is needed for delivery still prevent access for many".

1.3 **The Quality of Care** (QA) is seen as absolutely crucial:

> "Rural health facilities need to be made more credible places to have a baby. In many places rural health facilities are dirty, unreliable and not mother/women friendly at all".

Health care providers can be trained in QA systems and the use of benchmarking processes using structure, process and outcome criteria for example. Helping these countries to conduct audit of maternal (and perinatal) deaths in a non-blame atmosphere similar to the Confidential Enquiries into maternal deaths as in the UK or RSA will really help. Together with a process of setting standards and using criterion (standards) based audit this is a simple and effective mechanism for improving the quality of care. The Royal College of Obstetricians and Gynaecologists have a Guidelines and Audit Committee who have extensive experience in rolling this out and are able to assist with this. In addition, many Members and Fellows of the RCOG contribute to the UK Confidential Enquiry into Maternal Deaths.

1.4 **Referral systems** need to be in place and strengthened—this refers to both community to facility and facility to facility referral systems . . . Examples cited include:

> "The essential health care infrastructure is lacking in most places. The availability of mobile or hand phones is a major boost and needs to be exploited to the full".
>
> "Maternity Waiting Homes are invaluable in rural areas and wherever travel is over long distances and difficult terrain".

1.5 **Human Resources:**

Human resource development (HRD) is a key area that still receives inadequate attention. Clearly for achieving MDG 5, HRD is critical and can best be addressed through sector wide approaches. DFID through its support to both the National Safe Motherhood Programmes and the Health Sector Reform Process is thought to be well placed to put human resources for MDG 5 at the centre of its development efforts.

1.6 **Generally "manpower" is still severely lacking.**

Adequate numbers of staff need to be trained and deployed. Different levels of skills and training are needed including:

- Skilled Birth Attendants—it is generally agreed these should be trained midwives—but there is recognition among the respondents that in some instances there is still a need to use and train "indigenous midwives" (eg "dais" in India) to play a vital role especially at community level.
- Doctors with general skills as well as specialist Obstetrician Gynaecologists with teaching and management abilities are needed. Respondents include Clinical Officers, Medical Assistants in this category of staff.

Midwives and doctors should work together on all programmes.

Countries where progress towards MDG5 has been achieved are those where midwifery as well as medicine is highly professionalised and well recognised (including at government level).

> "The most challenging aspect of achieving MDG5 is the management of skilled human resources (HR)—doctors, nurses and midwives needed for provision of health care services to achieve MDG5".
>
> "In some areas eg South Asia there are generally sufficient HRs overall but the available HRs are mal-distributed. This is a major rights issue requiring capacity building of rights holders increasing their accountability for correcting the mal-distribution, ensuring proper policies, posting, retention etc that are evidence based".

1.7 Interesting possible solutions for implementing this were given: eg in case of regional/in country disparities a well functioning supported medical school could "adopt" a community and it was noted that public-private partnerships can work well to improve staffing levels where private health care providers are available and are trained.

There is very clearly a need to look at the issue of motivation of staff and "make it lucrative for the health care provider to work for our women".

Among existing health care providers skills and knowledge regarding provision of SBA and EOC is often lacking and **training in SBA and EOC** should be supported better than it currently is.

> "The major complaint of doctors and midwives working at district and provincial level in the developing world however is lack of access to appropriate, high quality training and coupled with that interaction with colleagues to reduce the sense of working in isolation".

1.8 A number of mechanisms are proposed:

- Send skilled obstetricians with teaching and management ability on short term attachments.
- Training should focus on training of available staff in SBA and EOC competencies, but also in QA systems.
- Linking with UK organisations (both professional and teaching) may guarantee investment is in a deliverable product and that expertise is shared more effectively.
- Training should have more funding allocated to it.
- Creating supernumerary positions for eg visiting clinicians from the UK who can both work and teach. Such supernumerary positions might be less threatening to the host institution staff than occupying a post that might be occupied by a national and could allow more time for training activities.
- Send skilled obstetricians (and midwives, gynaecologists, anaesthetists, paediatricians) with teaching and management ability on short term attachments.
- Support the inclusion of experience in rural areas (community medicine) in all medical (and midwifery) curriculae.
- Encourage consideration of training alternative non physician service providers eg non physician anaesthetists.
- Projects that reduce the "brain drain" must be prioritised (as above), licentiate type programs of training should be encouraged (for eg clinical officers).
- DFID should promote support and encourage professional schools of midwifery and nursing as well as professional organisations.
- Support to teaching hospitals (as when DFID was ODA) was discontinued but should have been sustained—"with better oversight though".
- Training at district level (as opposed to central level) in EOC is not being sufficiently supported by DFID.
- RCOG International Office working with DFID on initiatives to bring together doctors and midwives for the education and training of local health workers would be effective and encourage sustainability.

1.9 The recognition that there is a relationship between 'the brain drain' and training is very strong:

> "A positive approach to the problem of the "brain drain" or "skills drain" could be achieved by opening up funded exchange programmes at the Specialist Registrar level between the UK and selected developing world countries. Short term rotations from reasonably experienced UK graduates in training programmes (6 to 12 months) would offer them an opportunity to establish close personal contacts with doctors in the country in which they go to work which will allow collegial networks to be established. They will also have the opportunity to hone their diagnostic management and surgical skills under supervision".
>
> "Doctors from the developing countries rotated into the UK should not be attending for basic or MRCOG Part 2 training but should already be holders of local specialist qualifications which enable them to practice in their country of origin at specialist level. They can come to the UK and occupy Senior Specialist Trainee posts particularly in subspecialties such as foeto-maternal medicine, gynaecological urology, gynaecological oncology and reproductive health. On return they will have up to date knowledge which can be applied as appropriate in their own country, but more importantly will have continuing relationships with one or more units in the UK where through medium of email etc they can continue to obtain advice and discuss cases of interest with named colleagues with whom they have previously worked".
>
> "I would suggest that such schemes be initially launched on a small scale but with an appropriate budget to make sure that they are successful and such schemes rolled out to suitable hospitals across the developing world if the programme is seen to be successful".

1.10 **The "brain drain" must be more effectively addressed.**

DFID should fund projects that reduce the brain drain of doctors and midwives and facilitate doctors posted to work in rural areas to stay by financial, social and professional support. This should include mentoring to develop their clinical skills while freeing them from the distraction of excessive administration.

> "One of the major threats to maternal health in the developing world is the loss of skilled medical and midwifery staff to better paid posts outside the country of training. Interventions by DFID need to be applied sensitively and whilst the option of salary boost for the trained specialists is superficially attractive it is unlikely to be acceptable to governments where this type of targeted action will disrupt Civil Service pay scales. A wiser approach would be to improve terms and conditions of service particularly in relation to subsidised accommodation, transport, school fees etc which would make such posts more attractive".

Support to "licentiate" type programmes eg as in Zambia—where clinical officers with many years of experience are upgraded to effectively function as doctors in their country and are expected to return to their local hospitals where they have worked and many have their families.

1.11 **Evidence based** care should be encouraged at all levels.

Funding research and formation of guidelines from meta analysis into simple interventions like—quality antenatal care, training birth attendants for safe home and hospital delivery, supply of drugs for prevention and treatment of PPH should be supported.

Support for research into the use of appropriate technology eg ketamine for CS, the safe use of the vacuum extractor, use of Symphysiotomy in some cases of obstructed labour, baby friendly policies that are relevant to local practice etc is needed at all levels.

Adaptation of best practice to local conditions (not taking away the validity of what is good evidence based practice) is still not happening in many areas.

> "Kangaroo care and other clearly beneficial practices may be rejected on the basis that they are "not practised in the west".
>
> "Please encourage funding for rolling out of best practices. It is clear what can and should be done but it is not (yet) happening".

How the health system can be improved as a whole is also not always clear. There is a need to more effectively share experience and lessons learnt in order not to "reinvent the wheel time and time again" and in order to ensure that the interventions being implemented are really those that work (ie evidence based).

> "While DFID provides support to many areas for increasing availability of maternal health services, equity and access, affordability of maternal health services through removing user fees, providing demand side financing, supporting health sector reform etc, it is necessary to research how these various elements of support should be phased in to provide the most effective programe".

1.12 **Accurate data collection and research that is locally relevant** with local ownership should be encouraged. This will also ensure effective implementation of research into practice and implement change in practice.

Building national capacity and support for good quality research is needed especially in the area of maternal health. This should be done with the support of institutions such as the Liverpool School of Tropical Medicine, London School of Hygiene and Tropical Medicine, the Wellcome Trust etc.

> "Local research into the causes of maternal and perinatal death (through maternal and perinatal audit) and into morbidity for both rural and urban areas is vital to determine the focus areas for implementation".
>
> "Probably the most fundamental issue is the need for *reliable* demographic, social, economic and health statistics obtained bhy direct counts (*not estimates*) in a continuous rather than *ad hoc* basis. In places that lack them, a useful way to begin is the compulsory registration of all b irths and deaths. It is an action, which will open the eyes of every body in the society and teach the society to take responsibility for its actions. It is a way of stimulating people to work out for themselves what exactly they need".

Support for (ie funding) research programmes that address maternal and newborn health and sexual and reproductive health in general is essential and this is currently insufficient.

Dissemination of such research from developing (resource poor) countries is generally still poor and needs to be improved—the sharing of lessons learnt (including if the intervention did not work) is essential and should be much more actively supported and receive more attention.

> "Examples of improvement in maternal and child health, reduction in poverty from areas of Bangladesh and India have stimulated the further investments in countries like Pakistan, Yemen, Nepal and Cambodia".
>
> "Organisation of review meetings at regular intervals would result in sharing of lessons learnt by countries, organisations, and further raise the profile of maternal health".

1.13 The need for mainstreaming and continued support to **raise awareness and advocate** (lobby) for Sexual and Reproductive Health (SRH) and in particular Maternal and Newborn Health (MNH) was noted.

> "International and global initiatives and conferences to keep the need for women's empowerment and health status at the forefront of investment in low resource coutnries must be regulary high profile events".

There is a need to more strongly involve both local government, legislators and senior politicians (President, Governors, Finance and Planning ministers):

> "The burden of maternal mortality should be highlighted, lessons of success in other countries shared and the fact that most of the deaths are peventable (with use of simple technologies), but only if the leaders are **TOTALLY** committed to reversing the unacceptable trend".

1.14 Strong in-country **Government commitment** is seen as a key pre-requisite. Donors and DFID can support progress to MDG5 but

> "only if the countries involved do their part by actively supporting the aid work 'in word and deed'".
>
> "Funding from Donors should be used through locally organised in-country initiatives in which benefits go to the disadvantaged who become stakeholders. Local involvement ensures sustainability and capacity development".

1.15 Where government corruption is high DFID is asked to continue to exert what pressure they have . . . .

> "Our government system is so corrupt that to get involved in that system we fear for our lives and hence we need the backing of a strong organisation".

1.16 The issue of "**ownership**" was also raised by the majority of respondents—it is important to involve local people who are committed and empowered to improve maternal health.

A priority to build on existing local resources and developing these to their full potential in liaison with the local community, giving them confidence and improving self-esteem.

> "Look at local power relationships by clarifying roles and addressing structural and systems capacity in institutions as well as fostering accountability from, and engagement of, communities with social issues".

1.17 **Accountability:**

There is a need to make service providers more accountable for their actions/inactions.

> "Catalysing progress should be both by carrot and stick. More of the carrot to those on the ground facing the harsh realities of rural and poor community resources. More of the stick to governments who ought to be responsible for local political participation".

For accountability it is important to ensure appropriate audit trails to ensure money is used appropriately, achieve planned outcomes and minimise misappropriation.

Systematic problems at government level are known to be a barrier to implementation of funded programmes in several countries from which reports were received.

Perhaps these issues are best summarised by one of the respondents from Sub Saharan Africa (SSA):

> "These 11 questions for which answers are being sought from us, respondents, do not go into the heart of the problem of the persistence of high maternal mortality and morbidity rates. The fundamental operational factor is that the existing political, social, economic and financial arrangements in most societies in these countries are not meeting the needs of the vast majority of people in them. These are societies where haredly anythng works properly. So the need is to turn things round so that they work to the general benefit of society. It is not external donors with their myriads of projects that are important. Instead, the important thing is what the disadvantaged masses can do for themselves with donor support".
>
> "In essence, across SSA, what we are seeing is a failure of the political elite and the consequences of this failure. There is no accountability to the people they claim to serve. The picture is depressing. However, all things considered and looking at the history of evolution of other countries and their societies, it will be correct to see the situation in SSA as part of a well trodden dynamic process, and that we will eventually get there. Still, ways must be found to bring the disadvantaged people together to fight for political, demographic and financial rights".

1.18 There is a very clear message from respondents that **Coordination (or Harmonisation)** must also be improved:

> "Much stronger co-ordination between the various donor agencies and Government Parastatals who frequently 'do their one thing' is needed".
>
> "If DFID could promote better linkage of government health with existing micro-credit and development work, might get better synergy of grass-roots and powerful elite's working together for health".

Public-Private partnerships must be used wherever possible especially in areas where the private sector provides majority of the health care the private sector should be better leveraged. There is a need to encourage better NGO-government collaboration to reduce overlap of services.

> "Encourage donors to put asied political gain in order to increase benefit to the population; reduce overlap and overheads, increase collaboration and co-ordination".

Where DFID is playing a key role to ensure better harmonisation and co-ordination this is seen as beneficial.

> "there are few bilateral donors so harmonisation is less of an issue than elsewhere, but DFID pools its funding for some health and education programmes with the World Bank, USAID and the European Commission. Partnership agreements are in place between DFID and the World Bank, Asian Development Bank, UNICEF, UNDP and ILO and DFID is advising the Government as it establishes its own donor agency".
>
> "DFID has made commitments to pool some of its resources aimed at supporting implementation of the sector wide approach and harmonisation of program activities".

1.19 **Funding:**

The overwhelming majority view is that funding by DFID to achieve MDG5 is currently insufficient and needs to be significantly increased.

> "DFID is pooling its resources for the joint implementation of National Rural Health Mission, a flagship programme of Government, for increasing the public health spending from less than 1% of GDP to 4–5% of GDP" (India).
>
> "The budget is a drop in the ocean and will not achieve much".
>
> "There is a need to match the magnitude of the problem with sufficient resources".

It was felt support should be provided both through provision of Technical Support (knowledge and skills) as well as financial resources per se. Funding of work should be jointly by government, private and donor funds. **Making funds available to countries should be on condition that there is significant investment in maternal health.**

> **"Political structures (DFID) need to define criteria for overseas economic aid using maternal health care services investment and improvement in outcome as an indicator of continued investment. Money needs to be badged to defined criteria, otherwise the big black hole concept becomes a problem".**

Ensuring that money reaches those who most need it.

> "Use positive discrimination towards organisations that work and educate at grass-roots level—much international funding comes in at national or academic level—try reaching out to the local/village government/NGO workers".

And that money is used for the right type of activity:

> "Encourage funding for rolling out of best practice".

1.20 In many cases there is lack of awareness of what exactly DFID is doing to particularly progress MDG5 (among key interested health care providers in UK and also from resource poor countries themselves . . .)

Increased awareness by the population in the UK and more directly involving them with fundraising might be helpful (also for advocacy purposes) eg

> "Perhaps newly safely UK delivered women should be given information on maternal mortality overseas and a suggested contribution asked for by the NHS as a government sponsored initiative".

Q2: How effectively is DFID working with recipient countries to make Emergency Obstetric Care available and to ensure that adequate numbers of Skilled Birth Attendants and other staff are being trained to meet MDG 5, and are integrated within a robust health system?

2.1 Several countries report that DFID is assisting with this in a constructive manner but ask that more time and input is given:

> "DFID is assisting our government to increase the intakes in all health worker training institutions in the country as well as supplementing the salaries of some health workers so that they can remain in the system. DFID is also assisting in the construction of housing for staff especially for rural health facilities to make it attractive for health workers, especially midwives to work there and provide 24 hours obstetric service. The number of skilled attendants is still far below the required minimum standard and these initiatives are yet to show results—but are sound". (Malawi)
>
> "DFID's contribution to strengthening the health sector is very high. However, DFID's initiative to create access to emergency obstetric care is yet to gain major momentum. DFID has to play an important leading role in developing and operationalising the Skilled Birth Attendant training and institutionalise them in public health domain, through franchising and accreditation processes. This cadre of SBAs, when coupled with focused behaviour change among the communities, could lead to significant change in the maternal health outcomes". (India)
>
> "DFID has a broad and flexible approach that targets availability of EOC and Skilled Birth Attendance but also addresses the support systems surrounding the delivery of MNH services, including development of human resources. This approach is effective as it strengthens service delivery within the wider health systems. DFID has made a positive contribution". (Kenya)
>
> "DFID is quite effective through—
>
> — Sustained advocacy for recruitment of Skilled Birth Attendants and other staff.
> — Designation and upgrading of health facilities to provide BEOC and CEOC services (infrastructure and equipment).
> — Human Resource management (recruitment, retention, distribution and training of available staff in required competencies based on cadre).
> — System strengthening initiatives (eg quality assurance, laboratory services, HMIS, drug revolving fund schemes, deferral and exemption schemes).
> — Demand side initiatives (eg strengthening of facility health committees, addressing gender issues that relate to type 1 delays).
> — Involvement of the professional bodies and councils". (Nigeria)

2.2 There are acknowledged and well recognised barriers to effective implementation of good ideas . . .

> "We have a focus on moving towards achieving MDG5 by establishing BEOC and CEOC centres including providing sound buildings, drugs, equipment and training of staff. However getting the staff to make the centres functional is not easy as having an effective public service impacts on their own pockets as most run their own private clinics and thus they do not want functional public services. Also in this state people do not have faith in the public sector (any more)". (Nigeria)
>
> "There is what has been described as a 'crisis of governance'—politicisation of public administration, corruption obstructing private sector investment and public service delivery. Formal accountability mechanisms are weak, demand for reform is mainly externally driven, and knowledge of governance is patchy . . ." (Bangladesh)
>
> "DFID support the training of SBAs and the funding to encourage hospital deliveries. Staff in the different centres I visit see the introduction of incentives for delivering in hospital as the major factor in increased hospital deliveries. These hospitals are now able to offer increased services including manual removal of placenta and management of complications of abortion which must also encourage women to seek help at the hospitals. But . . . many district hospitals are still only a staging post from where the patient must be referred to a higher centre for the service they need". (Nepal)

2.3 Respondents clearly express the need to ensure that increasing availability of SBA and EOC needs strengthening of the health system as a whole. In addition there is the experience and observation that a focus on ensuring availability of and access to SBA and EOC will lead in itself to a better functioning complete health system. This leads respondents to believe that there should be a very strong continues and sustained emphasis on SBA and EOC.

> "DFID has supported the establishment of EOC since 1997. In the first phase DFID supported the establishment of the Safe Motherhood Project for strengthening EOC in several districts. The lessons learnt from this project showed that scaling up EOC was not possible through projects and required a functioning health system at all levels. Thus DFID assistance has since been directed to providing support to the National Safe Motherhood Programme through the Support to the Safe Motherhood Programme (SSMP). The SSMP is supporting scale up of EOC and establishment of skilled attendance and BEOC services at primary health care centre.
>
> Simultaneously, DFID is also providing support to the Health Sector Reform that aims to bring about change in national policies that would result in an increase in Ministry of Health and Population's capacity to deliver quality maternal health services as part of the package of essential health care services, with increased decentralization and public private partnerships. The reform process also aims to improve sector management—improved physical assets management, ensuring the availability of drugs and logistics, human resource management, financial management and improved monitoring systems.
>
> This is a programme that aims to develop government capacity and build partnerships between major donors in Safe Motherhood and the Health Sector Reform Process, to strengthen the health system and simultaneously the National Safe Motherhood Programme. Changes in the health sector are critical for achieving results in the Safe Motherhood Programme and these results, concurrently, would provide the indicators for change in the health sector reform process". (Nepal)

2.4 Respondents from all countries want the international community and donors to realise and accept that meeting MDG5 is possible but will take time . . .

There are repeated and emphatic calls to **give this process more time** . . .

> "While the concept requires strong partnerships to execute this tie up between two major programmes as well as government capacity building and stability, it also requires considerable time . . ."
>
> "MDG 5 seems to be the MDG seen as least likely to be achieved in the timescale, I would have to say that DFID and other agencies are *not* working effectively enough in these areas. But there are clearly huge obstacles . . . Priorities must be in the area of increasing capacity and of course ongoing training and support for the health system and infrastructure . . ."

There is also some doubt expressed as to whether DFID can ensure this . . .

> "Individual countries will receive aid for these elements. However, I imagine that DFID is a rather remote organisation to ensure the above".

2.5 More needs to be done:

> **"DFID is working in these areas in less than 10 countries, which is not enough to bring a critical movement".**

Q3: What steps is DFID taking to mainstream maternal health across related policies?

3.1 Making the linkage between MDG5 and MDG 1 (poverty and hunger), 2 (universal primary education) and 3 (promote gender equity) is seen as key here.

DFID is known to be taking a number of steps to ensure maternal health is mainstreamed across related policies which include:

Ensuring MNH is part of the process of **Harmonisation:**

> **"DFID support the budget for the SWAp in the health sector where maternal health is a priority area".**
>
> **"DFID has incorporated MNH into the Country Assistance Plan".**

— developing plans and policies that cut across different sectors;

— ensuring commitment, cooperation and coordination from all key stakeholders;

— ensuring that strategic health plans at national and state/provincial level address MDGs with clear targets;

— MH is a key output of programme logframe;

— ensuring integration and alignment of other programmes eg HIV, TB, Malaria prevention and treatment programmes with MNH programmes (not the other way around);

as well as via the **socio economic development and health rights approach**

— Continued emphasis on MH as part of poverty reduction strategies;

— looking at microcredit and financing groups to improve women's access to health care;

— promotion of SRH rights-based approach;

— valuing role of women in society; and

— liberating women to give them an effective political voice and insist on change.

3.2 **Advocacy** for mainstreaming of MNH is being done but needs to be sustained:

— Agreement between host nation politicians and donors to prioritise MNH.

— Raising the political profile of MNH through advocacy and BCC strategies.

— Using civil society organisations to demand for better investment in systems to address high maternal morbidity and mortality.

— Advocacy in media and local government focusing on men and improving their knowledge base, since they are often key decision makers.

Some say that the mainstreaming is happening but **less talk and more action** is needed:

> "it is not just policies that are required but clear implementation plans—ie getting policy into practice".
>
> "I am unable to comment on what steps DFID should be taking to mainstream maternal health across policies. We have enough programmes and policies in place. It is the implementation which is faulty . . .".

Several respondents are unaware of what steps DFID is taking and call for better dissemination and profiling of such activities by DFID.

Q4: How is achieving MDG 5 being prioritised and integrated into your countries' overall healthcare provision?

4.1 Countries report primarily that this is being done via a process of **Harmonisation or and Central Coordination.**

— DFID assistance in Nepal is directed to providing support to the National Safe Motherhood Programme through the Support to the Safe Motherhood Programme (SSMP).

— DFID Nepal is providing support to health sector reform that aims to bring about change in national policies resulting in better capacity to deliver quality maternal health services as part of the package of essential health care services, with increased decentralization and public private partnerships.

— Developing government capacity and building partnerships between major donors in Safe Motherhood and the Health Sector Reform Process is vital.

— Improving maternal health is one of the key priority areas in the National Health Sector Strategic Plan II and fully integrated into the delivery of KEPH, Kenya Essential Package of Health.

Suggestions for improvement include:

— A lot of political rhetoric but unsure how this is linked to resources to address the key issues.

— Professional societies need to be involved in policy, planning and implementation of safe motherhood.

Prioritisation of MDG 5 is reflected within the various government planning documents but lacking the necessary Government capacity and financial support for effective implementation. (Nigeria) In Malawi and Bangladesh, MDG 5 appears to be given priority but little commitment. In Mongolia it is very much a priority but in Laos this is reported to be "a different kettle of fish".

4.2 **Advocacy** is seen as an important mechanism through which prioritisation and integration of MDG5 can be achieved:

> "DFID advocacy is necessary at all levels, at national and international levels and should be done together with the UN Agencies . . . to increase ownership of maternal health and the benefits of achieving MDG5".
>
> "MMR is the best indicator of a functioning health system—DFID advocacy for the recognition of this fact in health sector reform process is important".
>
> "DFID advocacy has been successful in raising the profile of maternal health. However DFID's agenda must also become the agenda of national advocates particularly the Obstetricians and Gynaecologists as well as women's rights groups etc in order for government to make it their priority".

Q5: How is DFID supporting the 2006 recommendation by the UN General Assembly for an MDG target for universal access to reproductive health?

5.1 There was little or no awareness among respondents as to how DFID is supports the establishment of a target for universal access to reproductive health.

> "The fact that several of us working in different aspects of health and development here do not know the answer to this question implies that there is little dissemination of what DFID is actually doing—at least, dissemination has not reached those at the grass roots level . . ."
>
> "DFID could support networks to enable people to have a greater knowledge of what is happening so that there can be a sharing of knowledge, resources and experiences . . ."

5.2 It is suggested that international lobbying for this target is necessary if this is not already being done.

There is realisation however that sexual and reproductive health rights have remained a DFID priority with emphasis being given to adolescent reproductive and particularly comprehensive abortion care in the absence of US donor support.

5.3 There is a strong realisation that most developing country health facilities have minimal sexual and reproductive health provision capability at best distribution is not equitable with rural areas especially poorly affected and that universal access to functioning health services is desperately needed and should be a real priority for the next decade.

Q6: What progress is being made to reduce maternal deaths from unsafe abortions (which account for 13% of all maternal deaths)?

6.1 A variety of responses was received. Very good progress has been made in specific countries whereas in others progress is slow or non-existent.

Countries form which enthusiastic responses were received included:

Nepal:

Besides the support to EOC and skilled attendance, DFID has provided support through Government to the liberalization of abortion in Nepal and its implementation.

"Among many partners DFID supported training and service provision of Post Abortion Care (PAC) since 1997. Abortion was liberalized in 2002 and rolled out by Family Health Division, with the support of active women's' rights groups. Comprehensive Abortion Care (CAC) services are now available and integrated within the government system in most districts in Nepal. This programme provides a good example of service provision through public private partnership. Marie Stopes and other non-governmental agencies and the private sector have contributed significantly to the expansion of services to provide safe abortion care".

Issues of access (affordability sometimes remain . . .).

"Many doctors and nurses are receiving training in comprehensive abortion care and this is now available at hospitals in all the districts I visit. Fees charged may be too much for the very poor".

Significant progress is also reported from **India**:

- The Medical Termination of Pregnancy Act 1971 has been implemented since 1972.
- Over the years, the number of centers where pregnancy can be terminated has increased and at present there are 11,025 recognized MTP clinics in the country. However, considering the fact that a large number of unsafe abortions still take place more facilities for MTP services are needed.
- At present the Government of India under the RCH programme is undertaking training of medical personnel in MTP technique, and undertaking IEC activities for improving the awareness and knowledge of the community.
- The MTP Act, 1971 has been amended with the objective of delegating power to a Committee at the district level to facilitate recognition of more centres where MTPs can be undertaken.
- Use of Mifepristone (RU 486) followed by Misoprostol is an established and safe method for terminating early pregnancy. In April 2002, Drug Controller of India approved marketing of Mifepristone for termination of early pregnancy, a method also known as Medical Abortion. Currently its use in India is recommended up to 7 weeks (49 days of amenorrhea) in a facility with provision for safe abortion services and blood transfusion.
- The Department of Family Welfare has introduced the Manual Vacuum Aspiration (MVA) which is a safe and simple technique for termination of early pregnancy that makes it feasible to be used in Primary Health Centres or comparable facilities, thereby increasing access to safe abortion services.
- The project of introducing the MVA technique has been piloted in coordination with FOGSI, WHO and respective State Governments before accepted for implementation by the Ministry of Health and FW.
- Improving public awareness nationally through print and electronic media.
- Introducing sex education programme in the school curriculum (among pupils over 10 years of age).
- Effective introduction of emergency contraceptive pills in the national programme.

Respondents from **Nigeria report** progress:

Progress is being made through:

- DFID supports partners at the federal and state levels to train doctors, CHEWs and midwives in Life Saving Skill competencies that include MVA and post-abortion care (PAC) services.
- Promotion of family planning/birth control practice and family planning services being provided down to community level.
- Support to 'Girl child' education.
- Focus on adolescent reproductive health.
- Community awareness and advocacy.
- IPAS is the leading organization that partners with the government of Nigeria and other agencies to change the policy environment for abortion rights and PAC services).
- Ensuring effective referrals to reduce type 2 delays.

6.2 However, in several other settings progress is difficult and slow and respondents from especially eastern and SubSaharan Africa (SSA) were quick to point this out:

> "Several interventions are ongoing but there is not much progress because the Church Lobby is strong and is against legalising abortions". (Kenya)
>
> "I am aware that there is no progress. The need is for improved provision and use of family planning, and the proper hospital-based treatment of complicated abortion". (Nigeria)
>
> "Several interventions are being implemented (adolescent health services, FP, decentralisation of PAC services) but religious and cultural views around abortion remain major barriers in achieving the desired reduction". (Kenya)
>
> "Abortions are still illegal in East Africa, the part of the developing world I know best. Abortions are therefore still clandestinely provided at exorbitant prices. Those who can not afford the prices will therefore resort to untrained unlicensed abortionists with serious consequences". (East Africa)
>
> "The majority of the 130 million women without access to reliable contraception in the world are in sub Saharan Africa, which explains why 58% of all induced abortions in the world occur in Africa".
>
> "Minuscule efforts and progress is being made in most SSA countries. Most intervention efforts are in the curative arena, in the gynaecology wards, therefore missing the key preventive intervention of Family Planning both:
>
> — to prevent the first abortion and (after septic abortion is treated in hospital); and
> — to make it less likely that the same woman will be back again following a further unsafe abortion".
>
> "Addressing the issue of effective Family Planning and access to safe, preferably medical, abortion has low priority . . .". (Malawi, Bangladesh, Eastern Europe)
>
> "There is more being given to adolescent reproductive health; however some of the health messages need to be refined—eg the message is out there to delay first childbirth, but this has not been interpreted as delaying first pregnancy—so there are now an (increasing?) number of abortions ('safe' and 'unsafe') rather than promoting use of family planning and thus delaying first pregnancy.
>
> Also at the other end of the reproductive health age, there is a need to understand of cultural/social/religious barriers to permanent methods of family planning once the family is complete". (Bangladesh)

6.3 Some see the combination of **improved access to family planning services and liberalisation of abortion laws** as the way forward to achieve significant reduction of maternal mortality from unsafe abortion:

> "A major educational programme will be needed to convince certain religious groups of the need by women to limit their fertility by allowing birth control methods to be adopted. The obvious first step to reducing the incidence of deaths from unsafe abortion is reducing unsafe abortion itself, which means either legalising and professionalising abortion and/or (far preferably) increasing knowledge of and access to reliable contraception. I believe that this is expanding year by year but unfortunately—as with much good progress—advances are greater in the less poor countries while those with the lowest resources and associated worst rates of maternal mortality are still far from providing such access. Cultural and religious traditions also need to be taken into account".
>
> "Developing countries have the biggest problems with maternal death in association with unsafe abortion but at the same time have the most restrictive laws about abortion. The UK and other respected developed countries should be trying to assist in changing attitudes towards dealing with unplanned and unwanted pregnancies and assisting countries to change their legislation to a more liberal stance".

6.4 In other settings **preventing unwanted pregnancy through better provision of family planning services is seen as the primary key** to achieving reduction in maternal deaths from unsafe abortion:

> "Induced abortion is illegal; and unmet need for contraceptive services is high at about 30%. The option is the delivery of community-based family planning services to eliminate unwanted pregnancies, especially among the youth. No funding is available. USAID is planning to make the services in 8 of the 28 districts in the country and the country wishes for more support from other donors such as DFID". (Malawi)

6.5 There is also a strong consensus that there is lack of clear and accurate data on the extent of the problem and that such data are by definition difficult to obtain.

> "We have no idea what the denominator for illegal abortions in the third world is. The women for whom it is successful would not come forward. I am afraid social taboos make this at least as much a social issue as a medical one".
>
> "I have to look at these percentages with suspicious eyes since it is very difficult to get appropriate statistics from these countries".

6.6 In general reports indicate that professional associations/groups are in support of interventions to reduce maternal deaths from unsafe abortions:

> "Our national organisation of Gynaecologists and Obstetricians organised workshops a couple of years ago along with WHO to showcase the MR syringe (MVA) as a tool for reducing blood loss during abortions".

6.7 Again there is a call for better dissemination of lessons learnt:

> "Aware of reports commissioned to highlight the crisis in relation to unsafe abortion. Not clear what effective progress is being achieved although recent DFID Health Policy provides case studies of for example initiatives in Cambodia and Nepal. Would help to keep sharing lessons learnt from implementation and about what is effective in comprehensive abortion care programmes".

Q7: How effectively is family planning being promoted as a way to improve maternal health?

7.1 All respondents see family planning as an essential step to help reduce maternal mortality and improve maternal health:

> "Prevention is better than cure . . ."
>
> "Family Planning should be the main emphasis for the next decade. FP is low tech, cost effective and the most effective strategy in reducing maternal mortality in the short term".

7.2 Many countries report that good progress is made in this area:

> "Family planning has been promoted and well publicised". (Egypt)
>
> "The methods are promoted in all public health facilities. The spacing method promotion has gained significant momentum. The promotion of IUDs, Oral Contraceptives and Condoms (both male aqnd female) for spacing is a major program in India. The community based programmes also work on promoting spacing for better maternal health". (India)
>
> "Family planning is provided in 90% of cases through the government sector and only about in 9% cases through the NGO and private sector. The extensive reach of the government sector compared to the limited coverage of the private and NGO sector makes it imperative to further strengthen the government sector while also working on improved public private partnerships". (Nepal)
>
> "Family planning promotion and uptake is very variable across the region. In many areas it is not given much priority and people are ignorant and fearful of side effects from temporary and permanent methods". (Nepal)

7.3 There are clear ideas on how better coverage and uptake of family planning could be effected:

> Provision of FAR BETTER accessible, affordable voluntary family planning services and methods along with education including:
>
> — correct information re FP;
>
> — the removal of much MIS-information in many developing countries (eg in Sub-Saharan Africa (SSA) the widespread myth that the Pill causes life-time infertility; and
>
> — the RE-education of the men in many societies: to reduce sexual abuse, but above all allow all women access and CHOICE to control their own fertility which is currently often denied (by their male partners).

7.4 There is clear realisation that more needs to be done and that access is by no means universal and especially poor for rural women:

> "Facts reveal that 137 million women who wish to limit their family size have no access to any form of contraception".
>
> "There is a need to take the services to the people through the Community Based Distribution (CBD) approach".
>
> "The women at greatest risk are the elderly multiparous women. They tend to be from peasant families and often the poor and those who live in remote rural communities are neglected".
>
> "Family planning is actively promoted, though services are scarce especially in rural areas".

7.5 Shortages in trained staff and supplies have hampered progress severely in some areas:

> "All public health facilities, except for those run by the Catholic Church provide family planning service; but because of the shortage of staff, and the inadequate distribution of health facilities, contraceptive prevalence rate has stagnated at about 30% for the past five years". (Malawi)
>
> "It can be seen in many low resource countries that regular supplies of FP methods to rural areas is still poor and there is often little access to modern, long-term FP methods. Means to address the issues need to be linked to HR and supplies systems and training and governance related to the latter".
>
> "More funding required to procure supplies. Demand is there". (Kenya)
>
> "There was a country wide shortage of Depot Provera at the end of 2006 and beginning of 2007, due to bureaucratic incompetence, and the result of this has been many unwanted pregnancies and subsequent abortions and 'Menstrual regulation' procedures. Has the International donor community any role in ensuring that this does not happen again—years of hard work at promoting confidence in the FP system was shot to pieces through this". (Bangladesh)

7.6 There has also been "competition" for priority especially with regard to countries with programmes to address the problem of HIV/AIDS:

> "Support for family planning has decreased over the past decade with a shift of resources from FP to HIV/AIDS. It is slowly coming back on the agenda, not only to reduce fertility rates, but also for PMTCT of HIV and improving maternal health".
>
> "Promotion of FP is ineffective and in some areas FP is not promoted at all. Money for HIV programmes often donated by Christian organisations who do not support and indeed actively discourage contraceptive usage including condom worsening HIV rates".

Uptake of FP is seen to be related to general education, sex education and to health education:

> "Educating and empowering women is the most important factor as has proved in countries like Bangladesh, Sri-Lanka and Kerela state of India".
>
> "General education of women will lead to their emancipation, to their being valued and to the spread of sexual and birth control education. Such will lead to a reduction in the population in the continents where the population explosion is most fierce".
>
> "Advocate the dissemination of messages supporting later marriage, spacing of births—including the practice of exclusive breastfeeding to six months or more—and care following abortion or miscarriage to include contraceptive advice. Families may accept such advice even more readily if it is understood it will improve the survival of existing children under 5, as well as that of the mother".
>
> "One area of improvement is education in sexual health aimed at school children as well as adults. A novel initiative organised by Rotarians is the 'Health Fair' initiative for countries in need. Projects in South America and Eastern Europe are particularly effective".
>
> "The uptake of FP is variable and depends on religious views in country. In some areas FP may not even get discussed. Improving this is probably best achieved by educating women so that they demand access to good family planning".

7.7 The need for involvement and dialogue with religious leaders is recognised in many regions:

> "You will be aware of the religious influences on family planning in large Catholic communities in East Africa".

7.8 There is also the need to see the issue of FP in the wider context of the position of women in the community:

> There are too many economic issues with regard to family size for this to be considered in isolation. As we recently heard at Africa Day[1]—"t is easier and more economic for a man to get a new wife than to spend scarce resources on the existing wife's treatment to save her life".

7.9 And a caution that a combination of efforts is needed not "just" FP:

> "Family planning is just one method to improve maternal health, but the remaining indicators should not be neglected".
>
> "It is available where other health services are available but not seen as a priority by families for whom most healthcare choices are limited to crisis situations by their socio-economic situation. It should find its place in the pattern of service development together with SBA and EOC".
>
> "The National Family Planning programme is being implemented in all districts and is making reasonably good progress. It offers a good contraceptive mix and the most commonly used methods are female sterilization and Depot Provera. Family planning service provision is one of the important roles of the SBA". (Nepal)

Q8: *How effectively does DFID work with bilateral and multilateral donors, NGOs and other stakeholders to promote maternal health (in your country)?*

8.1 In general the approach of DFID to work with other donors, NGOS and stakeholders was seen as positive and effective:

> "DFID is a member of the technical working group on Reproductive Health and is also a member of the Donors Group on Reproductive Health which also include maternal and child health".
>
> "DFID has taken key roles in SWAPs and health systems support programmes but still works with and supports NGOs".
>
> "They collaborate with other partners to provide financial and technical support for training, equipment etc".
>
> "There is engagement with NGOs, CBOs at the community level on mobilization, awareness creation and monitoring and evaluation activities".
>
> "DFID is partnering effectively with other agencies on the Inter-Agency Coordinating Committee (IACC). At state levels DFID funded programmes are collaborating with other donors and NGOs in promoting maternal health".
>
> "DFID's approach to addressing the problem of maternal health is well conceptualized and ambitious. Perhaps it is the only way that it can be done—by strengthening Safe Motherhood and linking it with efforts to reform the health sector, without which scaling up Safe Motherhood is not really possible".
>
> "DFID advocacy has been successful in raising the profile of maternal health through its work in Safe Motherhood and the Health Sector Reform process. In both these areas, it works with a multitude of partners—government, multilaterals, bilaterals, the World Bank, NGOs, professional societies etc".
>
> "There are few bilateral donors so harmonisation is less of an issue than elsewhere, but DFID pools its funding for some health and education programmes with the World Bank, USAID and the European Commission. Partnership agreements are in place between DFID and the World Bank, Asian Development Bank, UNICEF, UNDP and ILO. DFID is advising the Government as it establishes its own donor agency".

8.2 The need to engage more with the professional associations was expressed as well as the difficulties that arise when there are new initiatives launched (? too often, or insufficiently well disseminated . . .):

> "DFID works quite effectively in the health sector with all other development partners for promoting maternal health. DFID could work more effectively with professional bodies like FOGSI, AICC RCOG to promote maternal health".
>
> "There appears to be little public information disseminated through the professional organisations".
>
> "There was a good momentum of working in partnership with bilateral and multilateral donors and civil societies, until the confusing announcement of the new initiatives . . .".

8.3 In some cases it is recognised that despite DFID's good intentions, effective partnerships may be hindered by local factors:

> "The current strategy seems to be to strengthen government capacity to prioritise under served areas and subcontract with other private/NGO providers, however the government has been reluctant to do so".
>
> "DFID is no longer working directly with small NGOs but is trying to co ordinate and promote larger consortia of private and NGO providers to cover underserved areas. There are big variations in implementation and government capacity and vision; compounded by political instability".

Q9: What leadership is the UN is providing and how well co-ordinated are its agencies?

9.1 The "reviews" were very mixed with some excellent examples of co-ordination but in some countries health care providers or staff working at national level were pretty negative about the level of coordination and partnership . . .

> "UNFPA and WHO have coordinated the development of the 'Roadmap for the Prevention of Maternal Deaths' and are providing technical support for the implementation of the Roadmap at district and national levels. WHO is supporting training in Skilled Birth Attendance. UNICEF is actively involved in the prevention of vertical transmission of HIV. There is a UN working group which provides a forum to share information about the various program activities that each organisation is providing". (Malawi)
>
> "Through the flagship program of NRHM (National Rural Health Mission) all the UN agencies and bilateral donors are well coordinated". (India)
>
> "The UN provides the needed leadership role in terms of collaborating with National and State Governments. Its agencies are well co-ordinated and provide support in terms of project design and implementation in various sectors of health care provision". (Nigeria)
>
> "The four UN agencies are working more and more closely and have now delineated areas of comparative advantages and strengths in maternal newborn and child health (New York meetings of 13 September 2006 and 11 July 2007, and forthcoming Washington meeting of 17 September). But it remains to fine tune co-operation at country level". (UNFPA)

In contrast to the above . . .

> "Technical guidance is provided but coordination between WHO, UNICEF and UNFPA could be improved". (Kenya)
>
> "I found there was very poor co-ordination with other UN agencies. This may have been because the purposes for which I went to the old Soviet Republics were short term and time limited".
>
> "Difficult to comment but as far as I know there is no one UN agency taking responsibility for MDG 5, and this is extremely unfortunate. WHO offers technical expertise from its Making Pregnancy Safer department, and of course this is also available from INGOs such as FIGO and ICM, who work closely with WHO, UNFPA and other agencies where appropriate. The Partnership for Maternal Neonatal and Child Health also has good aims in this area to do in-country work but I do not believe it is very clear exactly how all the agencies' various strands of work cohere and complement each other, and I believe there is scope for improved co-ordinations".
>
> "WHO is providing good leadership and technical support. UNFPA could be much more effective if there was better leadership. UNICEF is fairly useless". (Papua New Guinea)
>
> "Resolutions are passed but it is difficult to see the practical impact of these resolutions".
>
> "None, and poorly co-ordinated". (Bangladesh)

Q10: How is DFID addressing socio-economic barriers to women's empowerment and the low status of women in relation to maternal health (in your country)?

> **"Community mobilisation to empower women to take up maternal and newborn care services is one of the strategies of the Roadmap for Maternal Health which DFID is supporting.**
>
> **In addition DFID is supporting basic education for increased enrolment of girls, but still the dropout of girls in secondary school is very high". (Malawi)**
>
> **"Gender specialists at Division of RH are not aware of any specific activities by DFID in this field". (Kenya)**

10.1 Multiple examples were given from Nigeria although no comment was made on the effectiveness or not of these:

> The focus is on a combination of education and reduction of health care costs for women:
>
> — Girl child education programme.
> — Empowerment of women including taking part in home decision making.
> — Supporting male involvement in maternal health.
> — Introducing community based Emergency Loan Fund (ELF) schemes for pregnant women.
> — Introducing Emergency Transport Schemes (ETS) for conveying pregnant women to health facilities at any given time.
> — Support to Free MCH policy.
> — Design of voucher scheme for pregnant women.
> — Design and implementation of Deferment and Exemption Schemes for paying for health care.

10.2 There is a general consensus that empowerment of women is directly linked to financial independence/dependence and that this is a key area that must be addressed:

> "Women's empowerment can only be achieved through a comprehensive strategy of poverty reduction through micro credit etc reduction of illiteracy, improving health and supplying of clean water".
>
> "Practising compassionate care is more effective that talking about a matter that may be politically correct but culturally inappropriate".
>
> "DFID provides support to addressing equity and access issues through the 'increasing access' component of the Support to the Safe Motherhood Programme. This component of SSMP works on issues of women's empowerment and with the more disadvantaged sections of society to increase their access to services. While this is implemented in selected districts, DFID provides cash incentives to women delivering in health institutions to promote skilled attendance at delivery, at a national level". (Nepal)
>
> "An example of DFID support to women's rights is an income generation program".

10.3 Most health care providers said they were unaware what DFID was doing specifically to address these issues:

> "Do not know. There are adverts on the TV channels about the girl child's value, This I suspect must be sponsored by a donor because its very expensive to advertise. DFID should note that in the cities the private channels are watched, not the government run channels and DFID should rather use these".
>
> "DFID prioritises programmes which are poverty focused, demand driven and owned by 'an agent of change'—be that government, NGO or private; programmes which have impact on the lives of women and girls; have potential for pro-poor change; etc etc but how these aims are being worked out in practice is not clear to us where we are working" (rural Bangladesh)

Q11: How can the international community improve maternal health in crisis and conflict settings?

11.1 The central consensus was that the primary focus should be on ensuring and/or rebuilding the peace . . .

> "Firstly assist to end the cause of the crisis. Secondly mobilise maternal health services for the displaced persons. Finally assist in the rehabilitation of the affected people as soon as possible".
>
> "The international community should have principles that stick and are not abandoned for commercial considerations. Maternal health crucially depends on stable political and economic environment. When there is conflict the first to suffer are the vulnerable mother and child. It ought to be made a Crime against humanity that in any conflict situations if women and children are not specifically protected, warring parties should be punished".

Specific points:

> — Do its utmost to support adhesion to the Geneva Convention and UN Declaration of Human Rights to prevent all civilians, but in particular families with babies and small children, suffering death, injury, illness or forced disruption because of conflict.
> — Ensure the severest penalties against the use of rape as a weapon of war against women.
> — Support safe transport and facilities for medical and midwifery staff working in refugee camps or settings of potential danger.
> — Ensure that emergency response activities integrate maternal and child health issues especially access to Emergency Obstetric Care, Skilled Attendance at birth and access to Family Planning.
> — Integrated provision by the Relief Agencies of family planning (including especially Emergency Contraception by both hormonal and IUD methods) and safe abortion services and ideally counselling services, to the hugely increased number of victims of sexual violence and rape in these settings.

11.2 In addition there were many practical suggestions for how immediate help could be given and/or organised:

> "An international maternity squad can be sent to areas of conflict by the UNO. Squad should have Obstetrician, midwives, nursing staff and appropriate resources".
>
> "Highlight the need to prevent and where necessary address gender-based violence and the aftermath of crises where there is significant loss of life and the extra pressure on women to reproduce, marry younger, drop out of education etc".
>
> "Adequate funding from all concerned to ensure free or heavily subsidised maternal services via accessible and functional health facilities".
>
> "Promote and facilitate retired and concerned practicing obstetricians and Midwives to offer their assistance to those who organise healthcare in those situations. They may need support with appropriate technological resources, orientation and training".
>
> "Antenatal mothers can be grouped in special care hospital settings in a protected area, where doctors and nurses can look after them round the clock, with living quarters provided close by for immediate family members".
>
> "Set up equipped mobile health units".
>
> "Organise sustainable education courses for emergency response teams".
>
> "Develop a pool of emergency obstetric responders for crisis/conflict settings who can secure rapid release from regular duties".
>
> "Increase the profile of the RCOG IO among the relevant aid agencies".

The need to work closely with the relevant local community was emphasised:

> "Understanding the local cultural influences is essential before one can 'plunge' in with something the international community may view as effective".
>
> "A non-partisan non-judgemental approach is needed".
>
> "Identify and communicate through an effective body who command respect".
>
> and the need to work with experienced people:
>
> "Using UNHCR and NGOs like the RED CROSS and MSF who have experience in this field".
>
> "The activities of the Finnish International Red Cross give a perfect example of maternal health provision and improvement in conflict situations. Material for erection and operation of field hospitals and supporting health and physical infrastructure are kept in secure storage. Fully trained personnel, pre-selected, tested and passed fit to cope with the demands of the task are always in readiness for rapid deployment. Once the emergency period is over, medium and long-term needs are not much different from what they are in non-conflict situations".

11.3 Interestingly it was pointed out that the underlying cause of such conflict was related to absence of good maternal health services (in particular family planning) in the first place by a number of respondents:

> — In these situations, as with global warming, the problem is of man's (generic) making. The human population is greater than can be accommodated and radical worldwide means need to be undertaken to tackle the human population explosion on every continent except Europe.
>
> — If the human population is allowed to continue to increase exponentially, conflict, war, disease and crisis are the normal expected results. Thus, the international community can only improve the situation by agreeing to limit and then reduce its human population to that which its land can support.

11.4 Finally if and where comprehensive maternal health services (especially with CEOC) are in place it is anticipated and has been shown that in case of conflict existing services are equipped to deal with this better than if such maternal health services are not in place . . .

> "The scope of work of DFID is expanded to support the establishment of CEOC in many districts. The populations in crisis have access to better district health systems—improved surgical services, operation theatres, blood transfusion and infection prevention. This recommendation is based on an assessment of mass casualty management by the UN agencies in 2006, which showed that hospitals providing CEOC were better able to manage casualties during emergencies". (Nepal)

Memorandum submitted by Save the Children UK

Background

1. Save the Children UK was invited to provide evidence on maternal health in fragile states as part of a stakeholder consultation held by the UK International Development Committee. This document is intended to complement the verbal evidence given during the inquiry and to address the specific questions which form the basis of the inquiry. It is neither meant to be comprehensive of all issues discussed during the inquiry, nor to be exhaustive on maternal health issues in fragile states. It simply intends to provide a few concrete suggestions on **maximising the impact of DfID's work** on maternal health in fragile states.

2. **Maternal health outcomes** in fragile states are almost invariably bad: maternal mortality has been estimated at 1,600 per 100,000 live births in Afghanistan, 1,700 in Somalia, 2,000 in Liberia, 1,700 in Southern Sudan.[166] Maternal mortality in fragile states is 2 and half times higher than in countries with similar income levels. Multiple factors conspire to determine these outcomes in fragile states, including a near-total collapse of health services, high fertility, a low level of education and empowerment of women, low priority given to the health status of women by society.

3. Save the Children places great emphasis on **maternal and child health**, recognising the right to health of the mother and the child as **inalienable human rights**. This is reflected in programmes in multiple countries in Africa, Asia, Latin America to improve maternal and child health, and strengthen health systems in

[166] WHO (2004) *Maternal Mortality in 2000*—Estimates developed by WHO, UNICEF and UNFPA, WHO Geneva.

general. Improving maternal health outcomes is not only an imperative goal in itself, but it is also fundamental as part of **child survival** strategies: a child whose mother has died of AIDS, for instance, is four times more likely to die than a child whose mother is alive.[167]

4. Fragile states present **peculiar challenges** that should be taken into consideration when analysing strategies to catalyse change in health service provision: these include the deterioration or collapse of public management systems and governance structures, migration of health workers to safe areas of the country or abroad, a contraction of the resource envelope available for basic social services, the emergence of multiple and frequently poorly coordinated aid mechanisms and management structures, which lead to fragmentation and inefficiency. Looking beyond the health system, worsening education opportunities, economic decline and the exacerbation of gender-based discrimination and violence all contribute to the deterioration of maternal health outcomes in fragile states.

Summary of Key Issues and Recommendations

1. Improving maternal health outcomes can only be achieved through an **overall strengthening of health systems**, in particular in fragile states where health services and management systems are frequently in a state of near-total collapse. Health sector reform and health system building are processes that typically take place over a long period of time, and which therefore require **long-term political and financial commitment**.

2. There is increasing recognition of the **role civil society organisations** can play in strengthening health systems and improving maternal health outcomes: they can be the main vehicle of service provision where national governments are not able or not willing to provide services themselves; they can contribute to holding governments to account; they can advocate for a higher recognition of women's status, and for greater rights to reproductive and maternal health services; they can provide technical assistance and various forms of support to health systems; they can build the capacity of national institutions, both in the government and in the civil society, to better address maternal health needs; finally, they can pilot new approaches and conduct operational research on best practices and promising approaches which can be then rolled out at national level. Without adequate support, however, the unique contribution civil society organisations make can be lost. While it is true that in certain countries direct support to government mechanisms and financial channels may represent the most cost-effective and sustainable strategy to support the development of health systems, attempts should be made at **striking a balance** that allows at the same time establishing strong and accountable government mechanisms and **maintaining a vital civil society sector** to support and complement the governments' action.

3. While most of the interventions needed to improve maternal health outcomes are likely to have an impact only if sustained over long periods of time, a relatively easy to implement intervention that could represent a **quick-win** could be to reduce financial barriers to health services utilisation by **moving away from payment at the point of use**. DfID could play an important role by ensuring that the countries and the institutions it supports, such as the World Bank, display better consistency among their policy commitments, financial commitments, and programming.

Response to 11 Specific Questions

1. *How can donors (specifically DfID) catalyze progress towards MDG 5?*

1.1 Improving maternal health outcomes requires an effective and equitable health system. DfID's focus should therefore continue to be on **strengthening health systems as a whole** rather than supporting discrete components of service delivery. What this means concretely at country level varies according to the context. The newly launched International Health Partnership could provide the framework for supporting health system development and better donor coordination in this regard. Typically, the main challenges encountered by health systems in fragile states relate to poor governance, weakened or inexistent management systems, opaque financial flows, insufficient human resources in rural/ remote areas, and absence of referral systems. DfID should also use its key role in the IHP to ensure that civil society is given adequate recognition and support in its significant contribution to achieving MDG5.

1.2 In addition to building effective health systems, making maternal health services a political priority and empowering women may require a particular emphasis in terms of **advocacy and legislation**.

1.3 DfID can also contribute through operational **research** to expanding the evidence base on what interventions and approaches work well, and investigating the role that provision of basic social services can play in maintaining peace and in nation-building.

1.4 Donors' (and DfID's) role relates not only to assisting countries in providing adequate financing levels, but also in encouraging governments to strengthen their political and financial **commitment**, and be **accountable** on provision of health services.

[167] Basia Z, Whitworth J, Marston M, Nakivingi J, Ruberantwari A, Urassa M, Issingo R, Mwaluko G, Floyd S, Nyondo A, Crampin A. (2005) *HIV and Mortality of Mothers and Children: Evidence From Cohort Studies in Uganda, Tanzania, and Malawi.* Epidemiology. 16(3):275–280.

2. *How effectively is DfID working to ensure Emergency Obstetric Care is available and accessible with adequate numbers of skilled birth attendants?*

2.1 DfID's work to support the availability of maternal health services in developing countries is commendable; a particular mention must be made to the programmes that attempt to address the human resource crisis, such as the emergency human resources programme in Malawi, the collaboration with the NHS to slow down migration of health workers, and partnerships with the Global Health Workforce Alliance and the Federation Internationelle de Gynecologie et Obstetrique. Addressing systematically the human resources shortage, however, can only be done within a **broader context of civil service and health sector reform** at the country level, and through the introduction of adequate **financial and non-financial incentives** to encourage recruitment, proper management and retention of qualified human resources. This in turn requires dramatic improvements in governance and management systems.

2.2 The focus on training traditional birth attendants should be definitely abandoned, since it has been shown to be ineffective.[168] Fragile states in particular invariably lack qualified midwives.[169] **Prioritising training of skilled birth attendants** even before the crisis is over can lay the foundations for revamping maternal health services in the post-crisis period.

3. *How effective is DfID in mainstreaming maternal health across related policies?*

3.1 DfID has been very instrumental in placing the global debate on maternal health services in the broader context of health system strengthening, equitable health financing and aid effectiveness. Also the effort to link maternal health with newborn and child health is a positive step, although the integration between maternal health and HIV programmes could probably be improved. In order for these global policies to translate into real change for women, DfID should consider playing a more prominent role at the country level, **engaging directly with health sector partners in health policy debate**.

4. *How is MDG 5 being supported and prioritized into countries' overall health care provision?*

4.1 Through its support to government budgets, health sector programmes and discrete initiatives on maternal health, DfID is playing an important role in making maternal health a priority for health service provision. The focus on global health programmes, initiatives and special funds makes it difficult for maternal health services to be adequately supported at country level. DfID should **leverage its position as a leading global financier and advocate of health services and health reform more generally** to ensure maternal health services have the prominence they deserve in national level programming. This requires deployment of health advisers and a greater voice at country level.

5. *Is DfID's approach to supporting the 2006 MDG target of universal access to reproductive health effective?*

5.1 **DfID's work** at global level to support the right to reproductive health services is **commendable**. Also many interventions conducted at country level, such as the support given in Sierra Leone to the development of a sexual and reproductive health policy, are positive initiatives. Progress on availability of reproductive health services is however hard to track, and access to family planning services remains worryingly low in too many countries. Fragile states present the additional challenges of deficient health care networks and human resources to deliver services, a suppression of demand for social and cultural reasons, and a frequently low priority granted to women's issues and reproductive health in particular women's status and reproductive health in particular. DfID should advocate, directly or indirectly through its partners, for the **right to reproductive health services**.

6. *Is progress being made on reducing the number of women dying from unsafe abortions?*

6.1 DfID has played a leading role in focusing attention on maternal deaths arising from unsafe abortion complications. The legal, cultural and financial barriers present in many countries make this area one where **progress is likely to be slower** than in other areas of sexual and reproductive health. The issue is further complicated by the absence of or gaps in information systems in many countries that can document objectively the extent of unsafe abortions and monitor their trend and their impact on maternal mortality. This problem is even more acute where abortion is legally and/or socially and culturally restricted, women's status is low, service provision weak and health information systems virtually absent, as is the case in most fragile states.

[168] WHO, World Health Report, *Making Every Mother and Child Count*, 2005, WHO Geneva.

[169] Pavignani E, Colombo A. (2007) *Analysing disrupted health sectors : a toolkit.* Module 11: human resources. World Health Organisation, Geneva.

6.2 *Is effective family planning being supported in the countries you work in to support maternal health?*

6.3 Fragile states are characterised by **dismally low levels of uptake** of family planning: for instance the percentage of women who use modern ways of family planning is 3.6% in Afghanistan, 3.9% in Sierra Leone, 4.4% in DRC, 6.9% in Sudan.[170] In addition to improving the performance of dysfunctional health systems, major cultural, educational and societal challenges need to be overcome. Only a long-term sustained effort, aimed at addressing all these determinants, within the health system and outside, can create the right conditions for change.

6.4 More generally spending on family planning has stagnated over the last decade, and major advocacy efforts will be needed to bring a core mass of stakeholders of the global health arena behind a common vision on family planning before significant progress can be made.

7. *How effective do you think DfID is in working with bilateral and multilateral donors, NGOs and other stakeholders, to improve maternal health?*

7.1 DfID is a major global player in international health, both in relation to its role as a financier and in relation to its policy and advocacy work. As such it has the capacity and the opportunity to **demand greater accountability** from the partners it supports, whether they are beneficiary governments, other bilateral donors, international multilateral institutions or non-governmental organisations.

7.2 Efforts toward **harmonisation and alignment**, in line with the Paris Declaration and the International Health Partnership, **should not allow DfID's voice and support of pro-poor policies to be diluted**. This calls for greater involvement in policies determined at country level: support to government mechanisms and financial channels should be an occasion to engage beneficiary governments in a constructive dialogue on improving governance and service provision, and not a justification to drop uncomfortable or potentially controversial issues off the development agenda.

7.3 DfID can play a more active role in ensuring that international financiers in the health sector and governments move away from **user fees** as a financing tool, as it has been amply demonstrated that paying for health services at the point of use is both inefficient and inequitable, and represents an important barrier to increased utilisation.[171] DfID in particular should ensure that the international institutions it supports, such as the **World Bank**, translate their global commitments to pro-poor policies into programmes at the country level which do not include user fees as a financing instrument. Also some interventions supported by DfID at the country level could be made more consistent with DfID global position on payment at the point of service.

7.4 DfID's commitment to support maternal health services could translate in an increasingly prominent role in this area, playing a leading role not only with like-minded European donors, but also by **re-engaging USAID in a dialogue on reproductive health policies** after the American presidential elections of November 2008.

7.5 **NGOs can play an important role** in several aspects of maternal health in fragile states and in developing countries more generally. They can be the main vehicle of service provision where national governments are not able or not willing to provide services themselves; they can contribute to holding governments to account; they can advocate for a higher recognition of women in society, and for greater rights to reproductive and maternal health services; they can provide technical assistance and various forms of support to health systems, in particular at sub-national level where the capacity and the presence of UN agencies and bilateral donors is more limited; they can build the capacity of national institutions, both in the government and in the civil society, to better address maternal health needs; finally, they can pilot new approaches and conduct operational research on best practices and promising approaches which can be then rolled out at national level. There is increasing recognition of the positive role civil society organisations can play; this is not accompanied, however, by adequate support in terms of resource allocation, a problem which has been exacerbated by the recent shift in focus to supporting government systems through **budget support** mechanisms. While it is true that in certain countries direct support to government mechanisms and financial channels may represent the most cost-effective and sustainable strategy to support the development of health systems, attempts should be made at **striking a balance** that allows at the same time establishing strong and accountable government mechanisms and **maintaining a vital civil society sector** to support and complement the governments' action.

[170] Pocket world in figures, 2008 edition, *The Economist*, 2007.

[171] James C, Morris S, Keith R, Taylor A. 2005. *Impact on child mortality of removing user fees: simulation model.* British Medical Journal; 331:747–749.

8. *What leadership is the UN providing in addressing maternal health and how well coordinated are its agencies?*

8.1 The work of health UN agencies is characterised by **uneven levels of effectiveness and capacity**, in particular at country level; as a major financier of these agencies, DfID could improve the situation by **demanding greater accountability**, more transparent management processes, and competency-based recruitment.

8.2 While they are sometimes effective in advocacy, standard setting, procurement and coordination at national level, UN agencies are more rarely able to be effective actors at the sub-national level (districts, provinces), where health services are managed and the health system inter-faces with communities.

9. *How effective is DfID in addressing the socio-economic barriers to women's empowerment and the low status of women in relation to maternal health?*

9.1 At global level DfID's policies and maternal health strategy recognise the importance of gender imbalances, socio-economic determinants of poor health and inequitable financing. Translating the right policies in place at global level in the right programmes at the country level will require however stronger efforts, a **more vocal role at country level** and more emphasis on inter-sectoral coordination.

10. *How can the international community improve maternal health in crisis and conflict settings?*

10.1 Strengthening and expanding health systems requires **sustained efforts over a long period of time**. Commitment of political and financial support should be taken with a time horizon of 5 –10 years or more. A balance must be struck between strategies that allow achieving change rapidly (such as contracting out health services to NGOs, as done in Afghanistan) and building long-term sustainable health systems led by accountable governments.[172]

10.2 In many cases a **twin track approach** is warranted, with the combined support of long-term system building and the continuation of emergency relief operations until alternative mechanisms are in place. The role of contracting out of health services should be further explored, not only in relation to the capacity of this model to deliver rapid change, but also in relation to the long-term feasibility strategy of this strategy to create building blocks of a health system.

Memorandum submitted by STOP THE TRAFFIK

1. Maternal Health and Human Trafficking

1.1 STOP THE TRAFFIK welcomes the International Development Committee's Inquiry into Maternal Health, and DFID's contributions to maternal health programmes. This is key to assessing and implementing the Millennium Development Goals, and the recognition of the links between maternal health and other key development factors including poverty, infant mortality, population growth, and the status of women is crucial.

1.2 STOP THE TRAFFIK urges the International Development Committee to consider the implications of another key development factor on maternal health—human trafficking. This modern-day slave trade that deceives and coerces victims into commercial and sexual exploitation has a huge impact on maternal health. The catalogue of evidence is overwhelming:

1.3 The June 2007 Scoping Project on Child Trafficking in the UK by the Child Exploitation and Online Protection (CEOP) Centre records several cases where human trafficking has impacted maternal health:

- Five trafficked Chinese girls had been abandoned once they had become pregnant.
- One West African girl after being daily raped was beaten regularly in the stomach because she had become pregnant.
- Pregnancy is used as an instrument of oppression on trafficked girls. One baby of a child victim of trafficking was found dead after the mother's oppressors had taken it whilst she was enslaved.
- One trafficked girl was sexually exploited and forced to sell illegal drugs and commit credit card fraud until she became pregnant and was abandoned.
- Trafficked girls suffer from STDs, pregnancies, miscarriages, trauma, depression, drug addiction, and psychological instability.

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[172] Palmer N, Strong L, Wali A, Sondorp E. *Contracting out health services in fragile states.* British Medical Journal; 332;718–721.

1.4 The effects of human trafficking on maternal health are not just limited to the UK. This is recognised by the UN Office on Drugs and Crime (UNODC) Global Initiative to Fight Human Trafficking (GIFT):

> The objectives set for the Global Initiative will contribute to achieving the UN Millennium Development Goals of empowering women, improving maternal health, combating HIV/AIDS, eradicating poverty, improving education and developing a global partnership for development.

1.5 The UN Inter-Agency Network on Women and Gender Equality (IANWGE), through their work in Eastern and Central Europe, also link human trafficking and maternal mortality:

> Social phenomena such as violence against women, increased trafficking in women and prostitution contribute to the worsening of reproductive health.

1.6 The World Health Organisation (WHO) linked achieving the MDGs regarding reproductive health with human trafficking as part of an ILO course:

> The issues of poor nutrition for girls in adolescence, female generated mutilation, domestic violence and several trafficking are recognised as detrimental to reproductive health and violate several and reproductive rights.

1.7 The National Asian Pacific American Women's Forum also links reproductive health and human trafficking:

> Women and girls trafficked into sex work are vulnerable to contracting sexually transmitted infections . . . So when reproductive health issues arise, for example if women develop ovarian cysts, they are prohibited from receiving treatment.

1.8 PATH, an international NGO working in community health, highlight the pregnancy complications for trafficked women:

> They have a high risk of complications and infertility due to undiagnosed and untreated STIs, including HIV/AIDS, and risk complications from pregnancy and unsafe abortion.

1.9 STOP THE TRAFFIK therefore urges the International Development Committee to take full account of and recommend measures concerning improving maternal health through tackling human trafficking. Without such action the MDGs will not be achieved.

2. Answering the Questions

2.1 Donors can catalyse progress towards MDG 5 by recognising the impact of human trafficking, outlined above, and by improving access to holistic health services for mothers vulnerable to human trafficking. An anti-trafficking focus should therefore be included in all Poverty Reduction Strategy Papers (PRSPs) and DFID's Country Assistance Plans (CAPs). Measures should be focused on those specifically identified as vulnerable to trafficking, and the outcome should be an independently verified measurable increase in maternal health and reduction in human trafficking.

2.2 DFID should ensure that skilled birth attendants and other staff in recipient countries are being trained in identifying and caring for victims of trafficking, and that this is integrated within the local, regional, and national health systems.

2.3 DFID should mainstream awareness of and action concerning human trafficking across related policies, so as to provide a sustainable, self-generating, and systematic approach to improving maternal health and reducing human trafficking.

2.4 MDG 5, in relation to tackling human trafficking, should be prioritised and integrated into countries' overall healthcare provision, as women and mothers tend to be the homemakers and family providers.

2.5 DFID should only support the 2006 recommendation by the UN General Assembly for an MDG target for universal access to reproductive health if it recognises the detrimental role that human trafficking has, and implements measures to combat human trafficking to improve maternal health.

2.6 Many of the maternal deaths from unsafe abortions are experienced by trafficking victims (see the IANWGE link). There will only be a sustainable reduction if human trafficking is addressed through reducing both the demand for trafficked women and the supply of trafficked women. This can be achieved through implementing prevention, prosecution, and protection measures such as those suggested in the Council of Europe Convention on Action against Trafficking in Human Beings.

2.7 Effective family planning can improve maternal health, but only if it is provided on a free, accessible, safe, and sustainable basis, obtainable by the most vulnerable in communities, such as victims of human trafficking.

2.8 DFID can work more effectively with donors and stakeholders to promote maternal health by incorporating the advice, training, and resources of agencies that work to tackle human trafficking, thus providing a more holistic approach.

2.9 The UN is not providing leadership on maternal health and human trafficking, and its agencies are not co-ordinated. The UNODC is attempting to lead the other UN agencies on tackling trafficking and achieving the MDGs through GIFT, but the team are under-manned, under-resourced, and under-supported. Member states such as the UK should more actively promote efforts like GIFT, which will contribute to improving maternal health.

2.10 DFID has recognised the barriers to women's empowerment and the low status of women, but need to do more to implement MDGs 2 and 3. They particularly need to develop tailored education and training programmes for women and girls vulnerable to trafficking, which would include awareness raising and equipping for avoiding trafficking.

2.11 The international community can improve maternal health in crisis and conflict settings by ensuring that those personnel responding to such situations are trained and equipped to care for women and girls who have been trafficked, such as child soldiers, sex slaves, forced labourers and beggars, and other roles.

2.12 STOP THE TRAFFIK urges the International Development Committee to address these issues, integrate anti-trafficking into its Inquiry into Maternal Health, and mainstream tackling human trafficking in all its work surrounding the MDGs.

Memorandum submitted by the Support to Safe Motherhood in Nepal

1. Summary

— Concerted efforts have been made by the international donor community and the Government of Nepal to improve maternal health.

— There is sufficient evidence in Nepal to indicate that the maternal mortality rate decline is real and likely to carry on.

— Strengthening and improving the maternal health sub-sector has wide reaching impact on the health sector reform as a whole.

— The DFID-funded Support to Safe Motherhood Programme working closely with Government of Nepal is making a vital contribution to the strengthening of maternal and perinatal health services and decline in maternal mortality.

2. Introduction

The United Kingdom's Department for International Development (DFID) has been working with the Government of Nepal to reduce maternal mortality and improve maternal and newborn healthcare in Nepal for over 10 years. Since 2004, this has been in the form of the Support to Safe Motherhood Programme (SSMP), a £20 million programme funded by DFID, which has been working closely with the Government to develop and implement an integrated package of inputs within the national healthcare system. SSMP's goal is improved maternal and newborn health and survival, especially of the poor and excluded. The programme follows and builds on the DFID supported Nepal Safer Motherhood Project (NSMP), 1997–2004, which together represent a major contribution of DFID's to accelerating progress towards MDGs 4 and 5.

3. Progress in Reducing Maternal Deaths

The SSMP story is of particular interest to the IDC Inquiry into Maternal Health in light of recent evidence published in the final report of the Nepal Demographic and Health Survey (NDHS) 2006, that suggests a significant decline in the maternal mortality rate over this period, from 539 per 100,000 births in 1996 to 281 per 100, 000 live births in 2006. It is important to examine the evidence suggesting this decline further and SSMP is currently undertaking this further analysis. Despite debate over the actual level of the maternal mortality change and the magnitude of decline, indications are that there is sufficient evidence to suggest a real decline has occurred. In light of the investments in strengthening safe motherhood over the past 10 years and continued commitment to Safe motherhood by donors and the Government Nepal, evidence suggests that the decline is likely to continue.

This evidence includes:

— An almost three fold increase in the caesarean section rate between 1996 and 2006 (from 1.0% to 2.7%). These would have been carried out for women with prolonged/obstructed labour, eclampsia, ante-partum haemorrhage and uterus rupture, and thus are likely to have been life saving interventions.

— An increase in delivery by health professionals (doctor, nurse and auxiliary nurse midwife) from 9.0% in 1996 to 18.7% in 2006.

— An increase in the percentage of deliveries in a health facility from 7.6% in 1996 to 14.0% in 2006.

— A reduction in the total fertility rate, from 5.1 in 1996 to 3.1 in 2006. In simple terms the total fertility rate is defined as the total number of live births a woman has, on average, in her lifetime. A reduction in this is associated, not only with a reduced exposure to the risks of childbirth, but also improved overall health status, which reduces the risk of death.

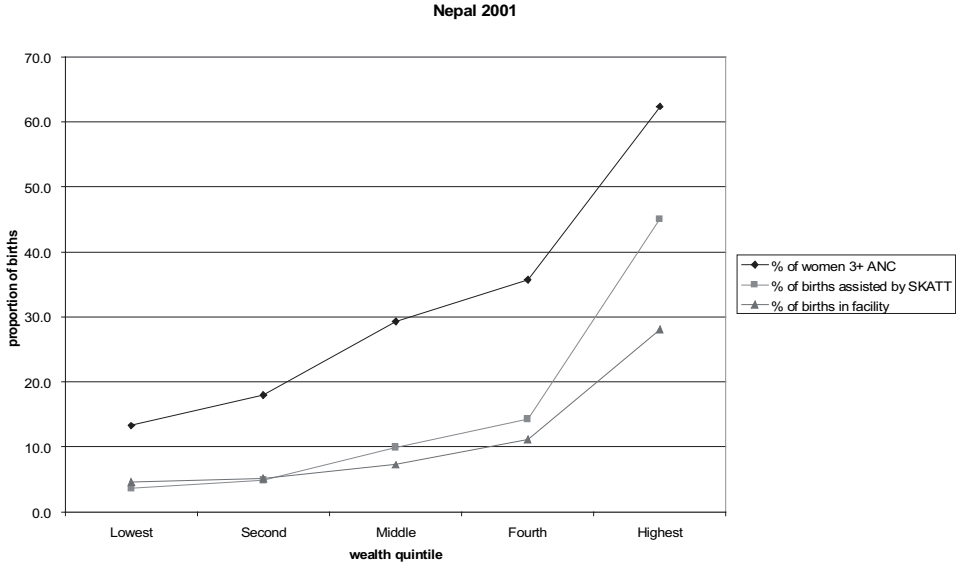
— The legalisation of comprehensive abortion care in 2002 (implemented from December 2003) which has been associated with over 80,000 women accessing safe abortions between April 2004 and December 2005, representing a huge reduction in risks from abortion complications.

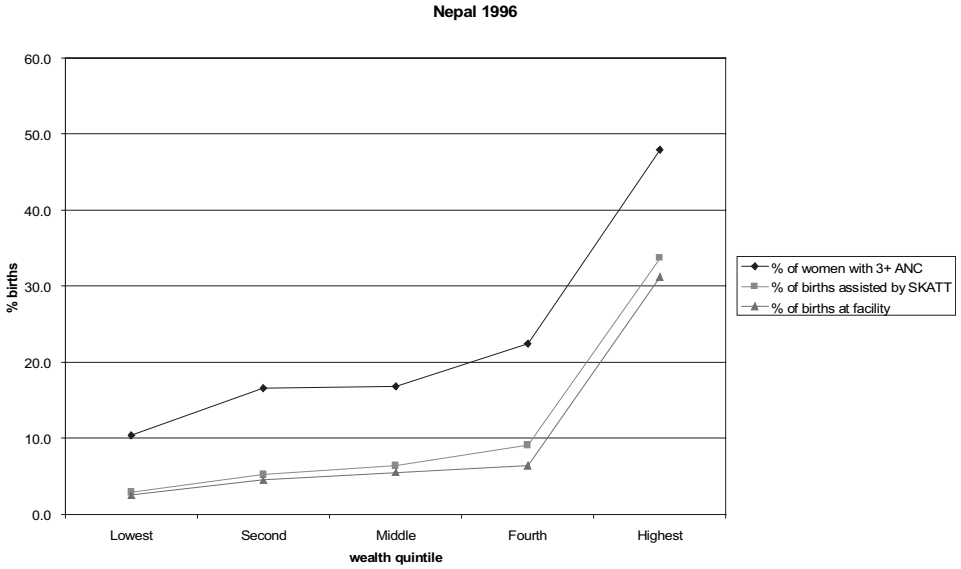
— A decrease in the percent reporting to have taken no Antenatal Care (ANC) from 33% to 12% between 1996 and 2006.

— A marked increase in the use of a safe delivery kit in home delivery in both urban and rural area between 1996 and 2006; urban: 4.41 times, Rural 10.28 times.

— Increase in equity (across the wealth quintiles) in the % of women accessing 3+ ANC visits; the % of births assisted by a skilled attendant and the % of births in the facility (see graphs below from Demographic and Health Surveys 2001 and 1996).

GRAPHS SHOWING PROPORTION OF BIRTHS PER WEALTH QUINTILES
(2001 AND 1996)





4. What has SSMP Helped to Achieve?

The factors that contribute to high rates of maternal and perinatal mortality are; a scarcity of skilled human resources; not enough and poorly maintained physical health infrastructures; unpredictable and scarce supplies of essential equipment, supplies and drugs; weak referral systems and inadequate blood supplies. In addition, health seeking behaviour reflects socio-economic and cultural inequalities. Even where care does exist the barriers to access result in delays in accessing health services with many women and their families not accessing them at all.

SSMP works on all fronts, translating proven interventions to strengthen the health system and quality of health service delivery from the foundations while delivering an intensive programme working with communities to increase demand amongst the most socially excluded. SSMP supports the implementation and evaluation of the nationwide maternity incentive scheme, which provides all women who deliver at a

facility with a cash payment to help cover costs incurred in accessing the facility. The scheme also pays an incentive to trained health workers who support women to deliver in facilities and at home and provides free delivery for complications in the most disadvantaged areas in the country.

Among SSMPs contributions to the strengthening of maternal and perinatal health services and decline in maternal mortality are the following:

- Strengthened policy development and planning, with endorsement in 2006 of the National Policy for Skilled Birth Attendance, Revised National Blood Policy, Essential SMNH Package and National SMNH Long Term Plan (2006–17), all of which are evidence based and reflect recent developments in global thinking and Nepal experiences. These documents have become the basis for implementation of district SMNH planning and programming.
- Safe abortion services are now available in 70 out of the 75 districts from 167 listed sites (89 government and 78 private). Over 132,205 women have received services since legalisation, 83% of these from non-government sites and 17% from government sites.
- The development and strengthening of 36 comprehensive emergency obstetric care facilities and 40 basic emergency obstetric care facilities, which have been developed and strengthened across the country.
- Current infrastructure support through SSMP Financial Aid (FA) to 127 sites, of which 90 are for two-room additions at 80 Health Posts (HPs) and 10 Primary Health Care Centres (PHCCs), to enable the provision of locally accessible 24-hour birthing services. So far 27 have been completed and the rest are expected to be completed soon. The SSMP FA is also providing support for construction at 18 BEOC sites, 13 CEOC sites, 3 major CAC sites and 3 minor CAC sites, including new sites planned for the year 2007–08.
- Working with the Logistics Management Division (LMD) to establish strict technical inspection of samples to ensure compliance with the specifications and good quality before awarding contracts. SSMP has also been exploring opportunities for co-operation with laboratories in adjoining countries for quality assessment where such service is not available in Nepal.
- Prioritising support for finalising and implementing the maintenance strategy, to halt the current wastage caused by a "crisis maintenance" approach.
- Continuing to support the Department for Urban Development and Building Construction (DUDBC) in establishing a co-ordination mechanism between the DUDBC district office responsible for implementing construction work, and the local facility management committees (users) to ensure local ownership and involvement.
- Working closely with DUDBC, SSMP has completed a database inventory of existing government health infrastructures containing details of their physical condition and with the capacity to provide information on the number of different types of facility, quality, land ownership details, physical condition, size and many other details. This major breakthrough made it possible to develop a maintenance strategy, which was presented during the recent Joint Annual Review (JAR). The strategy has a clear plan and estimated budget for regular maintenance, repair and reconstruction work required to ensure all government health infrastructures are functioning, see Annex 19 for extracts from the strategy document. The inventory will also support planning of future infrastructure expansion, upgrading, renovation and reconstruction needs and can be used to support pro-poor (inclusive) planning and many other purposes.
- Advocating for an equipment maintenance policy, with the support of other stakeholders. The standard equipment list will be used to develop a database of equipment at different facilities, as a base for development of an equipment maintenance plan. This will save resources currently wasted replacing major equipment that has been allowed to deteriorate.
- Strengthening government systems and capacity to improve the supply and procurement systems for essential drugs and commodities, SSMP is working to ensure year round availability of SMNH drugs where needed.
- Working to improve infrastructure tendering practices, which are currently affecting quality by allowing domination by a few powerful cartels.
- Advocating with the government to amend regulations that promote the practice of always awarding contracts to the cheapest bidder, which can compromise quality.
- Addressing Social Inclusion both in policy development and programme implementation through the Equity and Access. This involves implementing district level activities to stimulate demand and increase the access of women to Maternal and Neonatal Health (MNH) services, with particular emphasis on those from poor and excluded communities.[173] The EAP operates through a network of 26 independent Equity and Access Support Organisations (EASO) in 10 districts[174] providing intensive support to a total of 120 VDCs and 7 Municipalities.

[173] Socially excluded groups in the context of health services include: Women in general; the poor; Dalits; Janajatis; Religious minorities; people living in remote areas; internally displaced people; PLWA; and Disabled.

[174] Districts are: Dandeldhura, Dailekh, Surkhet, Baglung, Parbat, Myagdi, Rupendhi, Nawalparasi, Chitawan, Morang.

— Deliveries supported by health workers have increased 6% since the launch the scheme two years ago and the increase in the numbers of women delivering at a facility and with the support of a health worker continues to grow. A total of 111,745 deliveries between July 2006 and February 2007 involved the provision of cash incentives under the scheme.

5. The Way Forward

In the early years, DfID funded support to safe motherhood activities focused more directly on the sub-sector in particular. Today the Government of Nepal Family Health Division supported by SSMP is driving forward a number of initiatives which are not only critical to efforts to reduce maternal and perinatal mortality but also directly benefit the wider health sector.

If you mend the system that supports the delivery of strong safer pregnancy services, you contribute fundamentally to building the foundations of the health sector as a whole. All health services need strong, maintained infrastructure. Issues of recruitment and retention of human resources are not unique to safer pregnancy; reliable supplies, quality and well maintained equipment are needed in all areas of health care. It could be suggested that maternal mortality be used as a general indicator of the strength of a health sector. The structures, processes and mechanisms needed to establish a framework to get this right are not unique to one sector but maternal and neo-natal death rates will not decline without strengthening every aspect of health service delivery unlike many health conditions which can be prevented or treated with a more vertical approach. In addition in Nepal as in many parts of the world over 90% of women will quite predictably become pregnant at least once and every person born was once a neonate. These services touch more lives than any part of the health sector. For international aid to concentrate on strengthening maternal and neonatal health care structures and systems to reduce maternal mortality, they have the knock on effect of improving the health infrastructure of a country more widely. What this programme demonstrates is the extent to which strengthening this sub-sector has wide-reaching impacts on the health sector as a whole.

The challenge ahead now is one of long-term sustainability. How does the Government of Nepal and international donor community continue this momentum towards achieving MDGs 4 and 5 beyond 2009 when SSMP ends?

Memorandum submitted by Tadeyose Belay

How Effectively DFID is Working with Recipient Countries to Make Emergency Obstetric Care Available and to Ensure that Adequate Numbers of Skilled Birth Attendants and Other Staff are Being Trained to Meet MDG 5, and are Integrated Within a Robust Health System

1. This is a contribution with a good intention to galvanise on going effort in reduction of maternal and newborn mortality in Ethiopia. I may not be the right expert or academician to provide scientifically sound prescription or a person with reputable recognition in this specific area. I wish you understand my contribution as an ordinary professional who had a decade of solid experience in serving for the good cause of mothers and children health as a medical doctor and program manger across spectrum of health delivery level—rural health centre, district and referral hospitals and at the Federal Ministry of health. While I was working in the public sector and after I resigned I had the opportunity to be involved and lead country wide maternal and newborn health situation in this country. Thus, from this perspective I would like to bring to your attention potential constraints/challenges and commendable action in order to speed up access to essential and emergency obstetrics intervention to reach those helplessly dying pregnant mothers and newborns in this country.

2. I think **lack of co-ordination of donors' assistance and partner's role is a critical constraint** that requires an immediate action to maximise resource and to ensure concerted effort to accelerate progress in maternal and newborn mortality reduction. Sadly to note here the fact that the prevailing situation in Ethiopia vividly tells us that the working relation in the implementation of Emergency obstetrics and newborn projects among partners and agencies (including UN SISTERs) is undesirable and sometimes unhealthy. Rather than working to complement effort, they work hard to compete through maneuvering individuals at different level to gain unfair attention through undermining the effort of the other. Because of this undesirable environment, we can cite a number of constraints—confuse the government with different agenda and priorities; lack of collective voice for advocacy (eg skilled birth attendants strategy, waive service fee for delivery); undermine effort in scaling up effective intervention; cast question on credibility of recognised institution etc.

3. In the other side, the lack of co-ordination among donors further is fueling this unwanted situation through allowing partners to compete for funding. Let me readdress my point with a practical example so that you can understand how the competition is further complicated with donor's decision. As you are aware since 2001 WHO has brought the concept of MPS strategy in Africa at large and as a pilot implantation in five selected countries including Ethiopia. The government of Ethiopia has adopted the MPS intervention package as a national strategy to reduce the unacceptable maternal and newborn mortality in the country.

Accordingly, WHO has provided a led-technical and financial support for pilot implementation of the MPS strategy in four government selected sites (zones) across the country. To document evidence and changes gain due to MPS intervention, WHO has supported an evaluation mission of the pilot implementation in the four pilot sites in collaboration with the lead role of FMoH. The finding indicated an encouraging implementation gains and calls for resource mobilisation for consolidation of efforts and expansion to new sites.

4. Simultaneously, the European Union has been approached by WHO to support the initiative, and the UNION has committed a sizable amount of fund to support MPS implantation in six African countries including Ethiopia. The six countries which have received the EU fund via Afro WHO office already engaged in the scaling up of the MPS implementation. To the surprise of many, the fund allocated to MPS/Ethiopia has been relocated from WHO/Ethiopia country office to UNFPA country office. Having secured the "relocated fund" the country office spent much time to hire technical officers for MPS implementation and partly they succeed in taking technical officer working in the very WHO country office who had been hired for MPS program.

5. As I have been informed the fund is designed in such a way to be spent in the SAME INITIAL FOUR MPS sites. Since the inception of the MPS program in 2001 WHO is a lead agency and have built solid capacity at different level—HQ, Afro and country level. While resources are critically needed to scale up the MPS intervention through WHO at global and regional level to accelerate the unacceptable maternal and newborn mortality in African countries, such is a typical example which can be sited as an obstructive competition between two SISTER agencies at many fronts: critical MPS intervention priorities are being diluted to address annexed/additional institutional agenda; the situation created unequal voice/sometime sluggish response to implement Afro priority MPS intervention as indicated in the Biennial POA; and because of partners divergence/competing agenda difficult to reach consensus for priority advocacy themes. Furthermore, the project has posed a far reaching complication: regards the WHO Afro MPS implementation momentum at the country level to accelerate through duplication effort in the same pilot sites, which has been supported by WHO; undermine UN sister agency's complementarity through duplication of role; and eroding the partnership effort for at the country level . . . etc. **Unfortunately, this event has taught us an important lesson—despite your designated role, money at hand (grant/fund) becomes a critical instrument to get adequate attention of the government counterpart to pursue an important intervention**.

6. In this very example, I attempted to address a lesson that all of us (implementing partners and donors) should be learnt to rectify mistakes ensure a functional partnership to maximise resources for implementation of a health program towards MDG goals. Strengthening Partnership is also critical to ensure role complementarity and to stay focused on priority high impact health intervention to rescue those needlessly dying mothers and children those needlessly dying.

7. Taking into consideration this constraining situation, I would like to suggest that putting in place a co-ordination mechanism is a priority to ensure cohesion and complementarity of efforts among partners and donors at different level.

8. Please find below proposed action and effective interventions to accelerate access to basic and emergency obstetrics and newborn care in the Ethiopia context:

- **Strengthen co-ordination framework at MoH and RHB level**: The initiative can start by revitalising and **restructuring the existing weak Reproductive Health Task force at the Federal Ministry of Health**. The Task force is comprises of more than 30 partners working in the area of reproductive health including UN agencies, international and indigenous NGO, professional associations, academic institutions. The Task force also has four technical committees—Family Planning, Safe motherhood, logistic and supplies and IEC.

9. Apart from enhancing the leadership role of the MoH, I would like to suggest the following action to strengthen the role and function of the Reproductive Health Taskforce:

- Include key donors as core group to advice and share information.
- Define a binding ToR (definition of role, function, mandate) for RH task force and four sub technical committees.
- Develop a national INTEGRATED ROAD MAP owned primarily by Government and each partners to clarify roles, determine funding mechanism, agreed on priority interventions, implementation milestones and needed resources.
- Replicate the National RH task force at least in the biggest four regions.
- Encourage professional association (especially Ethiopian Gyn/bost society, Ethiopian Midwives Association, Nurse Association) as an advocate for ethics, professional competency and quality standards, rather than the current trend of implementing "projects".
- Initiate out reach residency program at AAU for final year postgraduate Gyn/Obs student. This is intended to fill a critical shortage of specialist doctors/GPs at district hospital for the provision of emergency obstetrics care (operative intervention). Arrangement can be made with the AAU gyn/obs department to deployed final year postgraduate student along with a group of four to five interns to provide emergency obstetrics and surgical intervention for two to three months as part of practical attachment. Supervisors would be jointly identified with university faculty and other

concerned partners. A modest financial reward for supervisors and per diem for students is required. This intervention is a new innovative proposal, which would partly address the current human resource crisis in the health sector and contributes to strengthening the pre-service education—offering more practical exposure for new graduate GP.

- Initiate maternal death audit/review mechanism and Health extension workers-led verbal autopsy at health facilities and community level health facility.
- Strengthen linkage and working relation between health extension workers and health center providers.
- Update midwifery curriculum at mid-level health training institution.
- Support delegation of life saving obstetrics procedures to midlevel health workers (HO, MW and nurses).
- Arrange performance rated financial incentives for health care providers in the provision of basic and comprehensive emergency obstetrics care. This will dramatically improve delivery at health centres.
- Forge a regular forum with professional association, partners and government counter part.
- In collaboration with professional association, organise regional level pool of experts (gynecologists/obstetrician, pediatrician) to initiate on-job training for health facilities; to assist/advice the RHBs; ensure supervisory support to the regional health bureaus, and facilitate local in-service training. It has a significant impact in retention of scarce experts at regional level and reduce the cost of in-service training.
- **District focused MPS program planning and implementation: fine-tune with ongoing district centered decentralisation; strengthen linkage/complementarity of facility based EOC with community based Health extension program**: support competency of health extension workers to manage normal/complicated delivery and essential newborn care; community mobilisation/behavior change communication; referral linkage with health facilities; introduction and application of best practices and tools for obstetrics and newborn care of (focused ANC, the 3 6's).
- **Intensify advocacy effort at different level** to enhance political national commitment and mobilise resource to accelerate maternal and newborn mortality reduction.
- **Strengthening pre-service midwifery education**—curriculum review, introduction of essential obstetrics/newborn care competencies and best practices/tools; training of tutors.
- **Building implementation capacity, both at programme and facility level**: technical assistance; program management training; adaptation/development of in-service training curriculum/guidelines for bEOC and cEOC; scale-up task shifting for midlevel health workers (HO and MW/Nurses); enhance capacity of front line health workers; strengthening pre-service education; pursue cost-effective best practices/lessons (eg create/organise local professionals/expert pool for on-job training . . . etc.

10. Strengthen Leadership Skill of Health Managers at the Decentralised Level in the Health Sector

10.1 *The problem*

The ongoing country wide *woreda* (district) centered decentralisation process shakes up many linkages existing within a health system while it turns the system upside down. Health managers at different decentralised level addressee the following challenges, depending on the management level at which they work:

10.2 *Challenge at the decentralised level—Region, Zone and district*

Achieve a balance between local and national priorities: Develop locally responsive health services while respecting national health policies; balance conflicting demands between providing routine local health services and participating in national health initiatives (eg, immunisation days); and meet the demands of unfunded central mandates.

Establish new working relationships: Develop supportive working relationships with the local administration, politicians, and organisations whose agendas may not be linked to priorities of local health professionals; and build partnerships with local communities to achieve better health.

Mobilise resources: Cope with unpredictable and delayed resource flows from the central government; and compete with other sectors for locally controlled resources.

Achieve a cohesive health system: Ensure appropriate referrals and technical support between hospitals and primary care facilities that belong to different jurisdictions.

Develop motivated and competent staff: Motivate a workforce whose job security, compensation, and professional development are threatened by changes resulting from decentralisation; and develop competencies for the new management responsibilities among local staff.

10.3 *Challenge at the central level—Federal Ministry of Health*

Achieve a cohesive health system: Develop a cohesive set of national health policies and strategies that protect vulnerable populations, guarantee nationally important services (eg reproductive health), and respond to local needs, despite competing interests of government ministries and politicians; ensure an integrated health system even when primary care facilities and hospitals fall under different jurisdictions; maintain competent management, technical expertise, and integrity of Family health program (maternal and newborn health, Family planning, PMTCT of HIV) and key disease prevention programs (malaria, tuberculosis, leprosy, HIV/AIDS, and immunisations); and develop national information systems with the essential public health and management information needed to support management responsibilities.

Maintain quality of care: Achieve compliance with minimum standards and practices across the nation without line control over decentralised service delivery. Maintain adequate preventive and behavior change services when local priorities focus on curative care.

Mobilise resources across the health system: Promote equitable access to services between rich and poor populations and geographic areas. Ensure the availability, affordability, and quality of pharmaceuticals when procurement has been decentralised to the local level.

Develop motivated and competent staff: Ensure equitable salaries and benefits, adequate opportunities for professional development, and flexible job transfers across jurisdictions. Develop new sets of skills and management systems to assist central-level managers; and share best practices and learning among decentralised areas.

10.4 *Rational*

To ensure a functional and a speedy transition of the ongoing district centered decentralisation, managers at different levee (including Regional, zonal and District) need to adopt new leadership roles to shape the process and bring smooth transition to the ongoing decentralisation. Their prior experience in a centralised system did not prepare them to take on new roles and deal with the added complexity of their health system.

10.4.1 Thus, a tailored training package on leadership and management is needed to deliver improved health management function at various decentralised level, especially at the district level. Managers at the regional, zonal and district levels come together to define new management responsibilities and to create supportive management structures, systems, resource flows, and activity plans. To ensure such changes, health managers at all levels need to become leaders who can mobilise people inside and outside their organisations to create new paths toward improved health.

10.4.2 Health managers at different levels need to be equipped with state-of-the-art leadership and management skills in order to redefine their roles and responsibilities to better support both the people they serve and the staff at management levels closest to the population. Moreover, health managers can adopt leadership practices to carry out their new roles and ultimately make decentralisation work. It offers ways for these managers to adapt specific leadership skills and practices so that they can not only adjust to the changes of decentralisation, but actively shape the process. By shaping the process, there will be a greater opportunity to actively involve staff and external stakeholders to achieve results that benefit their clients.

11. General Objective

To provide support to the ongoing government-led district centered decentralisation process in Ethiopia to ensure stable and cohesive health system through implementation of tailored management and leadership training for health managers at different level.

12. Specific Objective

- To define functional and effective complementary leadership and management roles that managers at different level have to play to bring decision-making closer to the population and to infuse government programs with a sense of local ownership.
- To introduce a user friendly management tools to achieve and sustain client responsive and high quality of health service without sacrificing efficiency and effectiveness.
- To equip managers at different level with a package of tools to ensure progress toward justice, fairness, and equity in health services?

— Familiarise managers with a contemporary leadership skill on how to maintain sense of stability amid personal confusion and organisational turbulence.

— To help manager to acquire and practice new skills required to perform new management responsibilities.

Memorandum submitted by the UK Network on Sexual and Reproductive Health and Rights Maternal Health Working Group

The UK Network on Sexual and Reproductive Health and Rights (the Network) is formed of UK based NGOs, academic institutions and independent experts with an interest in sexual and reproductive health and rights (SRHR) in developing countries. The Maternal Health Working Group of the Network focuses on maternal health with a particular interest in UK Government policy in this area.

The Maternal Health Working Group welcomes the opportunity to feed into the enquiry and have wherever possible tried to ensure that our input is in line with our Southern partners' experiences in the field. We would like to thank the following partners:

— In Cambodia we would like to thank Noun Sopheak (Health Unlimited Advocacy Co-ordinator) and the indigenous women of Ratanakiri Province who took part in the research into maternal health.

— In India we would like to thank Sarita Barpanda (Technical Advisor for Interact Worldwide) for her guidance and for co-ordinating the inputs of: Dr P K Senapati (Retd Director Health Services, currently Consultant MCH, Government of Orissa); Dr Suresh Mishra (Deputy Director, Drugs Control, Previously specialists in DFID PSPU, Orissa), Dr P K Das (Consultant RCH I & II), Dr H N Patnaik, (Retd Executive Director, initiated the NIPI in Orissa) and Dr Annapurna Mishra (Deputy Director, Orissa State AIDS Control Society).

— In Bangladesh we would like to thank Dr Kishwar Azad of the Perinatal Care Programme, Diabetic Association of Bangladesh (DAB).

— Thanks to Martha Bokosi (Programme Manager), Dr Ruth Lawson (Director), Cornelia Wakhanu (Midwife trainer), Jared Opodu (Midwife trainer) of Maternity Worldwide Ethiopia for their inputs and for facilitating discussion with their colleagues throughout Eastern Africa.

SUMMARY

The Maternal Health Working Group has concentrated its efforts in answering the questions set by the IDC on the role of the health system and sector in combating maternal mortality and morbidity. However, we believe that maternal health is a development issue that requires a multi-sectoral response. In this respect issues such as women's empowerment, law reform to safeguard their rights such as to inheritance, greater involvement in governance systems and girls education are all key. We hope that future inputs to the IDC will allow us to explore these elements further.

1. *How donors—and DFID specifically—can catalyse progress towards MDG 5*

1.1 *DFID's role at the international level.* We welcome DFID's renewed focus on strengthening developing country health systems as evidenced by their new health strategy,[175] their support for the "Global Business Plan on MDGs 4 and 5"[176] and the launch of the new International Health Partnership. There is ample evidence that robust and properly planned and implemented, fully staffed health systems with adequate supplies of skilled birth attendants,[177] medicines, supplies and commodities are crucial to improving maternal health outcomes. We commend them for their leadership in this area and for their support at the international level to catalyse action on stemming maternal morbidity and mortality, for example, through the Partnership for Maternal, Newborn and Child Health.

1.1.2 *However, as maternal health advocates we have concerns about the process and content of the International Health Partnership.*[178] In brief, we are concerned about:

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[175] DFID (2007) Working Together for Better Health www.dfid.gov.uk/pubs/files/health-strategy07.pdf

[176] Tore Godal (2007) Concept paper in relation to the development of the Global Business Plan to accelerate progress towards MDG 4 and 5 http://www.who.int/pmnch/events/2007/gbpconceptpaper.pdf

[177] The term skilled attendant refers to an accredited health professional—such as a midwife, doctor or nurse—who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns. Traditional birth attendants (TBA)—trained or not—are excluded from the category of skilled health-care workers. In this context, the term TBA refers to traditional, independent (of the health system), non-formally trained and community-based providers of care during pregnancy, childbirth and the postnatal period. http://www.who.int/reproductive-health/global_monitoring/skilled_attendant.html#definitions

[178] For more detail please see Annex 1 Evidence to the Department for International Development Consultation on "A new health access initiative: delivering the health MDGs" The UK Network on Sexual and Reproductive Health and Rights with inputs from the Maternal Health Working Group 20 August 2007.

— The lack of transparency in the development of the International Health Partnership both at the international and national level.

— The failure to involve civil society and national government beyond Departments of Health/ Development in the North and South in its formulation, in proposed mechanisms for the creation, implementation and scrutiny of national health plans and bi-lateral donor involvement.

— The lack of clarity of how the International Health Partnership will ensure the supply of human resources, medicines, supplies and health commodities.

— Indicators to track success. Particularly in tracking performance on the new target under MDG 5 to ensure universal access to reproductive health by 2015, universal access to comprehensive HIV/ AIDS services by 2010 and in improving upon the internationally agreed indicators under the MDGs to measure maternal health given their current inadequacy.

— Equity in health service access. In meeting MDG and other health goals and targets national governments will need to ensure health service access for poor/rural women and girls and for other groups often marginalised from sexual and reproductive health services.[179] It remains unclear how the International Health Partnership will address these underserved groups.

1.1.2.1 *Questions remain unanswered regarding the fit between the International Health Partnership and the Global Business Plan on MDGs 4 and 5*. The process of taking these two initiatives forward appears to be happening without adequate cross referencing, without the proper involvement of the recipient countries and in isolation from civil society advocates. This has led to an apparently rushed process, with confused messaging and a lack of buy in from other crucial partners in the process.

1.1.3 *Ensuring financing for global health.* We agree that it is vitally important that health financing and policy is harmonised and country owned in line with the Paris Declaration. In addition, more rational and efficient use of Official Development Assistance for health would no doubt improve the state of developing country health systems. This would appear to be a key aim of the International Health Partnership, and one that we support. However, there is international consensus that the health MDGs cannot, and will not, be met without a considerable increase in the financing available for health investment in developing countries. We commend DFID's support for innovative financing mechanisms to improve child health such as the International Financing Facility for Immunisation (IFFIm) but note that there has been no comparable commitment to securing the health of women and mothers. The Commission on Macroeconomics and Health[180] estimated that donor disbursements to global health would need to reach US$6 billion by 2002. In fact they only reached US$3.5 billion. By 2007 disbursements should have reached $US27 billion. Despite increases in the proportion of Official Development Assistance for health we are still some way from the target. For the UK to meet this "fair share" contribution they would need to more that double the percentage of GNI allocated as official development assistance for health from 0.043% to 0.1%.[181]

1.2 *DFID's role at the national level.* Civil society play a key function at the national level in ensuring that appropriate targets are set and monitoring progress towards them. This has been recognised by the Partnership for Maternal, Newborn and Child Health in their governance structures at national level which are working to co-ordinate maternal, newborn and child health plans and ensure congruence with other national health planning and financing mechanisms. To play an active role civil society need support from national government, this must be factored into planning processes and must be financially supported. This is not always the norm. For example in Orissa, in India, our colleagues have found that the Joint Review Monitoring is an important tool which helps in identifying the gaps in the health programme. However last year's Joint Review Monitoring findings have not yet been actioned and there is a strong need for support in developing and establishing an internal monitoring mechanism of civil society which could asses whether Government and donor goals are being achieved and set a timetable for the achievement of missed goals and build the capacity to implement it. We believe that this is an area in which DFID can add value.

2. *How effectively DFID is working with recipient countries to make emergency obstetric care available and to ensure that adequate numbers of skilled birth attendants and other staff are being trained to meet MDG 5, and are integrated within a robust health system. The steps DFID is taking to mainstream maternal health across related policies*

2.1 *Ensuring transparency with regard to spending at the national/state/district level.* Where DFID has pushed for action on health system strengthening the results of this work are not always transparent to the rest of government or to civil society. For example our colleagues in Orissa report that DFID was a key ally in the Orissa Health Sector Plan to support human resources, infrastructure, medicines, Information and Education Communication/Behaviour Change Communication etc. Despite having a budget of RS. 20 crores little is known outside the Health & Family Welfare Department about whether or how this money has been spent.

[179] For example, indigenous people, people living with HIV, young people, sex workers, sexual minorities, injecting drug users, people in prisons, internally displaced people, migrants and refugees.

[180] Commission on Macroeconomics and Health (2001) Macroeconomics and Health: Investing in Health for Economic Development www.cid.harvard.edu/cidcmh/cmhreport.pdf

[181] Action for Global Health (2007) Health Warning www.actionforglobalhealth.eu

2.2 *Ensuring that the role of the community, community level health system and traditional birth attendants is well understood, supported and rationalised within the broader health system*. Whilst every pregnant woman should be provided with care from a skilled birth attendant (SBA) (one with formal training from a recognised medical, nursing or midwifery school) traditional birth attendants (TBAs) and other community workers still play an important role in linking the community with the formal health system in many settings. Within health system financing there is a need to ensure adequate investment at the community level as it is at this level that the first two of the three delays take place. This financing should be used, in part, to strengthen referral and linkage with other community structures such as TBAs and the formal health system.

Although the training of TBAs has not directly led to reductions in maternal mortality they have had some positive impact in terms of neonatal health[182] and can play a vital role in referring women to skilled attendants. Our colleagues from India note that TBAs are still being supported in 14 Districts through the NAVAJYOTI scheme by Government of Orissa where the infant mortality rate is high and this initiative has been successful in not only reducing the rate of maternal mortality but has also been a strong initiative for maternal health. As reported at a dissemination meeting on "Scaling Up Community Mobilisation activities to improve maternal and neonatal health in Bangladesh",[183] while official policy in Bangladesh is that TBA training has halted it is doubtful that the target of 13,000 trained SBAs by 2010 (in Bangladesh) will be achieved (2,500 are now trained). TBA training is still being carried out in Bangladesh and TBAs will continue to operate whether or not Government wants them to.

In Ethiopia our partners report concerns about the efficacy and practical implementation of alternative community-based initiatives such as the Health Extension Package Workers; particular concerns include the low numbers of HEPWs, the lack of integration of the HEPWs at community levels and poor retention rates which undermines training and referral networks. Given that WHO's model of health systems includes the community as a key component we would call upon DFID to undertake research to better refine our understanding of the optimum role community structures and TBAs can play in improving health outcomes and that this is recognised and supported in national plans.

2.3 *Mainstreaming*. There is a need to actively promote and fund more inter sectoral agreement and practice as core factors to help mainstream maternal health across related policies. DFID can support with funding this but also through supporting the development of mechanisms for capturing and sharing learning and for piloting specific projects. The HIV/AIDS sector has useful models for integration and for improving stakeholder engagement.

3. *How DFID is supporting the 2006 recommendation by the UN General Assembly for an MDG target for universal access to reproductive health*

3.1 We commend DFID and the UK Government more broadly for the leadership role that they have played in bringing about the new target under MDG 5. However we have concerns that *the indicators under this new target have still not been agreed* and that they are subject to a great deal of scrutiny and criticism from governments who do not recognise the full spectrum of sexual and reproductive rights, for example the United States. Until indicators are in place there will be no impetus to measure progress towards the new target. We would suggest that DFID continue to negotiate strongly for robust and appropriate indicators in this area in its role at the UN and in negotiations with other bilateral actors.

3.2 DFID can also lead the way in ensuring that the success of the International Health Partnership is, in part, judged by its ability to stimulate progress towards universal access to reproductive health.

3.3 Furthermore, DFID could support the target by better communicating its existence to stakeholders both inside and outside government.

3.4 DFID have been very supportive in a limited number of countries (notably India and Malawi) where large scale programmes have shown some encouraging steps towards universal access to broad range of RH care. However it is not yet possible to comment on how this support can or will be rolled out to other programmes/projects.

4. *The progress being made in reducing maternal deaths from unsafe abortion?*

4.1 Where abortion is illegal, unaffordable or inaccessible, incidence of unsafe abortion is invariably high. Methods of unsafe abortion include; drinking poisonous substances or dangerous quantities of alcohol, inserting sticks and other sharp objects into the uterus and severe pelvic pummeling. Such methods are thought to be responsible for about 13% of global maternal mortality.

The key reason why women continue to risk their lives with unsafe abortion—despite its illegality—is desperation. Many fear that pregnancy outside wedlock will lead to them being ostracised from their family and community. Others are so poor that they literally cannot afford to feed another child and fear for the nutritional health of their existing children. These factors mean that thousands of women choose to face the risks of unsafe abortion every year.

[182] Lawn, J E, Tinker, A, Munjanja, S P and Cousens, S. Where is maternal and child health now? Lancet, 28 September 2006.
[183] Meeting hosted by DAB, Women & Children First and ULC, Dhaka 10 September 2005.

Legalising abortion, together with the roll out of access to safe abortion services, is therefore key to reducing these deaths. Recent successes include Mexico City and Nepal. However, pressure against the right to choose means that access to abortion has become even more restricted in some countries including Nicaragua.

4.2 When the opportunity to support safe abortion emerges, it is important that donors take it. *The Maputo Plan of Action* represents a huge opportunity in Africa, calling as it does for legislative reform to address unsafe abortion and having won the endorsement of the Africa Union Executive Committee in January this year. We urge DFID to advocate for the implementation of the plan in all of its stronger partnerships with African administrations and to provide financial support where appropriate.

5. *How effective family planning is being promoted as a way to improve maternal health*

5.1 Family planning prevents unintended pregnancies, many of which are unwanted. Unwanted pregnancies lead to abortion, many of which are unsafe in the developing world. Unsafe abortion is a leading cause of maternal death and ill-health. Family planning is critical to improving maternal health and needs to be a key strategy at the national and international levels to reduce unsafe abortion and maternal mortality. The current "unmet need" for sexual and reproductive health, care, education, information and services is enormous. "One in three deaths related to pregnancy and childbirth could be avoided if women who wanted effective contraception had access to it".[184] Indeed, "it is notable that contraceptive prevalence is low in countries with high maternal mortality".[185] UNFPA estimates "that meeting the existing demand for family planning services would reduce maternal mortality and morbidity alone by at least 20%".[186] Unsafe abortion can lead to long-term disability and maternal death. Indeed "around 13% of all maternal deaths are caused by unsafe abortion."[187] Family planning is, therefore, a key factor in the fight against poor maternal health and needs to be promoted as a preventative method for reducing maternal mortality.

5.2 DFID is a key supporter of family planning. They work with key governments, decision-makers and agencies to promote family planning as a way of improving maternal health. They also show leadership in a variety of international health initiatives such as the Partnership for Maternal, Newborn and Child Health (PMNCH) and the recently launched Global Campaign for the Health MDGs. They also advocate with key UN agencies and have increased their funding for a number of NGOs that provide reproductive health care services and commodities. Likewise, DFID is a member of the Reproductive Health Supplies Coalition (RHSC) which was set up to provide global leadership in making essential reproductive health products available to developing and transitional countries.

5.3 Despite the clear link between maternal health outcomes and family planning we believe that DFID could do more in-country to capitalise on the positive effects of the provision of family planning services. Our Southern partners have commented on the need to ensure that the infrastructure exists to support promotional and behaviour change communication work particularly in terms of health commodities, adequate supplies of human resources and appropriate community level structures. Universal access to reproductive health of which family planning services are a component is reliant on reproductive health commodity security. Without appropriate choices or the necessary quantity of commodities, sexual and reproductive health programmes will fail. The lack of adequate supplies in many countries is a result of funding and supply shortfalls. However, other problems exist which increases the level of unmet need: these include; "Inadequate forecasting of supply needs; a lack of adequate distribution systems in-country; regulatory, tariff and tax barriers that hinder the importation and provision of supplies by the public and private sector; inefficient use of public funds and a duplication of efforts and/or inadequate co-ordination among donors, governments, NGOs and other agencies in relation to commodity funding and delivery".[188] We believe that DFID should play an enhanced role in advocacy at the national, regional and global levels to encourage political leadership in this area to ensure that family planning is appropriately placed within national health plans and budgets.

6. *How effectively DFID works with bilateral and multilateral donors, NGOs and other stakeholders to promote maternal health*

6.1 *Relationship with the Reproductive Health and Research Department at WHO*. DFID has been instrumental in supporting the existence of the Reproductive Health and Research Department including arguing for earmarked funding for this area of work when it has been under threat. We hope that this is a Department that they will continue to champion.

[184] Facts about Safe Motherhood, UNFPA at http://www.unfpa.org/mothers/facts.htm [accessed 7 August 2007].

[185] Annex 9.6, The important issues in developing a national plan on maternal mortality reduction, Dr Pang Ruyan, Regional Adviser, MCH/FP/WPRO, at http://www.who.int/reproductive-health/publications/RHR_02_2/ax6.pdf

[186] Women's Health and Empowerment: A Key to a Better World, Statement by Thoraya Ahmed Obaid, Executive Director, UNFPA, Monterey, California, USA, 12 May 2003, at http://www.unfpa.org/news/news.cfm?ID=343&Language=1

[187] DFID Background Briefing: UK development assistance in health: abortion and maternal health, April 2001, at www.dfid.gov.uk/pubs/files/bg-briefing-health.pdf

[188] ICON: mobilizing business for appropriate and affordable access.

6.2 *Relationship with the Partnership for Maternal Newborn and Child Health*. DFID is one of the founder donors and an active participant in the Partnership for Maternal, Newborn and Child Health. The Partnership has the potential to stimulate advocacy for maternal health services and should be supported to play a role in the roll out of the "Global Business Plan on MDGs 4 and 5" and the International Health Partnership.

6.3 *DFID's support to UNFPA*. DFID has stepped in to fill funding gaps and to support UNFPA in the creation of the new target under MDG 5. This support should be sustained, strengthened and better communicated. DFID also has a part to play in building the capacity and monitoring the effectiveness of UNFPA.

6.4 *The US Government*. US policies such as the Global Gag Rule and restrictive programming with regard to HIV and AIDS undermine maternal health. DFID could play a more active role in promoting an evidenced based approach to these issues and filling financing gaps in the manner that they have with the Global Safe Abortion Fund. They should be advocating to and leveraging support from like minded donors to this end.

6.5 *DFID's relationship with the World Bank*. DFID's approach of spending more money with decreased staff at the centre and periphery make it likely that its budget for health system strengthening will increasingly be channelled through the World Bank. Given the World Bank's recent record on sexual and reproductive health, when first drafts of the Population and Nutrition Strategy failed to include a sexual and reproductive health and rights focus, and the difficulty in tracking positive health outcomes from central budgetary support, this strategy should be given more thought. The World Bank is not renowned for its pro-poor strategy and supports user fees that often inhibit access to health services, particularly for the poorest. In addition, channelling funds through the World Bank will reduce accountability between DFID and the British taxpayers who are concerned that their funds are spent effectively.

6.6 *The Global Fund to fight AIDS, TB and Malaria and the integration of sexual and reproductive health*. There is evidence to show that the integration of sexual and reproductive health components to HIV policies and programmes strengthens health outcomes yet this is a not yet a priority of Global Fund programming and financing. The UK Government has played a part in propagating this approach[189] and has been very supportive of efforts to integrate sexual and reproductive health in the HIV/AIDS components of country co-ordinated proposals submitted in July 2007 by Country Coordinating Mechanisms (CCM) for the 7th Round of funding by the Global Fund.

As a major donor, supporter and Board member, DFID should call for further technical guidance on SRH-HIV/AIDS integration to be outlined in the Guidelines for Proposals issued by the Global Fund, beginning with Round 8. The Guidelines must reflect the importance of SRH-HIV/AIDS integration, but the Monitoring and Evaluation (M&E) Toolkit provided by the Global Fund for potential grantees must do the same.

Within and in addition to its current efforts to define the Global Fund's role in strengthening health systems, the Board should be explicit in its support for SRH-HIV/AIDS integration by approving Guidelines that include SRH-HIV/AIDS integration and outline the funding opportunities for SRH-HIV/AIDS integration. There should be clarification that Health System Strengthening aspects of all proposals can include human resources, commodities, supplies and infrastructure for SRH.

Additionally the Technical Review Panel (TRP) must consider SRH integration as an "essential component" in HIV/AIDS proposals. This will, in part, be accomplished through a concerted effort by WHO and other agencies that provide technical support to the TRP to emphasise the many entry points for SRH-HIV/AIDS integration, the range of relevant interventions, and the positive outcomes these can have on HIV/AIDS and other diseases.

6.6.1 Additionally we have concerns about the lack of *gender sensitivity* in much of the Global Fund's policy and practice. For example, our partners report that many of the CCMs only have one place for the representation of people living with HIV and often this is taken by men meaning that issues of importance to women living with HIV, such as sexual and reproductive health and maternal health are inadequately represented. DFID is in a position to influence at Board level for gender specific monitoring processes.

6.7 *The UK Government as part of the European Union.* The European Commission has recently lowered its financing to sexual and reproductive health as part of the streamlining of health related budget lines through the Investing in People initiative and a reduction in financing for health as a proportion of overall ODA.[190] The UK Government should play a leadership role in ensuring the European Commission provides fair financing for the Global Fund for AIDS, TB and Malaria whilst maintaining and strengthening its

[189] Eg Nel Druce and Clare Dickinson with Kathy Attawell, Arlette Campbell White and Hilary Standing (2006) Strengthening linkages for sexual and reproductive health, HIV and AIDS: progress, barriers and opportunities for scaling up DFID Health Resource Centre www.dfidhealthrc.org/publications/HIV_SRH_strengthening_responses_06.pdf

[190] Although overall EU ODA has increased over the past years the proportion of the European Commission's allocation to health ODA has decreased since 2006. The investing in people initiative replaces budget lines including those for poverty related diseases and reproductive health care and gender (Regulation (EC) No 1568/2003 of the European Parliament and the Council of 15 July 2003). Collectively these budget lines contributed 110 million Euros a year to health. Now only 84 million euros is available for the Investing in People initiative and in 2007 the entire budget will be allocated to the Global Fund to fight AIDS, TB and Malaria (Action for Global Health, 2007).

financing to health system strengthening and sexual and reproductive health. We look forward to seeing how the UK Government positions itself with regard to the new plan for MDG Contracts (to make general and budget support work better for the health MDGS) and how they co-ordinate this approach with the new International Health Partnership.

6.8 *The IMF*. We are concerned that the policies of the IMF are restricting developing country government wage spending because of fears of a lack of fiscal space.[191] In part fears around fiscal space could be addressed through longer term, more predictable international development aid which DFID should move toward by expanding the number of countries that it has 10-year partnerships with and exploring ways to make binding financial commitments for the duration of the agreements. As the 4th joint largest donor to the IMF DFID should advocate for the removal of pressure on public budgets and to open up greater fiscal space for health spending.

7. *What leadership the UN is providing and how well co-ordinated its agencies are*

7.1 *Coordination issues*. We are concerned at the potential for lack of co-ordination between the UN agencies working on maternal health. In WHO alone there are three separate departments with overlapping remits: the Making Pregnancy Safer Team, the Department of Reproductive Health and Research and the Partnership for Maternal, Newborn and Child Health. Across the UN family there are some issues that are inappropriately prioritised or covered by more than one agency such as the procurement and promotion of condoms or maternal health services for women living with HIV and AIDS. DFID has had a major focus on UN reform overall and should play a role in advocating for rational and streamlined policy and programmatic guidance in these areas.

8. *How DFID is addressing socio-economic barriers to women's empowerment and the low status of women in relation to maternal health*

8.1 We welcome DFID's policy focus on tackling the low status of women. We agree that "underlying the failure to solve the problem lie broader social, cultural and political factors: the low status of women and the low priority given to their health, the failure to assure their rights to appropriate care, and the lack of political commitment to address the problem".[192] In the Second Progress Report on Maternal Health (April 2007)[193] three areas of progress are noted in relation to addressing wider social and economic barriers to maternal health; support to innovative financing mechanisms to scale up basic services; support to a workshop on FGM and other harmful traditional practices; presentation of evidence linking poverty and maternal health. In the "looking forward" section of the report (paragraphs 67–77) there is an assertion that the DFID priorities remain valid, but there is no explicit reference to women's status.

DFID has made women's empowerment and gender equality a high level commitment at the centre of its work. Therefore it now has a comparative advantage over other donors in its mission to strive to help developing countries to achieve gender equality and women's empowerment. Thus, we consider that *addressing socio-economic barriers to women's empowerment and the low status of women in relation to maternal health* should be a key point of implementation of DFID's Gender Equality Action Plan[194] by:

- Ensuring that all DFID's maternal health partnerships and funding are reviewed in light of a gender analysis and that these partnerships include a commitment to tackling the gender inequalities.
- Providing the gender champions and the Equity & Rights teams with the adequate power, support and budget to carry out their work—especially supporting the AIDS and Reproductive Health team.
- Ensuring that gender is a key consideration when monitoring and evaluating these partnerships and funding commitments; this includes the proper training for AIDS and Reproductive Health Team and Equality & Rights Team to carry out the gender equality analysis.
- Supporting country offices to review their partners in the response to maternal health to better promote gender equality and women's empowerment. Partnerships with organisations working in these areas should be prioritised.
- In funding civil society (eg through the Civil Society Challenge Fund and Governance Transparency Fund), ensure that there is a greater focus on health equity and women's leadership in health sector governance.

[191] Fiscal space is defined as the room in a government's budget that allows it to provide resources for a desired purpose without jeopardising the stability of the economy.

[192] Reducing Maternal Deaths: Evidence and action. DFID 2004 p1.

[193] DFID's Maternal Health Strategy Reducing Maternal Deaths: evidence and action Second Progress Report. DFID April 2007.

[194] DFID, February 2007, Gender Equality Action Plan 2007–2009: Making faster progress to gender equality.

— Incorporating indicators set in the Gender Equality Action Plan into indicators set for the Maternal Health strategy eg increased reference to gender issues, in particular inequality and empowerment, within policy papers, practice notes and guidance notes, increased proportion of new policy products that address gender inequality and women's empowerment.

8.2 An essential factor that is missing from the DFID analysis is equity in the access afforded maternal health services by marginalised groups. National strategies also need to include an analysis of the needs of different groups within each country.

Case Study on Inequity of Access to Services

A Health Unlimited study in the Ratanakiri Province of Cambodia[195] demonstrated that indigenous women experienced particular barriers in accessing maternal health services beyond those experienced by the general population. These included:

— Discrimination by service providers. This was not only due to their position as women but that as indigenous women they were typified as "backward, uneducated and stubborn".

— Language barriers. Women were found to be significantly less likely to be able to speak Khmer. They therefore relied more on husbands/relatives to speak for them in accessing services.

— Ritual obligation. This caused delays in accessing services as ritual sacrifice to ancestor spirits have to be performed before leaving village.

— Confidence in the health service. Due to the discrimination that they faced in the formal health setting indigenous men and women had more confidence in traditional birth attendants than in the government service providers.

— Traditional beliefs. For example, if a village thought a woman was likely to die, she may not be allowed to leave the village as they would be fined by each village they passed though when they brought the body back. Other traditional practices such as "roasting"[196] are seen as important to the woman/baby's recovery and cannot be performed in health facilities.

Community recommendations for the improvement of access to government health services included that:

— TBAs should be present in Health Centres, alongside midwives.

— No male staff should be involved.

— Staff should speak the local language.

— Families should be able to make animal sacrifices at the health centres.

Training should be provided for government health staff on ethical and culturally appropriate behaviour.[197]

9. *How the international community can improve maternal health in crisis and conflict settings*

9.1 According to OCHA, in 2003, 200 million people were affected by natural disaster and 45 million people were in need of life saving assistance due to complex emergencies. The majority of these people find themselves unable to access national health services and therefore fully depend on humanitarian relief efforts.

9.2 Many of these efforts however, largely overlook the sexual and reproductive health needs of affected populations. The critical importance of SRH care to reducing maternal death and morbidity is well documented and recognised by the international community. Yet, the humanitarian community continues to fail to ensure the inclusion of SRH service delivery as integral part of the humanitarian response.

9.3 SRH needs are particularly acute in countries emerging from conflict or natural disaster. Health systems in these countries are often characterised by damaged infrastructure, limited human resources and lack of capacity to provide health services, including sexual and reproductive health (SRH). In addition, stewardship of the health system in these countries is often weak and service delivery fragmented as a result of proliferation of NGOs. Moreover, general health NGOs may not have the experience, knowledge or commitment to deliver SRH according to internationally agreed standards.

9.4 In sum, major maternal health challenges in emergency settings that require urgent attention from the international community, including DFID, are:

— Ongoing lack of focus or priority given to SRH service delivery within a humanitarian response by key national and international actors, including; host governments, the UN system, donor governments and health focused NGOs.

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[195] Crossing the River and Getting to the Other Side: access to Maternal Health Services amongst ethnic minority communities in Ratanakiri Province, Cambodia. Eleanor Brown/Health Unlimited 2005.

[196] "Roasting" is the practice of outing a small fire under the bed of the woman once she has given birth. The process is strongly valued in some communities as it is thought that raising the temperature may help to fight post-birth infections. However, the medical side effects of roasting are unknown.

[197] Indigenous Women Working Towards Improved Maternal Health. Health Unlimited. May 2006.

— Lack of skilled staff in SRH service delivery, equipment, supplies, means of communication and transportation.

— Lack of access to life-saving SRH services, in particular emergency obstetric care (EmOC) and family planning.

9.5 There is a consistent need to push for the inclusion of SRH as part of the humanitarian response. Some progress has been made over the years in this area with some policies and guidelines in place. What is now required is a concerted drive to translate policy into action.

9.6 In this regard we *welcome the inclusion of language on SRH in the new CHASE Humanitarian Funding Guidelines for NGOs* (to be released in October) as an important step in encouraging agencies to include SRH in their humanitarian programmes. As a next critical step, DFID should to monitor it own performance in supporting humanitarian SRH programmes by tracking its grant money allocated to programmes that include SRH service delivery.

Moreover, DFID should use its influence at both national and international levels to ensure the incorporation of SRH as an integral part of humanitarian policy and action. More specifically, DFID should:

— Work with the humanitarian co-ordination system of the United Nations to ensure that SRH needs are adequately addressed from the outset of an emergency by ensuring that SRH becomes a core focus area of the Health Cluster as part of the Cluster Approach.

— Encourage humanitarian health focused agencies operational in emergency settings to develop the necessary human resources to set up and run effective comprehensive RH programmes in emergency settings from the outset of every emergency.

— Work with host governments, most notably the Ministries of Health and Finance to prioritise SRH as part of the humanitarian response and ensure its inclusion within national policies, budgets and action plans.

— Work with key partners on the ground (MoH, UN agencies and NGOs) to ensure the availability of skilled SRH health staff, appropriate equipment, supplies, means of communication and transportation, to enable access and quality SRH service delivery, including EmOC and family planning.

Annex 1

EVIDENCE TO THE DEPARTMENT FOR INTERNATIONAL DEVELOPMENT CONSULTATION ON "A NEW HEALTH ACCESS INITIATIVE: DELIVERING THE HEALTH MDGS" THE UK NETWORK ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS WITH INPUTS FROM THE MATERNAL HEALTH WORKING GROUP—20 AUGUST 2007

The UK Network on Sexual and Reproductive Health and Rights (the Network) is formed of UK based NGOs, academic institutions and independent experts with an interest in sexual and reproductive health and rights (SRHR) in developing countries. The Maternal Health Working Group of the Network focuses on maternal health with a particular interest in UK Government policy in this area.

The network welcomes this new focus upon the need to strengthen national health systems and the opportunity to be part of the consultation to shape its design and function.

We concur that better donor co-ordination, transparency, accountability and long- term investments are necessary to strengthen health systems. We are pleased to note that the new health access initiative aims to allow recipient countries to set health priorities and control the allocation of health budgets accordingly. We are particularly interested in how this health access initiative could stimulate progress towards the achievement of MDG 5 on improving maternal health and also have benefits for other health objectives such as MDG 6.

However, we believe that the content of the new health access initiative could be strengthened and that efforts could be made to improve the consultation process. We look forward to continuing dialogue on the points outlined below.

1. The Links between SRHR and Well Functioning Health Systems

A focus on SRHR within the new health access initiative is imperative. Well- functioning public health systems are key to the provision of comprehensive sexual and reproductive health (SRH) and all other health services. If we are to meet MDG 5 by 2015 we must build health systems that can deliver antenatal care; emergency obstetric care; post-partum care; family planning counseling and commodities; nutrition;

integrated HIV prevention and treatment services and access to safe abortion and post-abortion care. Because it is so reliant on clinical infrastructure progress on maternal health is a good test of the competence and strength of a health system and can be used as an indicator for health system strengthening.

The provision of comprehensive SRH services strengthens development processes. This has implications for attainment of the other MDGs particularly: those related to health, eradicating extreme poverty and hunger, promoting gender equality and empowering women and ensuring environmental sustainability. This link was acknowledged by the World Summit in 2005 when Heads of Government agreed to establish a new target under MDG5 to achieve universal access to reproductive health by 2015. This target was called for by the UN Secretary-General in his report of 2006 and the UN Inter-Agency Expert Group was subsequently asked to propose a set of indicators to measure progress in its implementation. Proposals for such indicators are: contraceptive prevalence rate, unmet need for family planning, adolescent birth rate and antenatal care visits.

The Network welcomes the leadership that the UK Government has shown in supporting the new target and indicators. We are hopeful that they will maintain this position and that it will be reflected in the health access initiative. Current indicators for MDG 5 are inadequate, particularly in tracking maternal deaths that occur during delivery and the post-partum period. Therefore the health access initiative will need to pay greater attention to this area and we look forward to providing further comment on this as the health access initiative's operational plan is developed.

Reproductive health conditions continue to be the second-highest cause of ill health globally after communicable diseases and the differences in reproductive health between the rich and the poor—both between and within countries—are larger than in any other area of health care.[198] Lack of access to SRH services for those who need them most replicates patterns of social inequality.

— The Network recommends that the health access initiative explicitly works towards the target of universal access to reproductive health by 2015 under MDG 5 and uses the indicators proposed under this target to measure its progress towards strengthened health systems. Indicators that better assess progress on combating maternal mortality, particularly during delivery and the post-partum period, should augment these. We also suggest that the initiative's success is tracked by indicators that measure equity of access to health services particularly for women and the most marginalised.

2. The Relation of the Health Access Initiative to the Global Business Plan on MDGs 4 and 5

The new health access initiative appears to be connected to the Global Business Plan on MDGs 4 and 5. The concept note states that the initiative "builds upon a number of past and ongoing efforts to increase external support for health and improve harmonisation and alignment of that support" and lists the Global Business Plan. Yet it is unclear how the two mechanisms will work together in practice and how donors will ensure that they do not lead to over-burdensome reporting and management requirements on developing country governments. If the new health access initiative is intended be subsidiary to the Global Business Plan it needs to clearly outline how broad health systems strengthening efforts would ensure maternal health outcomes.

— The Network recommends that the relationship between the health access initiative and the Global Business Plan on MDGs 4 and 5 is better defined and harmonised in such a way that maternal health remains a focus in health system strengthening without over burdening recipient governments. The Network also recommends more consultation on the Global Business Plan before it is launched.

3. Financing for Health

The new health access initiative "will not establish a new health financing mechanism". We agree that more could be done to make existing health financing work better through co-ordination, developing country leadership and priority setting and greater flexibility. However better co-ordination alone will not deliver the health MDGs. Even the relatively modest predictions of the Commission on Macroeconomics and Health[199] of adequate financing to meet the health MDGs have failed to be met.[200] In terms of

[198] UNFPA (2005) State of the World's Population 2005 http://www.unfpa.org/swp/2005/english/ch4/index.htm

[199] Commission on Macroeconomics and Health (2001) Macroeconomics and Health: Investing in Health for Economic Development www.cid.harvard.edu/cidcmh/cmhreport.pdf

[200] The Commission on Macroeconomics and Health estimated that donor disbursements to global health would need to reach US$6 billion by 2002. In fact they only reached US$3.5 billion. By 2007 disbursements should have reached $US27 billion. Despite increases in the proportion of official development assistance for health we are still some way from the target. For the UK to meet this "fair share" contribution they would need to more that double the percentage of GNI allocated as official development assistance for health from 0.043% to 0.1%. Action for Global Health (2007) Health Warning http://www.actionforglobalhealth.eu/content/download/6272/33180/file/AFGH_Report_UK.pdf

reproductive health the cost of fulfilling the demand for quality contraceptives and condoms alone is projected to rise from $1 billion to $1.8 billion between 2004 and 2015. In 2002, donor support for contraceptives amounted to $197.5 million—a 12% decline from the previous year.[201] This suggests that there should be greater emphasis on ensuring donor buy-in for the initiative, particularly on those donors who provide a large proportion of global health financing including the EC and the US.

— The Network recommends that the UK government offer greater clarity within the mechanism of what can be achieved through the improved use of existing resources and where financing gaps need to be filled and provides leadership in meeting these resourcing requirements. The UK Government should also make it clear when existing financing commitments for health will be met.

4. Addressing the Constituent Elements of Health System Strengthening

Ensuring ready access to health-related equipment, drugs and commodities is an essential element of health systems strengthening. This requires strengthened systems for procurement and registration, including transparency on the registration of generics. Failures to predict the type of commodity needed and where it will be needed, weaknesses in quality assurance and logistics for example, inadequate storage and badly planned distribution programmes also limit commodity availability. Security in reproductive health supplies requires the capacity to forecast, finance, procure and deliver high-quality and reliable supplies and services over the long term.[202]

Adequate numbers of appropriately trained and motivated health workers are vital to the delivery of health services and a prerequisite to health systems strengthening. Yet 57 countries face a critical shortage of health staff equivalent to a global deficit of 2.4 million doctors, nurses and midwives.[203] Midwives in particular often have only a limited number of the skills that define a fully-qualified midwife and cannot be expected to save pregnant women's lives without adequate training. Health system planning and equitable and integrated service delivery in fragmented systems with multiple service providers requires robust and joined up management systems. Health system planners need adequate training to ensure that national policy is implemented appropriately at the periphery. This is particularly true in the case of reproductive health services where health management personnel at the district and local level may lack the technical, managerial, and financial skills needed to deal with their new responsibilities and they may consider reproductive health less of a priority than central government.[204]

— The Network recommends that the health access initiative "compact" pays more explicit attention to these challenges related to the constituent elements of health system strengthening.

5. Supporting Recipient Governments to Decide how Health Services are best Provided

We are pleased to note that the health access initiative recognises the role of the non-state sector in the delivery of health services. We believe investing in public health systems through medical schools and training for public health workers and providing adequate salaries and incentives for public sector workers should be a priority. National plans must adequately recognise, incorporate and support the contribution of the private sector (profit and not for profit) in service delivery, in capacity building of state-run services and taking leadership in the development and monitoring of health policy.

— The Network recommends that the health access initiative ensures that decisions on health policy and services are determined at national level and guided by the national context, with the first priority being public health system strengthening.

6. The Importance of Meaningful Consultation with Civil Society

UK Government guidelines suggest that during the formulation of policy, departments should consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy and ensure that the consultation is clear, concise and widely accessible.[205] Given the clear links between strengthened health systems and SRH outcomes we were disappointed that the Network was not involved in earlier discussions on the health access initiative. Furthermore, the timeline

[201] UNFPA Securing Essential Supplies: Fast Facts www.unfpa.org/supplies/facts.htm

[202] UNFPA (2002) Reproductive Health Essentials Securing the Supply Global Strategy for Reproductive Health Commodity Security, UNFPA www.unfpa.org/upload/lib_pub_file/39_filename_securingsupply_eng.pdf

[203] WHO (2006) Working together for health: the World Health Report 2006 www.who.int/whr/2006/whr06_en.pdf

[204] Dmytraczenko, T, Rao, V and Ashford, L (2003) Health sector reform: how it affects reproductive health, Population Reference Bureau Policy Brief www.measurecommunication.org

[205] Cabinet Office (2004) Code of Practice on Consultation http://www.cabinetoffice.gov.uk/regulation/documents/consultation/pdf/code.pdf

of less than 7 days for written comment is extremely short and does not allow for discussion with our colleagues in developing countries or other donor countries.

— As the process of developing the health access initiative moves forward the Network recommends that the consultation process is strengthened, broadened, given sufficient lead-time and made more transparent.

20 August 2007

Memorandum submitted by World Vision

Introduction

1. World Vision is a Christian relief, development and advocacy organisation, dedicated to working with children, families and communities to overcome poverty and injustice. Motivated by our Christian faith, World Vision is dedicated to working with the world's most vulnerable people. World Vision serves all people, regardless of religion, race, ethnicity or gender.

2. World Vision is a member of the Partnership for Maternal, Newborn and Child Health, an alliance launched in September 2005 which is made up of some 130 members working to ensure that all women, infants and children not only remain healthy, but thrive.

Stalled Progress towards Millennium Development Goal 5

3. Every year, 50 million women give birth without the help of a skilled attendant.[206] More than 500,000 women die every year as a result of difficulties during pregnancy or childbirth.[207] In sub-Saharan Africa, a woman's risk of dying from such complications over the course of her lifetime in 1 in 16, compared to 1 in 3,800 in the developed world.[208] What should be a time of joy and celebration is too often a time of grief and loss. In addition to the women who die, many thousands are left injured or infertile after childbirth.

4. A mother's death can be devastating to the children left behind. In addition to the emotional trauma and grief of losing a mother, these children are much more likely to live in poverty, drop out of school, and be malnourished. Girls, especially, are expected to take on the responsibilities of the mother in caring for younger children, preparing food and carrying out household tasks.

5. Aid and development organisations like World Vision seek to improve maternal health by:

(i) Training and equipping midwives or birth attendants to support mothers in labour.

(ii) Improving access for girls to primary school. Educated girls are more likely to have fewer children and give birth to them later in life. They are also more likely to seek health care and have healthy babies.

(iii) Increasing access to emergency medical care.

World Vision's Work in Maternal Health

6. Afghanistan has one of the highest maternal mortality rates in the world. According to UNDP figures from 2004, one woman dies from pregnancy-related causes every 30 minutes. To help stem the tide of these deaths women must be trained as midwives and prepared to serve in remote, rural communities.

7. The best and most sustainable method is one that recruits women from the community to be trained as midwives. World Vision has been supporting a successful midwifery training programme in Herat which has seen 142 midwives graduate since opening in 2004.

8. Meanwhile neighbouring Ghor Province has had to rely on midwives coming from Tajikistan because the security situation deters midwives from Kabul and Herat from working there. A handful of women from within Ghor province had attended the midwifery training programme in Herat, but in Afghan society it is rarely acceptable for women to live or study so far from home.

9. So this year World Vision, supported by JHPIEGO (an international health organisation affiliated with Johns Hopkins University) is expanding its midwifery training programme to address the dire need for midwives in the mountainous, isolated districts of Ghor Province.

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[206] Global Health Council *Maternal and Child Health* 2006.
[207] United Nations *The Millennium Development Goals Report* June 2007.
[208] United Nations *The Millennium Development Goals Report* June 2007.

10. In collaboration with a local women's NGO called STARS, the 18-month training programme will include a furnished skills lab, practical clinic work, transportation to training sites, and housing. It is hoped that by granting easier access to training for women drawn from rural communities, the Ghor programme will create inroads to better health for mothers throughout the province.

11. In Indonesia, World Vision has been part of a pilot research project as part of the Information Communications Technology for Development Project (ICT4D) which has equipped 200 rural midwives with mobile phones. The study is to assess whether or not mobile communications can be used as an effective tool for impacting the quality of pre- and post-natal care in Indonesia.

12. In one anecdotal report, the number of pregnant women referred to hospitals by midwives with mobile phones actually decreased when they got mobile phones, as they could talk the problems through with the obstetrician, and in many cases life-saving treatment could be provided by the midwife.[209]

HIV and Maternal Health

13. There is growing evidence of the impact of HIV and AIDS on maternal health in areas of high HIV prevalence, with HIV reversing previous gains in maternal health in those countries most severely affected. A study in the Rakai district of Uganda showed the maternal mortality ratio was five times higher in HIV-infected than HIV-uninfected women.[210]

14. Given that the 2005 World Health Report states that 19 of the 20 countries with the highest maternal mortality ratios are in sub-Saharan Africa,[211] the impact of HIV and AIDS on maternal health must be considered a priority in these countries.

15. DFID's 2007 progress report on its Maternal Health Strategy states that:

> "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".[212]

16. Maternal health cannot be examined in isolation from newborn and child health and the impact of HIV on children is devastating. An estimated one third of infants with HIV die before their first birthday and half do not reach the age of two. In 2006 there were an estimated 530,000 children newly infected with HIV, with over 90% of these new infections occurring as a result of mother-to-child transmission.[213]

What DFID Can Do

17. The Partnership for Maternal, Newborn and Child Health is still in its infancy and struggles to have a co-ordinated and concerted influence, with so many different members, stakeholders and political voices. DFID can provide some of the leverage needed to achieve focus and coherence in this partnership. DFID's leadership in a strong Partnership is a key opportunity to use the global stage to accelerate progress towards Millennium Development Goals 4 and 5 and to bring together country-level stakeholders to co-ordinate more effective programming in maternal and child health.

18. Effective maternal and child health programming cannot be achieved without serious and sustained investment in health systems strengthening. DFID have reported early success in their significant investment in health systems in Malawi through their Emergency Human Resources Programme (EHRP) which aims to increase the numbers of health workers. Alongside the EHRP is a six-year Essential Health Package which includes specific support to improving maternal health services, identified as a priority due to Malawi's poor maternal mortality figures.

19. DFID has done much strategic work in maternal health and has invested significant resources, including bilateral spending of £243 million in 2004–05 and "significant contributions" to the maternal health programmes of the EC, the World Bank and international and national civil society groups.[214] An analysis of what has worked and what hasn't would be of use not only for DFID itself in terms of effectiveness and accountability, but also to partners and stakeholders.

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[209] Information Communication Technologies for Development (ICT4D) Update February 2006 (Available at: http://www.ntu.edu.sg/sci/sirc/download/Arul_presentation%20report.pdf)

[210] Ronsmans, C and Graham, W. *Maternal mortality: who, when, where and why* The Lancet, 2006.

[211] World Health Organization Facts and Figures from The World Health Report 2005 (Available at: http://www.who.int/whr/2005/media_centre/facts_en.pdf)

[212] Department for International Development, *DFID's Maternal Health Strategy "Reducing maternal deaths: evidence and action" Second Progress Report* April 2007.

[213] UNICEF *Children and AIDS: A Stocktaking Report* January 2007.

[214] DFID *Maternal Health Factsheet* November 2006.

SUMMARY OF RECOMMENDATIONS

World Vision recommends that the UK Government should:

1. Engage fully and take a leadership role within the Partnership for Maternal, Newborn and Child Health (PNMCH), in particular by committing to work with the Partnership in the area of advocacy at a global level, advancing the clear division of labour needed between UN agencies working on maternal, newborn and child health and being proactive in PMNCH working groups (country support, monitoring and evaluation and effective interventions) at the country level.
2. Taking lessons learned from the Malawi Emergency Human Resources Programme (EHRP) and the accompanying, targeted Essential Health Package, implement similar programmes in other countries with similar resource issues and political environments.
3. Ensure that maternal and child health is appropriately represented in the $1.5 billion funding commitment made by the G8 in 2007 for "maternal and child health and voluntary family planning", indicating when and how it will contribute its fair share of this commitment. Ensure that this money is allocated to a recommended package of MCH services, working within National plans and frameworks, and work with National governments to address discrepancies in urban/rural resourcing etc.
4. Contribute its fair share towards the funding commitments made by the G8 in 2007 of $1.5 billion for the prevention of mother to child transmission, indicating when it plans to do so and encouraging other G8 countries to do the same.
5. Provide support to the UN Inter-Agency Task Team (IATT) on PMTCT to provide technical assistance to national governments in developing and implementing national PMTCT plans to reach universal access to PMTCT for all pregnant women including access to a continuum of anti-retroviral treatment, counselling and support services after delivery.
6. Undertake meta-analysis research of DFID programming in maternal health over the last 10 years. Determine successful components of programmes and strategies and use this information to better work with partners and stakeholders in future programming.

September 2007

Memorandum submitted by YozuMannion Limited

How can donors "and DFID specifically" catalyse progress towards MDG 5?

1. It is now clear that MDG 5 will not be met in most low income countries and especially those in Sub-Saharan Africa. This was mentioned in the speech by Douglas Alexander at the launch of DFID's new International Health Partnership on 5 September 2007. More worryingly is the lack of any real evidence of progress in many countries where the maternal mortality rate is highest, this being an indication of the need for rethinking global and country strategies. In some the deterioration of the situation is further cause for concern and this is particularly pertinent in several countries that are emerging from conflict or classified as fragile states.

2. The policy environment among donors and UN agencies is an area where much work has been done. DFID has led the way and is one of the few donors with a defined strategy and one that actively works to encourage others to do the same. However the translation of this policy and strategy into implementation is the area where a new catalyst is required. Getting the aid management right is of course important but often the result is good policy and donor/government collaboration but continuing poor services and low utilisation rates in particular amongst the poor and rural communities.

3. The increasing tendency over the last decade is to view maternal health as a medical issue and focus more or less exclusively on medical solutions or interventions such as EOC, malaria prophylaxis and post abortion care. This is often prioritised in donor and UN strategy documents in the sections that focus on solutions and intentions. Where progress has been made and sustained for some time, such as Nepal and Bangladesh, the strategies have been more comprehensive and multidimensional, going beyond medical interventions (although including them as they should) to include girls' education, work on increasing the age of marriage and first pregnancy, family planning and abortion services and efforts to reach out to young people. These multidimensional approaches are necessary and must replace the growing tendency to view pregnancy as an illness. Recent challenges that potentially prove counter-productive to maternal and reproductive health global programming include: low priority given to birth spacing and contraceptive commodities by US funded agencies as guided by the US Congress; inadequate funding for reproductive health and gender based violence in conflict and post-conflict countries; and, lack of sustained support for a public—private sector health service delivery that will ensure appropriate cross referral systems and quality emergency obstetric care.

4. DFID and other donors need to invest in implementation in a way that effects change. This requires more focused and resourced action than is currently the case. The last DFID Maternal Health report (2005–06) shows only £16m of direct funding. This is insufficient particularly given the lack of investments by others. The champion role played by DFID at policy and aid architecture levels needs to be moved to effect implementation. The arguments that resourcing is in reality much higher due to sector and increasingly budget support mechanisms is unconvincing in terms of translating into better maternal health outcomes.

5. Most importantly tackling maternal health issues needs to be done with a focus on young people. It is an agenda that cuts across many issues in society and should not be centred in the medical domain. It is about empowerment of young women and girls, female literacy, male involvement, sexuality education and youth services. Most maternal deaths are among the poorest in the poorest countries but searching for a reference to either youth or maternal health in existing Poverty Reduction Strategy Papers and Policies is an unrewarding task.

How effectively is DFID working with recipient countries to make emergency obstetric care available and ensuring that adequate numbers of skilled birth attendants and other staff are being trained to meet MDG 5, and are integrated within a robust health system?

6. The move to budget support in many key countries where DFID has traditionally funded considerable health programmes, including ones focusing on maternal and reproductive health such as Nepal and Malawi, means that direct influence at the sector level is diminished. The agencies and partnerships that are supported to take up the issues at sector level are not proving effective enough to influence government budgetary allocations and/or the provision of adequate resources. DFID's approach has moved towards getting the aid management processes "right" rather than engaging in more "down-stream" technical implementation issues. A major constraint across the health sector in many countries but particularly in sub-Saharan Africa is the chronic lack of skilled health professionals. This is known, recognised and yet action remains limited due to reluctance to directly engage in issues that involve substantial recurrent costs. As is frequently argued this should indeed be an issue for national budget allocations but where this remains stubbornly low, often around the 3% level, then resources for personnel including skilled birth attendants will remain inadequate.

7. Establishing a stronger link to governance issues is critical. Progress on maternal health issues is, as for other things, linked to political will. This is clear in countries where progress has been made such as Vietnam, Honduras, Egypt and Sri Lanka. DFID can take a more proactive role in health and maternal health in particular within the EU following the "Division of Labour" discussions.

8. DFID has been a leading donor in this field but has also been referring back to the success of the Nepal Safe Motherhood Programme for a number of years. Despite the programme's success in working closely with the Government in a programmatic approach, this model has not been replicated. Lessons from the unsustainable Safe Motherhood model implemented by DFID in Malawi have been drawn but have not been widely published for others to learn from. DFID appears to be reluctant to fund more implementation programmes which involve working closely with Government—as demonstrated in Nepal— while also designed to focus on implementation that accelerates change in service provision and utilisation. DFID provides large amounts of funds to UN organisations but these are not implementation agencies by their nature.

What steps is DFID taking to mainstream maternal health across related policies?

9. There is some discussion on integrated approaches but this is slow and limited. The heady days of the Cairo Consensus are now all but over. The disease-specific focus of political debate has led to most donors prioritising Malaria, TB and HIV/AIDS through such mechanisms as the Global Fund, Roll Back Malaria and Stop TB. Only in the last year or so has more attention been placed on the need for building health systems and ensuring integrated approaches and some would argue that this is a result of the lack of progress in rolling out the disease by disease approach. Little funding now is given to family planning which provides simple and effective means for spacing deliveries, delaying age of first birth and other important factors linked to improving health of mothers and their children. However flawed at the point of delivery, UK domestic policy expects services to be planned and work in a joined up way "joined up thinking for joined up government". This does not seem to be pursued with such rigour in UK overseas policy. So as DFID and many others push for budget support on the one hand and disease specific interventions on the other, progress on issues central to MDG5 are inadequately addressed as they need a more holistic approach.

How is achieving MDG 5 being prioritised and integrated into countries' overall healthcare provision?

10. Maternal deaths are relatively rare occurrences and still not given high priority by most governments. Unless the political interest and will is present the General Budget Support approach will have little impact on the Maternal Mortality MDG in the vast majority of the poorer nations where maternal mortality and morbidity are highest. More work is needed to develop the debate on issues such as how maternal health

links to the burden of disease, the importance of healthy women to the economics of the household and the health of young children. This is not new but clearly the current messages and arguments do not have an impact on Ministries of Finance and other key government departments that control budgets.

What progress is being made in reducing maternal deaths from unsafe abortion (which account for 13% of all maternal deaths)?

11. DFID is supporting safe abortion through the "global safe abortion fund" being implemented by IPPF. This is an important step and DFID should be applauded for this step, particularly in the face of political opposition to safe abortion by some donors. In addition, DFID in Cambodia is funding a safe abortion programme; again this is likely to have an important impact on provision of safe abortion in that country. DFID is supporting UNFPA and should now apply more influence to direct their thinking in relation to the abortion agenda; UNFPA should be campaigning for the rights of women to access safe abortion.

How effectively is family planning being promoted as a way to improve maternal health?

12. Family Planning funding is not sufficient and has been an area of neglect now for many years. UNFPA and many non-governmental groups have been highlighting this actively. There are avoidable contraceptive shortfalls in many countries that would greatly support the position of women wanting to have more control over when and how many children to have. The international organisation around this issue is advancing but progress is slow in establishing an effective and well resourced global response. And yet the recent G8 Parliamentarian's forum on HIV/AIDS in Berlin (May 2007) highlighted the frustration of parliamentarians, service providers, advocates and others at the lack of attention being given to integrated approaches, including family planning. The increased resources for the treatment and care of people with HIV and AIDS are far out stripping that for prevention activities. This lack of funding for sexual and reproductive health with a youth focus is short sighted and will be counter productive not least as the numbers of people with HIV and AIDS will continue to rise.

How effectively is DFID working with bilateral and multilateral donors, NGOs and other stakeholders to promote maternal health?

13. As it is for so many sectors, DFID is a key participant and leader in the international debate on maternal health. However, it is widely recognised the MDG 5 is off target. The new International Health Partnership announced last week does not address this adequately or urgently enough. DFID should lead the thinking and direct resources towards more integrated and focused responses with a youth focused programme supported by several funders; at the same time acknowledging the need to allocate funding where the policy and budgetary framework within a country is inadequate.

14. DFID should try to influence the EU to improve their RH theme funding provision. The EU decision to include RH funding into its Investing in People theme, but then channelling 75% of the funding through the Global Fund in effect reduces the amount of funding to RH and focused it on the disease specific agenda.

What leadership is the UN providing and how well co-ordinated are its agencies?

15. DFID should be encouraging UNFPA to take a more focused and energised leadership role on youth centred programmes that have the potential to impact on maternal health. They should be strengthened to re-establish strong family planning and maternal services programmes.

16. The UN organisations are too caught up in their internal politics and interagency issues that they are not focussing on achieving their goals, but rather are diverted by trying to promote their agencies interests. UNFPA, UNICEF and WHO should be supported to define more clearly their respective roles and responsibilities with regard to maternal health and joint working arrangements. DFID should also offer more TA to improve their institutional effectiveness and continue to push the process of reform that requires a more results- based approach.

17. With the growing trend towards global health partnerships and collaborations, including the larger initiatives such as the Global Fund for HIV/AIDS, TB & Malaria, GAVI, IAVI and many more, bilateral governments need to monitor the balance between their direct budget support and their contributions to such global programs. Currently, the majority of global health funds are deployed vertically with limited opportunity to capitalise on integrated efforts to ensure that basic health services are delivered. DFID's role as a major donor to these large funds and many other global health programs can be further strengthened through collaborative monitoring of development efforts. Joint assessment and evaluation teams will enable increased impact on key indicators such as MDG 5. Attention through the new International Health Partnership, the existing Paris Declaration and other harmonisation efforts should be given to streamlining the recent proliferation of global health partnerships and initiatives to reduce overlap and unnecessary expenditure on maintaining all the respective Boards and management structures. UN agencies should be playing an active role in country co-ordination mechanisms, engagement in introduction of the Sector Wide

approaches in post-conflict countries and humanitarian co-ordination efforts including the Common Humanitarian Fund (CHF) to ensure effective and efficient deployment of complementary direct and indirect funding support for service delivery.

Has the international community improved maternal health in crisis and conflict settings?

18. The record is not impressive. The crisis and conflict zones are places where women are suffering greatly from violence and other abuse with the lack of access to services being the norm. The international community needs to do more to tackle issues around legislation and action. Providing the legislative environments and making these widely known and acted upon is a priority. Establishing effective forms of accountability is a prerequisite to creating the security needed for action on improving the health and well-being of women in crisis areas. As so clearly seen in Darfur the international community is failing badly in many instances as it is unable to provide either security or access to services. As countries emerge from conflict the UK and others should redouble efforts to start well co-ordinated programmes that bring services to those in need as soon as possible.

19. Southern Sudan is an example of a post-conflict country that has an MMR of 2037/100,000 (Sudan Household Health Survey 2006). With an ANC rate of 14% and an escalating incidence of unsafe abortion and miscarriages due to wife beating in pregnancy, this picture provides a snapshot of the absolute morbidity that women face in war affected communities. DFID is engaged in supporting health system strengthening through a pooled funding mechanism managed by the World Bank, with an investment of $225 million over three years to facilitate the transitional development phase of the Southern Sudan health sector. The transition efforts have being challenged by the lack of any clear exit strategies for humanitarian donors and service delivery agencies, leaving a serious vacuum in health service support at all levels of the health system. This is one of many countries where DFID can play a key role through mobilising adequate technical advisory services to facilitate capacity building of government health service managers, in order to deliver a decentralised health system.

20. Another example worth highlighting is that of the Democratic Republic of the Congo which has received limited funding for Gender Based Violence programs in the past five years despite many studies demonstrating the growing levels of gender based violence across Eastern DRC. DFID increased its budget support for health systems strengthening but due to inaccessibility and lack of community based initiatives these services are not reaching the women who are most at risk of maternal and reproductive morbidities.

14 September 2007

Supplementary memorandum submitted by the Department for International Development

Breakdown of DFID contributions to the Partnership for Maternal, Newborn and Child Health

£240,000 from May 2005 to December 2006 as an initial contribution.

£10,000 specialist management consultancy support in August 2005, in response to a specific request for governance support.

£1,000,000 towards the current Partnership{workplan and cost of advocacy around the landmark "Women Deliver" Conference.

Total £1,250,000.

Further specialist management consultancy support under consideration. Future support by DFID also under consideration.

DFID actual and projected spending on maternal health (directly targeted initiatives)

£16.2 million 2004–05

£18.7 million 2005–06

£21.9 million 2006–07

£53–54 million** 2007–08 (extrapolated figure based on planned future expenditure as new maternal health projects start spending)

(**Note: the £100 million announced for commodity supply would NOT be included under this figure as the programme would be coded as commodity supply).

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