



House of Commons
International Development
Committee

Maternal Health

Fifth Report of Session 2007–08

Volume I



House of Commons
International Development
Committee

Maternal Health

Fifth Report of Session 2007–08

Volume I

Report, together with formal minutes

*Ordered by The House of Commons
to be printed 6 February 2008*

International Development Committee

The International Development Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department for International Development and its associated public bodies.

Current membership

Malcolm Bruce MP (*Liberal Democrat, Gordon*) (Chairman)
John Battle MP (*Labour, Leeds West*)
Hugh Bayley MP (*Labour, City of York*)
John Bercow MP (*Conservative, Buckingham*)
Richard Burden MP (*Labour, Birmingham Northfield*)
Mr Stephen Crabb MP (*Conservative, Preseli Pembrokeshire*)
James Duddridge MP (*Conservative, Rochford and Southend East*)
Ann McKechin MP (*Labour, Glasgow North*)
Jim Sheridan MP (*Labour, Paisley and Renfrewshire North*)
Mr Marsha Singh MP (*Labour, Bradford West*)
Sir Robert Smith MP (*Liberal Democrat, West Aberdeenshire and Kincardine*)

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk.

Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/indcom

Committee staff

The staff of the Committee are Carol Oxborough (Clerk), Matthew Hedges (Second Clerk), Anna Dickson (Committee Specialist), Chlöe Challender (Committee Specialist), Ian Hook (Committee Assistant), Jennifer Steele (Secretary), Alex Paterson (Media Officer) and James Bowman (Senior Office Clerk).

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

Footnotes

In the footnotes for this Report, references to oral evidence are indicated by 'Q' followed by the question number. References to written evidence are indicated by the page number as in 'Ev 12'.

Contents

Report	<i>Page</i>
Summary	3
Background and acknowledgements	5
1 Introduction	6
The global maternal mortality burden	6
DFID's response	7
The key bottleneck: a failure of advocacy and political will	8
The structure of this report	10
2 More than a medical problem: maternal health as a development issue	11
Addressing gender inequalities	11
Girls' and women's education	11
Gender-based violence	12
Socio-economic empowerment	12
Other demand-side barriers	14
Transport	14
Strengthening civil society's capacity to hold governments to account and influence policy	15
Ensuring pro-poor health financing	16
A rights-based approach	19
Unsafe abortion	19
3 Securing political will: global strategies for maternal health	23
The UN: challenges and opportunities in its current approach	23
Other major global initiatives	26
The Partnership for Maternal, Newborn and Child Health	26
The Global Campaign for the Health MDGs	28
Seizing opportunities	30
The Global Fund to Fight AIDS, TB and Malaria	30
The Japanese Presidency of the G8	32
The UK's role in stepping up advocacy	33
4 Strategies for success	35
What works in preventing maternal deaths	35
The example of Nepal	35
What works in strengthening health systems	37
Boosting human resources	37
Increasing the availability of equipment and supplies	40
Balancing the demand and supply-side of care	42
Working in conflict-affected and fragile states	42
The need for improved health information systems to monitor progress	45

5	The challenge for DFID	48
	DFID's current mix of aid instruments and policies	48
	Financing strategies	48
	Budget support and maternal health	49
	DFID's human resource capacity	51
	Managing expectations of DFID's work and aid harmonisation	52
	DFID's comparative advantage	52
	Re-appraising priorities	53
6	Conclusion	55
	Recommendations	56
	List of acronyms	65
	Formal Minutes	66
	Witnesses	67
	List of written evidence	68
	List of unprinted written evidence	69
	List of Reports from the Committee during the current Parliament	70

Summary

Millennium Development Goal 5 (MDG 5), which seeks to reduce by three-quarters the level of maternal mortality by 2015, has seen the least progress of all the MDGs. A key factor in this collective failure has been insufficient political will to drive actions to improve the health of women, both at the international and national levels.

The Department for International Development (DFID) has been a leading donor to maternal health programmes. It deserves credit for its creation of international partnerships, its willingness to address sensitive issues such as abortion, its support to research and its consistent focus on strengthening health systems.

Major challenges remain. Only two in five women in sub-Saharan Africa deliver their babies with the assistance of a skilled attendant and this is largely unchanged since the early 1990s. Addressing the huge shortage of midwives worldwide and increasing the availability of emergency obstetric care to all women has been and must remain at the centre of DFID's approach. Increasing access to basic drugs and equipment—including family planning supplies—is also vital.

It is also crucial to address the gender inequalities that prevent women fulfilling their right to health. Improvements to health information systems in developing countries need the continuing support of DFID so that policies and programmes can be evidence-based and progress towards MDG 5 can be tracked reliably.

Lack of data from countries with some of the worst death tolls, a tendency to under-report maternal deaths and the use of national averages create uncertainty about the real scale of maternal mortality, particularly in sub-Saharan Africa and Asia. Whilst the number of maternal deaths for 2005 is cited as 536,000, it could be as high as 872,000. We fear that the higher figure could indeed be nearer the truth. It has also been estimated that for each woman who dies, 30 further women will become disabled, injured or ill owing to pregnancy, so it is reasonable to assume that millions of women suffer in some way due to childbirth.

Inequalities in access to maternal care are driven primarily by poverty. DFID should continue to support the abolition of charges for health care and help governments to identify and address the major barriers to care, especially for the poorest women and in conflict settings where demand for maternal care is higher and access more difficult.

DFID cannot single-handedly bring about the progress needed to reach MDG 5. It needs to step back and prioritise carefully in order to maximise the series of crucial opportunities offered in 2008. The Department must play to its strengths and support other actors, especially the UN, in playing their part. Only then will maternal health receive the urgent political commitment that it deserves.

Background and acknowledgements

1. In July 2007, we announced an inquiry into the UK Department for International Development (DFID)'s support to maternal health. The main purpose of the inquiry was to examine how donors—particularly DFID—can support progress towards Millennium Development Goal 5, which seeks a reduction by three-quarters in the level of maternal mortality worldwide and universal access to reproductive health by 2015.
2. We received 24 submissions of written evidence from a wide range of development organisations and actors, including: non-governmental organisations (NGOs); multilateral aid organisations; consultancies; universities; professional bodies; and individuals. We are grateful to all those who submitted written evidence, and to those who supplied us with background papers.
3. We would like to thank the individuals and organisations who gave oral evidence during five evidence sessions at Westminster between October and December 2007. We are particularly grateful to those from developing countries, and with close links to developing countries, who took the time to engage with the inquiry. We greatly value their input and look forward to more input from developing countries in future inquiries.
4. We would like to thank our Specialist Advisers, Professor Wendy Graham of the University of Aberdeen and Regina Keith of Cara International Consulting, for their assistance throughout the inquiry.
5. We would also like to thank those who took part in informal discussions with us, including Professor Oona Campbell from the London School of Hygiene and Tropical Medicine and Dr David McCoy of University College London.

1 Introduction

The global maternal mortality burden

6. Becoming pregnant for some women in the world today is a cause not for joy but for fear, not a celebration of new life but an acceptance that death in childbirth is a very real possibility. There are over half a million maternal deaths per year, 99% of them in developing countries¹ (86% in sub-Saharan Africa and Asia) and for each of these deaths, an estimated further 30 women will become disabled, injured or ill owing to pregnancy.²

7. Maternal deaths are to a large extent preventable.³ Health professionals know what to do to prevent women from dying, and the technologies involved are relatively simple.⁴ Approximately 15% of all pregnancies will have serious complications that could lead to death but even the five “big killers”—haemorrhage, infection, unsafe abortion, eclampsia and obstructed labour—can be treated or prevented if births are attended by a skilled health professional and emergency care is readily available.⁵ Yet this knowledge has failed to help many women across the globe: for, instance, one in seven women in Niger can expect to die in childbirth, compared to one in 8,200 in the UK—more than a 1,000 fold difference.⁶ Of all health measures, maternal mortality indicators represent the greatest gap between rich and poor countries. Eleven countries accounted for almost 65% of maternal deaths in 2005. India had the largest number (117,000), followed by Nigeria (59,000), the Democratic Republic of Congo (32,000) and Afghanistan (26,000).⁷

8. What makes these statistics even worse is that they are largely unchanged from 20 years ago. In 1990 it was estimated that for every 100,000 live births 425 women died of maternal causes, and in 2005 this indicator—the maternal mortality ratio—had fallen to 402. However, because of the absence of data from countries with some of the worst death tolls, the apparent decline of 2.5% per year could in fact be considerably lower (as low as 0.4% per year).⁸ In sub-Saharan Africa, in particular, the levels of maternal death remain very high, with no significant progress in reducing maternal mortality ratios (MMR) over the last 15 years.⁹ An annual decrease in the MMR of 5.5% between 1990 and 2015 is needed worldwide to achieve a three-quarters reduction by 2015, but with the apparent annual decrease being less than half this, MDG 5 is unlikely to be reached.¹⁰ However, **such is the**

1 Ev 122

2 Q 242 [Dr Gill Greer]

3 Q 246 [Dr Gill Greer]

4 Q 54 [Dr Grace Kodindo]

5 Ev 158

6 WHO, ‘*Maternal Mortality in 2005: Estimates developed by WHO, UNICEF, UNFPA and the World Bank*’ (2007), p.27. Online at http://www.unfpa.org/upload/lib_pub_file/717_filename_mm2005.pdf

7 Ibid

8 Ibid

9 There was an estimated 1.8% decline in the maternal mortality ratio in sub-Saharan Africa between 1990 and 2005. Ken Hill et al, ‘Estimates of maternal mortality worldwide between 1990 and 2005: an assessment of available data’, *The Lancet* Vol 370, 13 October 2007

10 WHO/UNICEF/UNFPA Press release, 12 October 2007, ‘Maternal Mortality Declining in Middle-income Countries; Women Still Die in Pregnancy and Childbirth in Low-income Countries’

uncertainty about the real scale of maternal mortality, particularly in sub-Saharan Africa and Asia, that whilst the number of maternal deaths for 2005 is cited as 536,000, the figure could be as high as 872,000.¹¹ Many studies have found a tendency for maternal deaths to be under-reported and we fear that the higher figure could indeed be nearer the truth. Moreover, using national averages to assess the magnitude of the problem often masks enormous differences between areas and groups of women.

9. Within countries there are often huge inequities in access to maternal health care. For example, in Afghanistan the remote district of Ragh had a maternal mortality ratio more than 15 times higher than the capital, Kabul.¹² High levels of maternal mortality reflect a fatal intersection of inequalities, including: multiple levels of gender discrimination; urban versus rural location; poverty-related barriers to access and quality of care; and imbalances based on ethnicity, caste, level of education and presence of conflict.¹³ Such inequities are compounded by weak health systems, characterised by a lack or uneven distribution of doctors and midwives, insufficient and ill-equipped health facilities and a dearth of essential drugs and supplies. 36 out of 46 African countries have critical shortages of health staff.¹⁴

10. In 2000, at the Millennium Summit, maternal health was embedded in the list of targets agreed by global leaders as urgent priorities for global human development, the Millennium Development Goals. Initially the maternal health goal, MDG 5, had one target: a reduction of three-quarters in the maternal mortality ratio between 1990 and 2015, to be measured directly and through monitoring the proportion of births attended by skilled health personnel.¹⁵ In 2006, an additional target was added: universal access to reproductive health by 2015.¹⁶

DFID's response

11. The role played by DFID in securing the second MDG 5 target was recognised and appreciated in evidence to our inquiry.¹⁷ DFID produced its most recent Maternal Health Strategy in 2004. The Department spent £385 million on health in 2005–06 (excluding budget support and contributions to multilateral agencies such as the UN) and within this £16 million was spent on maternal and newborn health.¹⁸ The then Parliamentary Under Secretary of State for International Development, Baroness Vadera, told us the £16 million sum had since “doubled and will double again [...] to over £50 million by next year

11 Figure derived from estimates in Ken Hill et al, 'Estimates of maternal mortality worldwide between 1990 and 2005: an assessment of available data', *The Lancet* Vol 370, 13 October 2007

12 Figures for 1999-2002. Carine Ronsmans and Wendy Graham, 'Maternal mortality: who, when, where, and why?', *The Lancet Maternal Survival Series* (September 2006), p.21

13 Ev 122

14 Ev 84

15 The Maternal Mortality Ratio (MMR) is the number of maternal deaths for every 100,000 live births.

16 Report of the Secretary-General on the work of the Organization, General Assembly Official Records: Sixty-second Session, Supplement No.1 (A/62/1) (2007), p.67

17 For instance, Ev 162; Ev 116; and Ev 140

18 DFID, *Maternal Health Strategy – Reducing maternal deaths: evidence and action, Second Progress Report* (April 2007), p.8

[2008].”¹⁹ DFID was one of four donors who collectively provided over half (51%) of total Official Development Assistance (ODA) to maternal, newborn and child health in 2004.²⁰ The Department channels its financial support to maternal health in a number of ways, including: general budget support; sector budget support; Sector Wide Approaches (SWAs) for health; and contributions to multilateral organisations, NGOs, research institutions and other partners.

12. Praise for DFID’s work was extended across many aspects of its maternal health programme: the evidence we received was largely in agreement that DFID is a leading donor to and champion of maternal health.²¹

The key bottleneck: a failure of advocacy and political will

13. DFID’s support to and leadership of maternal health has, however, to be set in an international context of disappointing results. As described above, the launch of MDG 5 seven years ago has so far resulted in limited progress in reducing the frequency with which women are dying of maternal causes. Indeed, of all eight Millennium Development Goals, MDG 5 has seen the least progress.²² Maternal mortality has not fallen since 2000 in large areas of sub-Saharan Africa, South Asia, West Asia, Latin America and the Caribbean.²³ Only two out of five women giving birth are attended by a skilled attendant in sub-Saharan Africa, and this has remained largely unchanged since the early 1990s.²⁴ Witnesses expressed dismay at the lack of progress.²⁵

14. **Over the course of the inquiry, we have been saddened by the stagnancy of MDG 5 and the fact that so many women continue to die during pregnancy and childbirth. A clear message from the evidence we took was that a key bottleneck in securing progress on maternal health is a failure of advocacy and a lack of political will.** Brigid McConville of the White Ribbon Alliance told us that advocacy—communication of the need to act quickly and robustly to reduce maternal deaths—was the “key” that will “unlock the process.”²⁶ Richard Horton, Editor of *The Lancet*, explained the stoppage in simple terms :

“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.”²⁷

19 Qq 271- 272 and Ev 229. DFID spent the following amounts on maternal health: £16.2 million in 2004/05, £18.7 million in 2005/06 and £21.9 million in 2006/07. Projected spending for 2007/08 is £53-54 million (an extrapolated figure based on planned future expenditure as funds begin to be spent under new maternal health projects) (Ev 229).

20 The other three donors were the World Bank, USAID and UNFPA. Ev 151

21 For example, Ev 226; Ev 177; and Q 121 [Brigid McConville]

22 Allan Rosenfield, Deborah Maine and Lynn Freedman, ‘Meeting MDG 5: an impossible dream?, *The Lancet Maternal Survival Series* (September 2006), p.5

23 Ev 156

24 UNDP, *Human Development Report 2007-2008* and UNICEF, *Maternal mortality: Trends in skilled care at delivery (1990-2000)*, online at http://www.unicef.cz/download/MaternalMortality_D7341Insert_English.pdf

25 Q 129 [Brigid McConville] and Q 246 [Dr Gill Greer]

26 Q 131 [Brigid McConville]

27 Q 142 [Richard Horton]

15. In order to bring about comprehensive results, advocacy clearly needs to take place at two main levels: international advocacy by donors and multilateral bodies to ensure and to support the commitment of national governments to act; and national and local advocacy by governments and community groups to promote and deliver maternal health within countries. Thoraya Obaid, Executive Director of the UN Population Fund (UNFPA), emphasised that political will was needed from national governments as well as donors.²⁸ The evidence we received highlighted both levels of advocacy as requiring far more attention.²⁹ Further, specific advocacy efforts are needed within countries to ensure a multi-sectoral approach is taken to maternal health: as Dr Grace Kodindo, an obstetrician from Chad, told us, “it should not only be the problem of the Minister of Health.”³⁰ Advocacy and political commitment alone will not, of course, save lives, but they are necessary conditions for securing action on maternal health.

16. We believe that lack of progress towards MDG 5 is a global collective failure. Responsibility for this belongs at both international and national levels. Donors and national governments carry a particular responsibility to heighten awareness both of the unacceptability of the situation and of the urgent need for greater political will for progress. The responsibility to act lies not with one sector but across sectors—the Ministry of Finance, for example, as well as the Ministry of Health—and with a whole range of actors, from UN agencies to grassroots groups at village level.

17. DFID’s own advocacy for improved maternal health, for the strengthening of health systems and for gender equality has undoubtedly helped to secure some high-level ‘political will’ to address maternal mortality.³¹ DFID was credited by witnesses for its leadership in wider global advocacy, for instance through spearheading the new International Health Partnership in 2007, and for other efforts to boost political will—particularly its publication of a dedicated maternal health strategy (DFID being the only major bilateral donor to do so), its support for research and its rights-based approach.³²

18. But actions to enable progress remain inadequate. This is evident in the continuing substantial financing shortfall for maternal health: a further US\$14 billion needs to be found for maternal, neonatal and child health if the international community is to reach the US\$25 billion estimated as necessary to ensure that a basic package of health services is available to all.³³ The situation has been made worse by the failure of the United Nations (UN) to tackle maternal mortality. We received a significant amount of evidence that indicates that the UN agencies with a mandate for maternal health are fragmented and poorly co-ordinated.³⁴ Challenges and opportunities for the UN, and for other major global partnerships on maternal health, will be assessed in Chapter 3.

28 Q 2 [Thoraya Obaid]

29 Q 131 [Brigid McConville] and Q 132 [Richard Horton]

30 Q 24 [Dr Grace Kodindo]

31 Ev 157

32 See, respectively: Ev 170; Ev 135; Ev 150; and Ev 153

33 Ev 113

34 Q 128 [Richard Horton]; Ev 228; and Ev 131

19. There is evidence that where maternal health is pushed high up the political agenda, maternal mortality can be reduced relatively quickly. Some industrialised countries halved their maternal mortality ratio in the late 19th century, primarily through professional midwifery care at birth. In the post-war period, Thailand, Malaysia and Sri Lanka all saw declines in their maternal mortality ratios of over 50% between 1960 and 1984.³⁵ More recently, both local advocacy and national policy changes played a key role in stimulating actions which reduced maternal mortality in Nepal between 1996 and 2006.³⁶

20. Research from Sri Lanka indicates that even resource-poor nations with areas of conflict can make sustainable progress with relatively affordable investments, as long as strong political commitment exists. Sri Lanka spends less than 2% of GNP on health yet over 90% of Sri Lankan women deliver in clinics. This is due to a series of measures including providing equitable access to free health care and ensuring that health facilities are available within 10 kilometres of every citizen's home, amongst other broader policies such as improving girls' education.³⁷

The structure of this report

21. Our inquiry has made clear to us the need to find effective advocacy strategies that will help catalyse political will and actions to improve maternal health. We will indicate throughout the report why and where we believe advocacy can make a difference. In Chapter 2 we start by looking at why maternal health is so central to development and how addressing socio-cultural inequalities such as gender and poverty can help reduce maternal deaths. In Chapter 3 we look specifically at how the international failure of advocacy has happened and what can be done at global level, particularly by DFID, to invigorate the drive to save women's lives. Chapter 4 will identify strategies for success, focusing on approaches that have been proven to work in preventing maternal deaths and whether they can be replicated at scale. This chapter will also address the crucial question of how to strengthen the measurement of progress on maternal health more accurately. Chapter 5 will conclude the report by looking at the implications for bilateral agencies such as DFID. It will specifically ask whether the Department is making optimal use of its own financial and human resources in order to remain a leader and champion for achieving MDG 5.

35 Carine Ronsmans and Wendy Graham, 'Maternal mortality: who, when, where, and why?', *The Lancet Maternal Survival Series* (September 2006), p.16

36 Ev 160

37 K.McNay, R.Keith and A.Penrose, *Bucking the Trend* (Save the Children UK, 2004)

2 More than a medical problem: maternal health as a development issue

Addressing gender inequalities

22. Maternal health can be viewed as a barometer of a nation's development. Women's experiences of pregnancy and childbirth exert influences far beyond their own health, crucial as this is, to affect their status and empowerment, their children and wider family's health, education and wealth and, indeed, their nation's society and economy. Children without mothers have lost the parent who makes the biggest difference to their well-being and are much more likely to live in poverty, drop out of school, and be malnourished.³⁸ A recent article in *The Lancet* argued that maternal health "is not only central to women's potential, but also has telescopic, ripple effects for broader development concerns facing the world today."³⁹

Girls' and women's education

23. Women's ability to exercise their right to reproductive health and to negotiate their access to health services is directly affected by the gender, social, cultural and economic inequities they face. We heard evidence from a number of witnesses highlighting that reductions in maternal mortality are directly linked to improving girls' and women's educational opportunities.⁴⁰ Over 40 million girls remain out of school worldwide.⁴¹ They are disempowered in multiple ways by not having their right to education fulfilled: they miss out on crucial messages about health and sex; are less likely to become economically independent; are likely to marry and have children earlier; and face higher risks of HIV/AIDS, female genital cutting and domestic abuse by male partners.⁴² It is estimated that failure to reach the target for MDG 3, seeking equal access to primary and secondary education for girls and boys by 2005, will result in 10 million unnecessary child and maternal deaths over a decade.⁴³

24. DFID published a strategy paper on girls' education in 2005 and a Gender Equality Action Plan in 2007.⁴⁴ **Girls who are not in school are having their right to education undermined and are at increased risk of early marriage, domestic violence and HIV/AIDS. We urge DFID to ensure that the interdependency between maternal**

38 Ev 128 and Ev 224

39 Kirrin Gill, Rohini Pande and Anju Malhotra, 'Women deliver for development', *The Lancet* Vol 370, 13 October 2007, pp.1347-1348

40 Q 142 [Richard Horton], Q 222 [Dr Gill Greer] and Q 249 [Baroness Vadera]

41 United Nations: *Millennium Development Goals Report 2007*

42 Global Campaign for Education, 'Girls can't wait: Why girls' education matters, and how to make it happen now' (2005), online at http://www.campaignforeducation.org/resources/Mar2005/b10_brief_final.doc

43 D. Abu-Ghaida and S. Klasen, 'The Economic and Human Development Costs of Missing the Millennium Development Goal on Gender Equity', World Bank Discussion Paper 29710 (Washington: World Bank, 2004). Online at <http://commdev.org/content/document/detail/1858/>

44 DFID, 'Girls' Education: Towards a Better Future for All' (January 2005) and DFID, 'Gender Equality Action Plan 2007-2009' (March 2007)

health, gender inequality and education is acknowledged and acted upon in its own strategies for these three areas as well as in national country development plans.

Gender-based violence

25. Other socio-cultural norms strongly affect women's experiences of pregnancy and childbirth. Female genital cutting substantially increases the risk of delivery complications for women.⁴⁵ Gender-based violence has a powerful impact on women's health, and contributes to unplanned pregnancies, abortions and the spread of sexually transmitted infections, including HIV and syphilis, which lead to a higher risk of neonatal and maternal deaths.⁴⁶ Studies from Rwanda, Tanzania and South Africa indicate a threefold increase in the risk of HIV amongst women who have experienced violence compared to those who have not.⁴⁷ In turn, HIV-positive women have been found in some populations to be about four times more likely to die in pregnancy or childbirth than a woman without HIV.⁴⁸

26. DFID supports a range of interventions aimed at combating gender-based violence (GBV). One example is a four-year initiative (2004–2008) called *Working Towards Safe Motherhood in South Asia: Combating gender-based violence during pregnancy in Bangladesh and Nepal* which is funded under DFID's Civil Society Challenge Fund.⁴⁹ The project raises awareness of services available to the high numbers of women experiencing GBV in Bangladesh and Nepal—including counselling, emergency shelter and legal advice—with a specific focus on pregnant women. In written evidence, IPPF said the project “has enabled IPPF Member Associations to address GBV during pregnancy for the first time in a comprehensive and effective manner.”⁵⁰ Other evidence we received said that donors need to ensure that access to contraception is available alongside counselling for sexual violence to help prevent unwanted pregnancies, and that health workers need to be trained more effectively in this area.⁵¹ **The DFID-funded project to address gender-based violence towards pregnant women in Nepal and Bangladesh is achieving promising results and this approach should be communicated, and, where relevant, replicated. Contraceptive services and counselling by trained health workers should be integral parts of such projects.**

Socio-economic empowerment

27. Another key priority for donors is supporting initiatives to empower women to make decisions, access services and increase their socio-economic status. Dr Grace Kodindo, an obstetrician from Chad, emphasised the importance of “financial and cultural access” to

45 Ev 174

46 Ev 136

47 The Global Coalition on Women and AIDS and WHO, ‘Violence Against Women and HIV/AIDS: Critical Intersections—Intimate Partner Violence and HIV/AIDS’ (Information Bulletin Series, No.1), pp.1-3, online at <http://www.who.int/gender/violence/en/vawinformationbrief.pdf>

48 Ev 86

49 Ev 146

50 Ev 146

51 Ev 118

maternal health care. She told us that in countries such as Chad, where 80% of women are illiterate, helping to empower women to make their own decisions—for instance, over finance, legal issues and their own health—is of signal importance.⁵²

28. IPPF's written evidence highlighted two DFID Country Assistance Plans that incorporate a focus on women's decision-making: Bangladesh's 2003–06 Plan, which identified gender inequality (especially issues such as dowries, inheritance, access to health services and physical security) as a key constraint to poverty reduction, and the Nepal Country Strategic Plan 1998 (now under review) which “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”.⁵³

29. Microfinance and microcredit schemes (financial services for people in poverty, including insurance, savings, credit and money transfer services) offer women scope to manage household finances and start small businesses and through this to change their socio-economic status quite dramatically. Such projects also provide an opportunity for health education to be provided in a non-threatening socially-acceptable forum. Professor Charlotte Watts of the London School of Hygiene and Tropical Medicine told us of a project part-funded by DFID in South Africa that sought to link microfinance with participatory activities around gender, violence and HIV. This project—‘Intervention with Microfinance for AIDS and Gender Equity (IMAGE)’⁵⁴—found that integrating an HIV/AIDS component into existing microfinance programmes helped women facing violence and the risk of HIV infection from male partners. Training sessions with microfinance clients explored issues such as gender roles, sexuality, relationships, violence and HIV/AIDS, and women mobilised communities to work with men and youth on these issues.⁵⁵ The women involved in the study experienced a 50% reduction in violence from male partners over a two-year period.⁵⁶ Professor Watts encouraged DFID to look at how the project could be replicated.⁵⁷ **Microfinance and microcredit schemes have been shown to work well in empowering women socially and economically and can be used to promote better health and uptake of care. We recommend that DFID build on the success of projects such as the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) in South Africa, which added gender, violence and HIV/AIDS components to existing microfinance schemes and promote relevant opportunities for replication and adaptation to improve maternal health.**

52 Q 24 [Dr Grace Kodindo]

53 Ev 147

54 IMAGE was a collaborative study between the University of the Witwatersrand, the Small Enterprise Foundation in South Africa and the London School of Hygiene and Tropical Medicine.

55 Paul Pronyk and Julia Kim, ‘Preventing intimate partner violence and HIV’, *Id21 Insights*, online at <http://www.id21.org/insights/insights64/art10.html>

56 Q 205 [Professor Charlotte Watts]

57 Q 206 [Professor Charlotte Watts]

Other demand-side barriers

30. Poor women are amongst society's most marginalised groups, yet they also carry a disproportionate share of the burden of maternal ill-health. In some countries, this is reflected clearly in the risk of maternal death, with the poorest women being three to six times more likely to die compared to the richest women, as shown in written evidence provided by Impact.⁵⁸ It is therefore vitally important to support women to assert their right to be healthy, to participate actively in health system planning and monitoring, to challenge governments and donors to invest in services and to hold them to account over their pledges.⁵⁹

31. Demand-side barriers that prevent women from articulating their rights to and needs for maternal health and care include: poor educational opportunities, gender inequalities and violence (as discussed above), plus: poverty; social and cultural norms (for instance, beliefs that male health staff should not provide care to female patients); geographical constraints especially in remote rural areas; transport to health facilities; the presence of conflict; and the direct and indirect costs of accessing health care. Developing policies and providing resources to address these barriers has contributed to improved maternal health in countries such as Sri Lanka, Burundi, Zambia and Uganda. Addressing demand-side barriers such as those described above is embedded within DFID's strategy for reaching MDG 5, which has four pillars:

- Advocate—raise the profile;
- Scale up evidence-based interventions;
- Address wider social and economic barriers to access; and
- Develop and apply new knowledge.⁶⁰

32. The other set of barriers to health and uptake of care relates to problems in the supply of services, including weaknesses in the overall health system such as insufficient numbers of health professionals, a lack of clinics and hospitals and constrained access to drugs and supplies. We shall return to these supply-side barriers, and the appropriate balance between demand- and supply-side strategies, in Chapter 4.

Transport

33. In many regions, lack of access to transport is a key barrier to using maternal health care services. In some rural areas of Africa and Asia, where motorised vehicles are a comparative rarity, women in labour can face an agonising walk or stretcher ride to the nearest facility for delivery. This situation is even more problematic where a complication has arisen and the woman urgently needs emergency obstetric care. Timely and appropriate medical intervention in such cases frequently makes the difference between life

58 Ev 127 and C. Ronsmans and W. Graham 'Maternal mortality: Who, when, where and why?', *The Lancet* Maternal Survival Series (September 2006). Impact—the Initiative for Maternal Mortality Programme Assessment—is an international research initiative co-ordinated by the University of Aberdeen.

59 Ann Starrs, 'Delivering for Women', *The Lancet* Vol 370, October 13, 2007, p.1286

60 Ev 87

and death, for the woman and her baby. Even where cars or trucks are available, roads may be of very poor quality, or travel costs too high. Furthermore, companions—a family member or friend—will generally be needed to accompany women in labour and this carries extra costs. Dr Grace Kodindo described to us the dilemma facing many women:

“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.”⁶¹

34. Research from Nepal shows that transport costs can equate to 70% of the total expenditure for a delivery.⁶² Community initiatives to pool funds and collaborate with local transport groups have been shown to increase the use of maternal health services (although householders often still have to make up the shortfall in transport costs).⁶³ Dr Nynke van den Broek from the Liverpool School of Tropical Medicine told us that there are “very imaginative ways of dealing with emergency transport including motorcycle ambulances.”⁶⁴ This is an approach being supported by DFID in Ghana, where they are funding motorcycles for health workers.⁶⁵ Dr Monir Islam from the World Health Organization also highlighted the use of maternity waiting rooms, where women stay before they are due to deliver until the birth, so they are close to the care they need.⁶⁶

Strengthening civil society’s capacity to hold governments to account and influence policy

35. Supporting citizens’ ability to advocate better maternal health care and hold their governments accountable for commitments to improve maternal health is integral to strategies for achieving MDG 5. DFID gave us examples of countries where it seeks to strengthen civil society’s capacity to do this: for instance, Malawi, where civil society organisations are supported to create awareness of women’s health and improve the accountability of health providers, and India and Nigeria where DFID supports media and civil society efforts to increase political accountability for maternal health.⁶⁷

36. Witnesses were generally impressed with DFID’s support to civil society. In their written evidence, Marie Stopes International said “DFID commitment to supporting grass roots advocacy is admirable.”⁶⁸ Brigid McConville from the White Ribbon Alliance told us that DFID had “supported some excellent projects”, for instance a participatory project in Tanzania in which mothers and midwives had made a film about maternal health issues,

61 Q 23 [Dr Grace Kodindo]. Obstetric fistula usually occurs after several days of obstructed labour without medical intervention. The mother’s pelvic tissue is compressed and the resulting hole between the vagina and bladder or rectum can lead to chronic incontinence and subsequent rejection by families and communities.

62 Q 75 [Dr Tim Ensor]

63 J.Borghji, T.Ensor and A.Somanathan, ‘Mobilising financial resources for maternal health’, *The Lancet Maternal Survival Series* (September 2006)

64 Q 116 [Dr Nynke van den Broek]

65 Q 311 [Baroness Vadera]

66 Q 188 [Dr Monir Islam]

67 Ev 88 and 93

68 Ev 158

which was eventually shown in the Parliament building in Dar es Salaam and on national television. Ms McConville suggested that DFID should fund the kind of work currently being undertaken in-country by civil society groups, including the White Ribbon Alliance, in verifying government statistics on health workers and holding governments to account on their pledges to increase access to social services such as health and education.⁶⁹

37. However, supporting civil society needs to go beyond project grants to include a focus on actual participation in the policy-making process. Evidence submitted jointly by NGOs was broadly appreciative of DFID's record on this: "DFID continues to support the voices of the poor, civil society and the marginalised being included in health policy determination, implementation and monitoring."⁷⁰ However, the UK Network on Sexual and Reproductive Health and Rights believed DFID could go further: one particular concern was that the International Health Partnership, a multi-donor co-ordination framework launched in September 2007 by the Prime Minister, had had little input from civil society in its planning.⁷¹ There was also concern relating to DFID's influence on the use of the increasing amounts of its funds spent through partner agencies such as the UN and the World Bank. A specific example given was that DFID should encourage the World Health Organization (WHO) to include civil society when determining indicators and benchmarks for measuring progress in health.⁷² **DFID deserves credit for its support to strengthening civil society's capacity to hold governments to account for maternal health care. However, we believe that the Department could do more to ensure citizens are appropriately involved in the national policy-making process, including for example appropriate engagement in auditing government statistics and measuring progress on maternal health.**

Ensuring pro-poor health financing

38. The financial cost attached to accessing maternity care in many developing countries is a key deterrent, often with long-term adverse effects for poor women and their families. Households currently face large costs for health care in many countries and this is a key factor preventing women from seeking the care they need.⁷³ In many cases, households will pay for maternal health services through 'user charges' which are charged at the point of delivery and generally collected by staff to cover health staff salaries, diagnostic tests and the costs of drugs and other supplies. Other out-of-pocket expenditure for women delivering at health facilities will include indirect costs such as transport and loss of wages and these may be as large or larger than direct costs.⁷⁴

69 Q 123 [Brigid McConville]

70 Ev 112

71 Ev 215

72 Ev 120

73 WHO's 2005 World Health Report stated that 100 million people are pulled into poverty each year through paying for health care. Save the Children UK's 2005 series *The Cost of Coping with Illness in East and Central Africa* states that over 30% of populations assessed did not seek healthcare due to cost, while a further 30% were pulled into poverty by doing so—with women and children having the least access.

74 Ev 129 and J.Borghini, T.Ensor and A.Somanathan, 'Mobilising financial resources for maternal health', *The Lancet Maternal Survival Series* (September 2006), pp.52-55

39. User charges for health almost always impact most on the poorest people. There is strong evidence for their removal in favour of universal free care.⁷⁵ A normal delivery can cost a huge amount but birth complications can make the price prohibitive. In Sierra Leone, a birth costs £13, the equivalent to 43 days' earnings (£2,200 in UK terms) and a caesarean section costs £60, 194 days' earning (over £10,000 in UK terms).⁷⁶ Time spent finding or borrowing the money to pay for health care can delay the decision to seek care, and may mean women end up delivering at home without skilled assistance. WHO estimates that 100 million people are forced into poverty annually by 'catastrophic' payments, unexpected and substantial costs for health care that push households further into poverty.⁷⁷ In 2005, at the World Health Assembly, 189 countries agreed that moving away from user fees for health was essential in order to reach MDGs 4 and 5.⁷⁸

40. Many countries are choosing to abolish user charges. In Sri Lanka, this has been highly successful: services are free at the point of access and over 95% of women deliver with a skilled midwife.⁷⁹ Others have found the transition more difficult: Ghana, Uganda and Zambia all used debt relief to fund free health care but had initial difficulties implementing and sustaining the policy given the numbers of people requiring care.⁸⁰ DFID supported the abolition of health care fees in countries including Zambia and Burundi and was encouraged in evidence to continue its support for the removal of fees.⁸¹ In Uganda and some districts in Zambia, health care utilisation rose by over 100% and up to 75% respectively when fees were removed.⁸² The lessons learned were that where fees are abolished, government funding needs to increase substantially in order to support the expanded demand for care. Written evidence from the DFID-funded Towards 4+5 Research Programme Consortium stated:

“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.”⁸³

41. Dr Tim Ensor of Immpact and the University of Aberdeen told us that when considering free care, providers needed to focus on the main financial barrier for patients. In Nepal, the main barrier is in fact transport costs, and accordingly the Government of

75 J.Borghi, T.Ensor and A.Somanathan, 'Mobilising financial resources for maternal health', *The Lancet Maternal Survival Series* (September 2006), p.51-52

76 R.Keith and P.Shackleton, *Paying with their lives: the cost of illness for children in Africa* (Save the Children UK, 2006), pp.9

77 *Ibid.*, pp.9-12

78 WHO, 58th World Health Assembly (2005), Resolution 58.31, 'Working towards universal coverage of maternal, newborn and child health interventions, online at http://www.who.int/gb/ebwha/pdf_files/WHA58/WHA58_31-en.pdf

79 K.McNay, R.Keith and A.Penrose, *Bucking the Trend* (Save the Children UK, 2003) and UNDP, *Human Development Report 2007/2008*

80 Q 76 [Dr Sam Adjei] and BBC Online, 'Zambia overwhelmed by free care' (April 2006), online at <http://news.bbc.co.uk/1/hi/world/africa/4883062.stm>

81 Ev 88, 113 and 152

82 R.Keith, 'Can Commonwealth nations lead the way towards universal coverage for all, to ensure dramatic change for children is achieved?' Commonwealth Health Ministers Book 2007 (Commonwealth Secretariat)

83 Ev 152

Nepal developed a policy whereby women were paid a cash sum when they reached a health facility to offset the cost of travelling there. Early results suggest the proportion of women delivering with a skilled attendant present is increasing.⁸⁴ Providing cash to individuals or households, conditional on their use of specified maternal health services, has also worked in Mexico and Honduras, where uptake of antenatal care increased by 8% and 15–20% respectively.⁸⁵ Dr Ensor also believed that voucher schemes, which remove the need for cash, could work in subsidising maternal health care, but that such schemes risked creating a parallel administration infrastructure that could be highly bureaucratic (as in Bangladesh).⁸⁶

42. Ghana is now starting to use another option for pro-poor financing of health care, a health insurance system.⁸⁷ Dr Ensor was hesitant about the sustainability of insurance schemes, particularly community-based ones—and pointed out that many schemes do not cover even normal deliveries as they are “predictable events.” Similarly, emergency obstetric care is often also excluded as it is so expensive.⁸⁸ Immpact’s written evidence noted that, in Indonesia, women covered by the Government’s social insurance for the poor still had the lowest uptake of delivery with a health professional (less than 21%) and the highest level of mortality (maternal mortality ratio—MMR—of 630 maternal deaths per 100,000 live births). This compares with the equivalent figures of 31% and MMR of 410 for women without any insurance, and 81% and MMR of 235 for those with other insurance.⁸⁹

43. User fees for maternal health care almost always hit the poorest women hardest and we believe that there is a strong case for their removal in favour of universal free care. We believe that DFID should continue to support countries to abolish user fees. We recommend that, when doing so, DFID and other donors should help ensure that other revenue sources—for instance, the tax base or additional donor funds—are identified in order to support the expanded demand for care. We believe that governments, when considering free care, need to identify the main financial barriers for women (for instance, transport), particularly the poorest, and seek to address these using financing options which are sustainable and most relevant to the country’s circumstances.

44. There is evidence that cash transfer or voucher schemes can work in encouraging women, particularly the poorest and those living in remote areas, to give birth in facilities with a skilled attendant, rather than at home. We recommend that DFID prioritise support to efforts to identify, implement and evaluate context-specific options for reducing financial barriers to maternal health care.

84 Q 76 [Dr Tim Ensor]

85 In the first trimester of pregnancy. J.Borghgi, T.Ensor and A.Somanathan, ‘Mobilising financial resources for maternal health’, *The Lancet Maternal Survival Series* (September 2006), p.55

86 Q 79 [Dr Tim Ensor]

87 Q 76 [Dr Sam Adjei]

88 Q 83 [Dr Tim Ensor]

89 Ev 129

A rights-based approach

45. As Thoraya Obaid, Executive Director of the UN Population Fund (UNFPA) told us, part of empowering women is engendering the understanding that health is a human right.⁹⁰ Taking a rights-based approach to maternal health helps link the provision of services to national governments' legal obligations enshrined in human rights treaties and principles, and is therefore a means of enhancing political accountability.⁹¹

46. Written evidence from the Towards 4+5 Research Programme Consortium praised DFID for encouraging mainstreaming of maternal health on the human rights agenda, and commended DFID's publication of a document on human rights approaches to maternal health.⁹² Evidence submitted to us jointly by NGOs agreed that DFID has developed a strong maternal health policy based on rights but believed that this:

“is not always followed through into programming and funding [...] Rights-based policies are a step in the right direction but more funds are needed for DFID and their partners to implement these policies and to measure the positive impact that this type of programming can have on societal change.”⁹³

The use of a monitoring framework which assesses the implementation of the rights-based approach by country programmes is one route to help address these concerns. **We believe that DFID deserves credit for its rights-based approach to maternal health. However, the Department must ensure that the approach is accompanied by adequate funding and implementation strategies. To ensure that the approach is fully implemented at programme level, we believe that DFID should support monitoring frameworks which assess how effectively country programmes are applying a rights-based perspective.**

Unsafe abortion

47. One major aspect of maternal health that is tied closely to the rights agenda is unsafe abortion. Abortion is the third biggest cause of maternal death.⁹⁴ Unsafe abortion is seen by many as one of the most neglected public health challenges in the world today.⁹⁵

48. Sixty-nine countries—representing 26% of the world's population—currently prohibit abortion and here the risk of death for women seeking illegal, unsafe abortions carried out by unregistered practitioners is very high. About a quarter of women who have undergone an unsafe abortion—nearly all of them in developing countries—will be hospitalised due to serious complications such as haemorrhage, infection or poisoning, while an unknown number of women suffer similarly serious complications but do not seek treatment.⁹⁶ According to evidence from the Institute of Development Studies, the abortion mortality

90 Q 22 [Thoraya Obaid]

91 Ev 93

92 DFID, 'How to reduce maternal deaths: rights and responsibilities' (2005) <http://www.dfid.gov.uk/pubs/files/maternal-how-to-final.pdf> and Ev 153

93 Ev 115 and Ev 119

94 Ev 84

95 David A. Grimes et al, 'Unsafe abortion: the preventable pandemic', *The Lancet* Vol 368 (2006), pp. 1908

96 Ev 132

rate in countries where abortion is legal is around 1 per 100,000 abortions and where it is prohibited the rate rises to 330 per 100,000.⁹⁷

49. There are three countries worldwide—Nicaragua, Chile and El Salvador—where abortion is illegal under any circumstances, including rape or if the woman’s life is endangered by her pregnancy. Thirty-four of the 69 countries banning abortion make exceptions where the mother’s life is at risk, and the remaining 32 allow their laws to be interpreted to mean abortion is allowed in these circumstances.⁹⁸ Even where abortion is generally against the law, wealthier urban women may be able to obtain safe abortions, but poor, rural women are unlikely to have the means or money to gain access and will instead use unskilled practitioners.⁹⁹ Safe abortion is not simply about having the legal right and access to professional care but also about having the necessary information and being empowered to exercise the right. Thoraya Obaid of UNFPA told us:

“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.”¹⁰⁰

50. Baroness Vadera told us that helping women to understand their rights and the way the law works is difficult in these situations, but that DFID seeks to fund agencies that can help ensure that women are aware of the services that are available.¹⁰¹ She said that the most effective way for DFID to work was not to “become evangelical about this” but to go where interest already exists and “provide evidence, fund NGOs and civil society” and that “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.”¹⁰² This conforms with the official consensus agreed at the 1994 International Conference on Population and Development in Cairo, which stated that decisions on abortion are national and should not be imposed from outside.¹⁰³

51. In recent years, many countries have liberalised their abortion laws and there has been a demonstrable drop in maternal mortality in most countries where abortion has been legalised.¹⁰⁴ It is essential that legalisation is accompanied by expanded access to safe abortion services, as achieved in South Africa where, following legalisation, deaths from abortion complications decreased by 90% between 1994 and 2001.¹⁰⁵ Abortion was legalised in Nepal in 2002 after many years of campaigning, and maternal mortality here appears to

97 Ev 131

98 Rory Carroll, ‘Killer Law’, *The Guardian*, 8 October 2007, online at <http://www.guardian.co.uk/g2/story/0,,2185811,00.html>

99 Ev 132

100 Q 20 [Thoraya Obaid]

101 Q 312 [Baroness Vadera]

102 Q 270 [Baroness Vadera]

103 Q 19 [Thoraya Obaid]

104 Q 244 [Dr Gill Greer]

105 Ev 133 and Janie Benson and Marcel Vekemans, ‘The health dangers of unsafe abortion’, id21 Insights: Unsafe Abortion (August 2007)

have been in decline for over a decade.¹⁰⁶ DFID told us that it supported work in both these countries that helped bring about liberalisation.¹⁰⁷

52. DFID is one of the few donors actively to promote efforts to prevent unsafe abortion.¹⁰⁸ Witnesses agreed that DFID has played a leading role in focusing global attention on unsafe abortion and challenging policies and laws which act as barriers to progress in this area.¹⁰⁹ Baroness Vadera gave the example of an effective approach which been used in the Matlab region of Bangladesh, where women can come to “Menstrual Regulation Centres” in safety and without stigma.¹¹⁰ Family planning was also emphasised in Matlab as a way to prevent unplanned pregnancies.¹¹¹ Maternal mortality has decreased by over 50% in the region over the last 15 years due in part to a focus on preventing unsafe abortions.¹¹² **Unsafe abortion is responsible for tens of thousands of women dying each year and is a highly neglected public health challenge. We agree with DFID’s approach of not trying to impose abortion decisions on countries but seeking to support civil society where interest in changing the law and improving services already exists. In countries where abortion is illegal, we believe that DFID should continue to look for opportunities to help ensure women are aware both of the circumstances in which abortion is permitted and of the safe services that are available to them.**

53. Another example of DFID’s support to safe abortion services is its £3 million funding (over two years) of the Safe Abortion Action Fund (SAAF), launched in February 2006 and managed by IPPF. Denmark, Norway, Sweden and Switzerland have joined in support of the SAAF.¹¹³ The \$11.9 million fund attracted 172 applications totalling \$43 million in its first call for funding (for advocacy, action-oriented research and/or service delivery) demonstrating the high demand for action that exists.¹¹⁴ An “extremely rigorous process of technical review” carried out by an independent panel (with DFID and other donor representation) identified 45 final recipients.¹¹⁵ Dr Gill Greer, Executive Director of IPPF, assured us that “clear expectations are in place for monitoring and evaluation” and said that there would be a “clear audit trail on expenditure”.¹¹⁶ The first results of the projects will be available a year after they started (roughly July 2007).¹¹⁷ In written evidence, IPPF told us:

“DFID has advocated for other donor governments to commit towards the SAAF and should continue to do so [...] DFID should continue to fund and increase its

106 Ev 159-160

107 Ev 98 and Q 270 [Baroness Vadera]

108 Ev 87

109 Ev 117 and Ev 203

110 Q 312 [Baroness Vadera]

111 Ev 89

112 Ev 89 and C. Ronsmans and W. Graham ‘Maternal mortality: Who, when, where and why?’, *The Lancet Maternal Survival Series* (September 2006), p. 16

113 Ev 98

114 Q 227 [Dr Gill Greer]

115 Q 227 [Dr Gill Greer]

116 Qqs 227 and 230 [Dr Gill Greer]

117 Q 228 [Dr Gill Greer]

funding for the SAAF given the fact that we received in excess of 130 proposals—testament to the size of the need.”¹¹⁸

54. The hugely oversubscribed first call for funding from the Safe Abortion Action Fund (SAAF) demonstrates the size of the need for funds to improve abortion services. We agree that DFID should continue to advocate for new donors to contribute to the Fund and if, following evaluation results, there is sound evidence for the effectiveness of the SAAF, we believe that DFID should also consider a substantial increase in its own support for the Fund.

3 Securing political will: global strategies for maternal health

55. Women's health is both their individual human right and of critical importance to a country's social, economic and political development. Yet it is rarely a political priority, even though world leaders signed up in 2000 to meeting MDG 5. Progress on MDG 5 is vital to the achievement of MDG 4 which is seeking to reduce child mortality¹¹⁹ and to most other MDGs.¹²⁰ As we said earlier, we believe the lack of progress on MDG 5 represents in large part a failure of international advocacy and of political will at national level to prioritise resources and interventions to improve maternal health.¹²¹

56. Evidence submitted jointly by NGOs saw 2007–08 as a crucial year to galvanize international efforts to improve maternal health, with new leaders appointed in several G8 countries and within a number of the multilateral bodies working on health, including the World Bank, the World Health Organization and the Global Fund to Fight AIDS, TB and Malaria.¹²² 2007 marked 20 years of the Safe Motherhood Initiative, a global advocacy movement to reduce maternal deaths, with a key international conference ('Women Deliver') and a chance to re-group and find ways to drive progress on MDG 5.¹²³ This chapter will draw upon evidence submitted to our inquiry to explore the reasons why international advocacy has thus far failed to ignite sufficient political commitment to ensure action, and assess how DFID could strengthen the global effort and boost political will.

The UN: challenges and opportunities in its current approach

57. Witnesses believed that the UN bears significant responsibility for the lack of global leadership and political will for improving maternal health.¹²⁴ A number of UN agencies, including the UN Population Fund (UNFPA), the UN Children's Fund (UNICEF) and the World Health Organization (WHO) have remits that include maternal health. DFID's health spend through these agencies for 2002–03 to 2006–07 is substantial and is set out in Table 1. DFID is one of the largest donors to UNFPA, was the second largest donor to UNICEF in 2006 and is the largest donor to WHO.¹²⁵

119 Ev 84-87. Because deaths of newborn babies around the time of birth form nearly 40% of total under-five deaths, efforts to reach MDG 5 overlap significantly with efforts to achieve MDG 4.

120 Ev 86

121 See Paragraphs 14-16.

122 Ev 110-111

123 Q 134 [Richard Horton]

124 Q 128 [Richard Horton] and Ev 163

125 Ev 100

Table 1 DFID expenditure on health through UN agencies

UN agency	DFID funding 2002–03 to 2006–07
UN Population Fund (UNFPA)	£77 million plus an extra £100 million over 5 years, announced in October 2007
The UN Children’s Fund (UNICEF)	£94.3 million
The World Health Organization (WHO)	£146 million
The Partnership for Maternal, Newborn and Child Health (hosted by WHO)	£1.25 million ¹²⁶

Source: Ev 90

58. UN agencies were criticised by a number of witnesses for being fragmented and incoherent: no single agency leads on maternal health and there is a lack of definition over respective roles.¹²⁷ Maternity Worldwide believed that the UN used an inconsistent approach across continents and countries.¹²⁸ Written evidence submitted by YozuMannion stated:

“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.”¹²⁹

The Network on Sexual and Reproductive Health and Rights highlighted the duplication of effort and poor co-ordination within the UN agencies. WHO, for example, has two separate departments with overlapping remits, Making Pregnancy Safer and Reproductive Health and Research, and also hosts the Partnership for Maternal, Newborn and Child Health.¹³⁰

59. Thoraya Obaid of UNFPA insisted that the remits of each agency were clear, but to us the list of roles seemed confusing:

“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; post-partum and care of mothers, et cetera, is UNFPA; and the management of newborns is UNICEF [...] WHO sets standards for us; they do the

¹²⁶ Ev 229. Figures for DFID expenditure from May 2005 to the present. DFID has contributed: £240,000 from May 2005-December 2006 as an initial contribution; £10,000 in specialist management consultancy support in August 2005; and £1 million towards the current Partnership workplan and the cost of advocacy for the Women Deliver conference. Further specialist management consultancy support and DFID’s future support are under consideration (Ev 229).

¹²⁷ For instance, Q 128 [Richard Horton]; Ev 228; Ev 163; and Ev 131

¹²⁸ Ev 163

¹²⁹ Ev 228

¹³⁰ Ev 219

protocols and guidance notes [...] They provide technical assistance to governments.”¹³¹

Ms Obaid said that on health more generally there were not just three but eight agencies trying to work together: the ‘H8’ coalition additionally includes the Global Alliance for Vaccines and Immunisation, the Global Fund to Fight HIV/AIDS, Malaria and TB, the World Bank and the Gates Foundation.¹³²

60. It is far from clear to us how the UN divides up responsibility for different aspects of maternal, newborn and child health. The overlapping remits between agencies has contributed to a lack of confidence in the UN as a global leader. Whilst maternal health is multi-factoral in nature and requires input from several agencies, we believe that a clearer delineation of each UN agency’s role needs to be set out and communicated widely.

61. Richard Horton, Editor of *The Lancet*, believed that the UN was failing to drive advocacy efforts not just at the global level but at the level of civil society. He said that the UN system, “frankly, does not work very well” and thought that DFID could play a “vital role, an increasing role, in trying to mobilise that global leadership which is absent now.”¹³³

62. When we asked about how DFID could seek to bolster the UN’s approach, Baroness Vadera agreed that there is a lot more “the UN could do in terms of impact and effectiveness.” She agreed that fragmentation has affected progress towards MDG 5, particularly as reaching the Goal is so dependent on strengthening health systems, for which co-ordination is important.¹³⁴ She said that DFID continues to “press very hard” for improved co-ordination between the UN agencies.¹³⁵

63. However, the Minister did see some signs for optimism within the UN, pointing out that the UN was trusted on the ground by countries which, particularly on sensitive issues, made it more effective.¹³⁶ Further, Baroness Vadera believed UNICEF and UNFPA to be showing “some signs of improvement.”¹³⁷ She also said that there was now a group of three women leaders at the top of WHO, UNICEF and UNFPA who could act as champions for maternal health.¹³⁸ However, these leaders’ remits clearly extend far beyond maternal health. We thus felt identifying specific champions to act as ambassadors for maternal health within the UN agencies would be useful and could have the added benefit of uniting UN efforts towards MDG 5.

64. The Minister also highlighted the DFID-funded ‘One UN’ Programme—a process being piloted in eight countries aiming for greater cohesion at the country level through

131 Q 5 [Thoraya Obaid]

132 Q 6 [Thoraya Obaid]

133 Q 128 [Richard Horton]

134 Qq 254 and 255 [Baroness Vadera]

135 Q 257 [Baroness Vadera]

136 Q 254 [Baroness Vadera]

137 Q 254 [Baroness Vadera]

138 Q 253 [Baroness Vadera]

one UN programme, one UN budgetary framework and one UN leader.¹³⁹ She was cautious about how long it would take to extend the programme beyond the initial pilot countries: “possibly” by 2010 seven to eight more countries would have rolled out the programme, but this depended on the evaluation of the eight pilots during 2008.¹⁴⁰ Thoraya Obaid of UNFPA also implied that extending this programme would take some time: “The [UN] General Assembly has taken a decision to study the eight pilots to see what we have learnt from them before proceeding further.”¹⁴¹

65. Fragmentation amongst UN agencies has slowed progress on MDG 5 and constrained the UN’s ability to provide global leadership on maternal health. We urge DFID to continue to press strongly for concrete actions that will sharpen co-ordination between UN agencies, including the rapid roll-out of the ‘One UN’ programme, and the appointment of official maternal health ‘champions’ within the UN.

Other major global initiatives

66. Over the last few years, concerns about parallel donor structures for the health MDGs and about the UN’s weak global leadership have brought about the creation of a number of international partnerships aiming to unite global efforts. As Thoraya Obaid of UNFPA told us, “We cannot have so many different initiatives that the countries themselves cannot deal with them.”¹⁴² Two recent partnerships have aimed specifically to co-ordinate and strengthen international advocacy for health: the Partnership for Maternal, Newborn and Child Health and the International Health Partnership.

The Partnership for Maternal, Newborn and Child Health

67. The Partnership for Maternal, Newborn and Child Health (PMNCH) was launched in 2005 to help harmonise and strengthen international efforts towards MDGs 4 and 5. It brought together three previously overlapping health partnerships: the Child Survival Partnership, the Healthy Newborn Partnership, and the Partnership for Safe Motherhood and Newborn Health.¹⁴³ The Partnership has three key aims:

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

68. The Partnership, hosted by WHO, has more than 80 members including UN and multilateral agencies, partner countries, NGOs, professional associations, bilateral donors and the academic community. DFID helped to establish the Partnership and provided

139 Q 255 [Baroness Vadera]. The eight pilot countries for the One UN programme are: Albania, Cape Verde, Mozambique, Pakistan, Rwanda, Tanzania, Uruguay, and Vietnam. The pilots will be evaluated during 2008.

140 Q 256 [Baroness Vadera]

141 Q 6 [Thoraya Obaid]

142 Q 14 [Thoraya Obaid]

143 Ev 100

funding of £1.25 million between 2005–2008.¹⁴⁴ The PMNCH does not itself disburse funds but offers advocacy and technical support. It has four main areas of activity co-ordinated by international working groups: Advocacy, Country Support, Effective Interventions, and Monitoring and Evaluation.¹⁴⁵

69. Despite being created primarily to address poor co-ordination amongst global maternal health actors, the Partnership was accused in written evidence from World Vision of failing to work in a co-ordinated manner:

“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.”¹⁴⁶

The submission went on to encourage DFID to “engage fully and take a leadership role within the PMNCH”, a view reiterated in the evidence submitted jointly by other NGOs.¹⁴⁷ Yet DFID resigned from the PMNCH Board at its most recent meeting in Addis Ababa in December 2007. Dr Stewart Tyson from DFID said that this was simply due to DFID’s pragmatic approach of rotating its membership of international boards in partnership with other donors.¹⁴⁸ However, Dr Tyson also said that DFID does not have the capacity to continue to serve on the management boards of all the global partnerships.¹⁴⁹ The Norwegian development agency will represent DFID on the Board for now.

70. Balancing internal capacity constraints with DFID’s international leadership role for maternal health is likely to get more difficult as civil service headcount restrictions continue to affect DFID. Fulfilling a pivotal role in this key international partnership, particularly during the initial years—when the Partnership will be at its most fragile—will certainly be less feasible if DFID does not sit on its Board. As Dr Francisco Songane of the Partnership told us, sitting on the Board allows donors to “exert influence to change the way institutions behave.”¹⁵⁰ We will return to the issue of DFID’s staff capacity for maternal health in Chapter 5. **Whilst we appreciate the need to balance membership of global partnership boards according to capacity and shifting priorities, we were concerned to hear that DFID has resigned from the Board of the Partnership for Maternal, Newborn and Child Health, particularly at a time when the need to accelerate progress towards MDG 5 is so acute. We urge DFID to return to the Board as soon as staff capacity permits, and in the meantime to work closely with the Norwegian Government to ensure DFID’s leverage and push for co-ordination is retained within the Partnership.**

144 Ev 229, Ev 214, Ev 218 and Q 268 [Dr Stewart Tyson]. See Footnote 126 for a breakdown of DFID’s contributions to the PMNCH.

145 See <http://www.who.int/pmnch/activities/en/> for further information.

146 Ev 225

147 Ev 112

148 Qq 268-269 [Dr Stewart Tyson]

149 Q 268 [Dr Stewart Tyson]

150 Q 9 [Dr Francisco Songane]

The Global Campaign for the Health MDGs

71. This international campaign was launched in September 2007 and brings together several inter-related initiatives on the health MDGs, including the International Health Partnership, the Norwegian-led Network of Global Leaders, the Global Fund to Fight AIDS, TB and Malaria (which we will assess in the following sub-section) and the advocacy and communications drive *Deliver Now for Women & Children*, co-ordinated by the PMNCH.¹⁵¹ This sub-section will focus primarily on the International Health Partnership, which has been led by the UK.

72. The International Health Partnership (IHP) was launched on 5 September 2007 as a way to help aid agencies work together more effectively on the three health MDGs, thereby reducing duplication and the time needed at country level to process individual donor demands and meet reporting requirements.¹⁵² The IHP does not disburse funds but is a co-ordinating framework aimed at making the aid process simpler and more effective for both recipient countries and donors themselves—a practical attempt to implement the 2005 Paris Declaration on Aid Effectiveness within the health sector.¹⁵³

73. The UK played a strong role in the creation of the IHP and the launch was announced by the Prime Minister. Eight ‘first wave’ pilot countries are participating initially.¹⁵⁴ These countries sign a compact that involves commitments from them and the donors, including measurable targets that are agreed by both. Evidence we received from NGOs said that the compact needs to ensure the active involvement of national and international civil society and professional organisations, who could help to track progress of the compact in line with the Global Health Partnership Principles.¹⁵⁵

74. The UK’s leadership in launching the IHP was widely recognised in the evidence we received.¹⁵⁶ However, evidence from the Peoples’ Health Movement and Global Health Watch Secretariat was concerned that the IHP will be hard to deliver, especially given that it does not bring with it major new finance and that “operational guidance” in-country may be constrained given DFID’s own headcount restrictions.¹⁵⁷ Evidence also highlighted that the IHP will only be possible to implement effectively if the necessary resources—health staff, medicines and supplies—and a functioning health system exist at country level.¹⁵⁸ It was significant that Baroness Vadera also emphasised to us the importance of implementation in connection with the IHP.¹⁵⁹ **DFID deserves credit for spearheading**

151 More information on the Global Campaign for the Health MDGs is available at www.norad.no/default.asp?FILE=items/9244/108/GlobalCampaignHealthMDGs.pdf

152 Participating donors in the IHP include: the UK, Norway, the Netherlands, Germany, Canada, France and a number of multilateral agencies.

153 The Paris Declaration was agreed in 2005 by over 100 ministers and aid agencies as a commitment to improve the effectiveness and harmonisation of aid.

154 The eight pilot countries are Burundi, Ethiopia, Kenya, Mozambique, Zambia, Mali, Cambodia and Nepal.

155 The five Global Health Partnership Principles are: ownership, alignment, harmonisation, managing for results and accountability. For further details see ‘The High Level Forum for Health: Best Practices and Principles for Global Health Partnerships’, online at <http://www.hlfhealthmdgs.org/Documents/GlobalHealthPartnerships.pdf>

156 Ev 159, 170 and 214

157 Ev 172

158 Ev 120 and 214-215

159 Q 288 [Baroness Vadera]

the International Health Partnership. We were pleased to see this practical application of the Paris Declaration on Aid Effectiveness and hope it will help both recipient countries and donors to maximise development assistance for health. DFID must maintain its leadership role and help drive the IHP's implementation phase, ensuring that parallel donor efforts to strengthen health systems are delivered.

75. Marie Stopes International said that the IHP's proposed shift towards greater government ownership of national health plans "further intensifies the importance of effective advocacy in-country."¹⁶⁰ As we said in Chapter 1, advocacy is a key tool in empowering women to achieve their right to health and in creating the momentum to prioritise resources for maternal health such as sufficient numbers of health personnel and improved hospitals and clinics.¹⁶¹ Such advocacy relies on commitment from governments to put maternal health high on the political agenda, and on the recognition that different government ministries need to work together to enable this.¹⁶² However, evidence from the UK Network on Sexual and Reproductive Health and Rights perceived there to have been a failure to involve civil society and national governments—in both developed and developing countries—in devising and implementing the IHP.¹⁶³ **Greater national ownership of health policies, as envisaged by the IHP, is dependent on effective advocacy for improved health by governments. We recommend that DFID use its leadership role to ensure that governments and both national and international civil society groups are fully involved in the implementation of the IHP so that successful advocacy for improved health takes place in tandem with improved aid effectiveness.**

76. There were also concerns about the initial limitation of the IHP to eight pilot countries. Dr Francisco Songane of the Partnership for Maternal, Newborn and Child Health 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."¹⁶⁴

Baroness Vadera said that the eight countries represent a wide range of contexts and that there is interest in joining the IHP from many countries.¹⁶⁵ DFID was trying to encourage the same countries participating in the 'One UN Programme' initiative to join the IHP in the spirit of co-operation (although we noted that the only country participating in both initiatives currently is Mozambique).¹⁶⁶ The Minister also said that there was no need to wait for the reviews to be completed and that DFID was flagging up the IHP principles to countries not currently involved so that they could begin to look at them.¹⁶⁷ **We recommend that DFID and the other organisations involved in the IHP take steps to**

160 Ev 159

161 See Paragraphs 14-16

162 Q 2 [Thoraya Obaid] and Q 24 [Dr Grace Kodindo]

163 Ev 215

164 Q 9 [Francisco Songane]

165 Qq 287-288

166 Q 257 [Baroness Vadera]

167 Q 289 [Baroness Vadera]

ensure that the process of reviewing pilot countries is managed promptly and efficiently. Assuming successful reviews emerge, the IHP should then be extended to other interested countries as soon as possible.

Seizing opportunities

77. A number of new openings and opportunities for addressing the failure of advocacy and the lack of political will for improved maternal health came to our attention over the course of the inquiry. In this section we assess how DFID and other donors can capitalise on these opportunities. We also consider specific ways in which DFID could help step up global advocacy efforts for maternal health.

The Global Fund to Fight AIDS, TB and Malaria

78. One institution which we believe could contribute more to global efforts on maternal health is the Global Fund to Fight AIDS, TB and Malaria, an international financing mechanism aiming to increase resources for the three major infectious diseases. The Fund operates as a partnership between governments, civil society groups and the private sector. Since its inception in 2001, the Fund's first two rounds of grant-making have issued US\$1.5 billion of funding to support 154 programmes in 93 countries worldwide. DFID sits on the Fund's Board and is a key donor to the Global Fund, having committed £359 million through to 2008.¹⁶⁸

79. Historically, policy and financing strategies for HIV/AIDS, TB and malaria on the one hand and sexual, reproductive and maternal health on the other have developed separately.¹⁶⁹ This has resulted in HIV programmes diverting resources earmarked for maternal health in some settings; for example, in South Africa where midwives were moved from maternity care to work on prevention of mother to child transmission of HIV.¹⁷⁰

80. The accepted approach is now to support the integration of the two issues, given the series of intersections between them. HIV positive women are four times more likely to die in pregnancy or childbirth than women without HIV infection.¹⁷¹ More than two million HIV positive women become pregnant each year and face a higher risk of succumbing to infectious diseases such as tuberculosis and malaria—in terms of incidence and severity—than non-HIV positive mothers. Furthermore, pregnancy itself increases the risk of HIV infection; this is thought to be due to a combination of physiological and behavioural factors.¹⁷²

81. The implementation of integrated responses to HIV and sexual, reproductive and maternal health has been disappointing thus far, including in programmes funded by the

168 Q 269 [Baroness Vadera]

169 Q 180 [Catharine Taylor]

170 Ev 153

171 Ev 86

172 Nel Druce and Anne Nolan, 'Seizing the Big Missed opportunity: Linking HIV and Maternity Care Services in Sub-Saharan Africa', *Reproductive Health Matters* Vol 15, Issue 30 (November 2007), p.190

Global Fund.¹⁷³ This is despite the fact that integrated interventions can address the two issues very effectively, through, for instance: condom provision; prevention of mother-to-child transmission of HIV; and reproductive health programmes for adolescents and young people.¹⁷⁴ Ensuring that screening and treatment for sexually transmitted infections including HIV are available at family planning clinics is of key importance. Attending such clinics is often routine for women and thus the stigma attached to HIV testing is removed.¹⁷⁵ Witnesses agreed that the Global Fund should do more to support integrated HIV, maternal, sexual and reproductive health interventions, for instance the training of skilled birth attendants.¹⁷⁶

82. There are signs that that this lack of integration may be about to change: DFID itself has a well-integrated maternal health and HIV programme in Zimbabwe,¹⁷⁷ and a number of national proposals submitted to the Global Fund in 2007 incorporate sexual and reproductive health programming in addition to HIV.¹⁷⁸ At the Fund's most recent Board meeting it was agreed that a gender strategy would be developed, enabling a closer link between the Fund's work and maternal and women's health concerns.¹⁷⁹

83. Baroness Vadera felt that generally there were new opportunities to work with the Fund. Whilst she was frank about “the fact that we have some issues” with the Fund—she even said that the Fund “fixated” her—she spoke encouragingly of the new Director, Dr Michel Kazatchkine.¹⁸⁰ Further, the Minister was pleased that the Fund had signed up to the IHP, a step that she believed would increase DFID's and other donors' ability to engage with the Fund.¹⁸¹ **We believe that DFID and other donors should build on a series of opportunities at the Global Fund to Fight AIDS, TB and Malaria—its new Director, gender strategy and membership of the International Health Partnership—and should encourage the Fund to support more maternal health care interventions which have direct relevance to these three diseases as well as to health systems strengthening.**

84. Peter Godfrey-Faussett of the Global Fund emphasised to us that the Fund uses a demand-driven process. He believed it to be the role of donors, rather than the Fund, to advise partner countries on improved integration between HIV/AIDS and reproductive/maternal health strategies: “The Global Fund does not decide what countries should ask for [...] it is more up to DFID, WHO, more technical agencies, to be encouraging countries with what they could apply for.”¹⁸² He thought that engaging

173 Nel Druce et al, 'Strengthening linkages for sexual and reproductive health, HIV and AIDS: progress, barriers and opportunities' (DFID Resource Centre, 2006), p.3

174 WHO HIV Technical Briefs, 'Strengthening Linkages between Sexual and Reproductive Health and HIV' (April 2007), p.2

175 Q 186 [Catharine Taylor] and Q 238 [Dr Gill Greer]

176 Q 197 [Catharine Taylor]

177 Q 180 [Catharine Taylor] and Ev 95

178 Marge Berer, 'Maternal Mortality and Morbidity: Is Pregnancy Getting Safer for Women?', *Reproductive Health Matters* Vol 15, issue 30, p.6

179 Q 280 [Baroness Vadera]

180 Q 269 [Baroness Vadera]

181 Q 269 and Q 280 [Baroness Vadera]

182 Qq 198-200 [Peter Godfrey-Faussett]

countries in a closer dialogue about their priorities would help here.¹⁸³ He said that strengthening health systems—a key condition for progress in improving maternal health as well as fighting infectious diseases—was “an entirely legitimate use of the Fund’s money” but that “to date countries have not availed themselves of that resource as they might.”¹⁸⁴

85. Whilst we appreciate that it would be inappropriate for the Fund to control the nature of applicants’ proposals, it seemed to us that the Fund could do more to encourage proposals for funding of maternal, sexual and reproductive health projects. Baroness Vadera believed that the Global Fund was open to funding such interventions but that this willingness needed to be made clearer to countries.¹⁸⁵ **We believe that the Global Fund needs to communicate more clearly its willingness to accept funding proposals for maternal, sexual and reproductive health programmes—particularly those integrated with HIV/AIDS, TB and malaria interventions—to countries seeking funds. DFID should use its Board membership to help encourage a closer dialogue between the Fund and its recipients so that there is a clearer understanding of how the Fund’s resources can be spent.**

The Japanese Presidency of the G8

86. Japan has said that it will use its G8 presidency in 2008 to lead an international health drive aiming to get the world back on track in meeting the MDGs.¹⁸⁶ Baroness Vadera told us that this is likely to include a specific focus on health systems and maternal mortality.¹⁸⁷ Japan will host the G8 summit in July 2008 and has also invited African leaders in May for the fourth summit of its Tokyo International Conference on African Development (TICAD) initiative.

87. In his oral evidence, Richard Horton suggested that DFID should engage with the Japan G8 agenda to ensure a focus on maternal health:

“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.”¹⁸⁸

Baroness Vadera told us she had met with the Japanese G8 ‘Sherpa’ and had “influenced” his speech about the importance of maternal health. She said she planned to visit Japan in February 2008.¹⁸⁹ She was hopeful that the other G8 members would agree to make health a priority in 2008.¹⁹⁰ We hope that her successor will now follow this initiative. **We were**

183 Q 199

184 Q 200 [Peter Godfrey-Faussett]

185 Q 281 [Baroness Vadera]

186 Agence France-Presse, ‘Japan’s G8 to focus on global health: foreign minister’, 25 November 2007. Online at http://afp.google.com/article/ALeqM5h-77yuLhieJL_rieyf6vmwi9Nvwg

187 Q 252 [Baroness Vadera]

188 Q 133 [Richard Horton]

189 Q 252 [Baroness Vadera]

190 Q 275 [Baroness Vadera]

pleased to hear that DFID is engaging with Japan regarding its Presidency of the G8 in 2008. DFID should support Japan to realise its pledge to make health—and maternal health especially—a key priority for the Presidency. This should include advocating for this prioritisation amongst other G8 members.

The UK's role in stepping up advocacy

88. In addition to the two specific opportunities outlined above, we believe there are several other ways in which DFID could help step up global advocacy efforts for maternal health. Baroness Vadera agreed that political leadership and advocacy for maternal health were “very central” in 2008 and that DFID needed to “up its game” and “push harder in terms of international advocacy”. She said that the Prime Minister is keen to push on MDG 5 specifically during 2008, including at the UN General Assembly meeting on the MDGs in the autumn.¹⁹¹ **We are pleased that DFID recognises the need to step up its efforts on international advocacy. We will keep a watching brief on how these efforts are translated into action during 2008, especially at the UN General Assembly meeting on the MDGs in the autumn.**

89. The Minister emphasised that, in parallel with global efforts, advocacy for maternal health was needed within countries.¹⁹² She thought one route to supporting this would be to establish champions for the issue and told us that DFID was talking to the Elders Group—a network of 12 men and women including Nelson Mandela and Archbishop Desmond Tutu created to address global problems by offering expertise and guidance—about how to establish champions.¹⁹³ DFID already supports national civil society groups which train ‘change agents’ and lobby senior political and traditional leaders to support health, for instance the Change Agent Programme at the Health Reform Foundation of Nigeria.¹⁹⁴ **We agree that supporting specific maternal health champions and change agents in developing countries is a good idea. We recommend that DFID pursue its discussions about empowering such champions with the Elders Group.**

90. Richard Horton of *The Lancet* believed that the scientific research community could play a major role and mobilise itself more effectively in strengthening advocacy efforts, especially in-country where “science for civil society” can have a profound impact.¹⁹⁵ This kind of science did not mean “stuff that goes on in the lab or even clinical trials”, but practical research applications and monitoring of government policies so that countries can work out why women are dying and how to prevent deaths.¹⁹⁶ This could act as “a kind of accountability mechanism [...] I do not say it is about shaming, but it is about naming, and in a very public sense.”¹⁹⁷ **The scientific research community is an advocacy mechanism in its own right and should be supported by donors so that it mobilises itself more effectively. This is particularly important within developing countries where**

191 Q 251 [Baroness Vadera]

192 Q 252 and Q 314 [Baroness Vadera]

193 Q 252 [Baroness Vadera]

194 For more details, see <http://www.herfon.org/aboutus.html>

195 Q 141 and Q 149 [Richard Horton]

196 Q 137 [Richard Horton]

197 Q 138 [Richard Horton]

research can be applied practically as a way to inform and monitor government policies for maternal health.

91. What Baroness Vadera did not support was the establishment of a 'global fund for women's health', a call that had emerged from the Ministers Forum at the October 2007 'Women Deliver' conference. She believed another separate, parallel structure would only create further confusion and that a global advocacy campaign built around the Japanese G8 and the other initiatives set out above was far more sensible.¹⁹⁸ We believe this to be the correct approach. **We agree that focusing intensified global advocacy efforts around existing processes, such as the 2008 Japanese G8 Presidency and the UN General Assembly's meeting on the MDGs in the autumn of 2008, is likely to be more effective than creating a separate global fund for women's health.**

4 Strategies for success

92. This chapter will address strategies that have been shown to work in improving maternal health, and assess whether they can be replicated in other contexts and at scale. A number of promising approaches have been explored earlier in this report; for instance, the IMAGE microfinance, HIV and gender equity project in South Africa described in Chapter 2. A particular focus in this chapter will be what has worked in strengthening health systems—health workers, equipment and supplies (including essential drugs), clinics and infrastructure—and how donors can balance these supply-side approaches with appropriate demand-side interventions as discussed in Chapter 2. The chapter will also look specifically at successful approaches to improving maternal health in conflict-affected and fragile states. Finally, the chapter will address the crucial question of strengthening the measurement of progress in maternal health.

What works in preventing maternal deaths

The example of Nepal

93. One country which was frequently mentioned when we asked witnesses for examples of successful donor support to maternal health was Nepal. In 1996, Nepal was reported as having one of the highest levels of maternal mortality in the world. This was due to several inter-related factors such as: low access to family planning; high prevalence of early marriage; the prohibition of abortion; low uptake and provision of skilled birth attendance; and limited availability of emergency obstetric care.¹⁹⁹

94. A decade later, Nepal was reported to have experienced a significant decline in its maternal mortality ratio (MMR), from 539 in 1989–1995 to 281 per 100,000 live births for the period 1999–2005.²⁰⁰ The DFID-supported Nepal Safe Motherhood Project (1997–2004) and Support to Safe Motherhood Programme (SSMP, running from 2004–2009 with £20 million DFID funding) were credited by witnesses as playing a key role in this reduction.²⁰¹ It is important to note, however, that there is debate over the true extent of the maternal mortality reduction, since there are wide and almost overlapping lower and upper limits for the MMR estimates of 581 for the period 1989–1995 and of 281 for 1999–2005 (392 to 686 versus 178 to 384 respectively).²⁰² The SSMP told us that there was sufficient circumstantial evidence to suggest that a real decline has taken place.²⁰³

199 Ev 159-160

200 Ev 207

201 Ev 160 and Q 245 [Dr Gill Greer]

202 Ministry of Health and Population (MOHP) [Nepal], New ERA, and Macro International Inc. 2007. *Nepal Demographic and Health Survey 2006*. (Kathmandu, Nepal: Ministry of Health and Population, New ERA, and Macro International Inc.).

203 Ev 207-208

95. The SSMP takes a multi-pronged approach that seeks to assist policy formulation, provide safe abortion services, improve emergency care and strengthen infrastructure.²⁰⁴ DFID funds are given in the form of financial aid, technical assistance and direct support to UNICEF, the agency which helps to implement the programme.²⁰⁵ The Towards 4+5 Research Programme Consortium highlighted a number of specific achievements under SSMP: support to emergency obstetric care; the training of more skilled birth attendants; the integration of maternal health work with the national health programme; and a financial incentive scheme to encourage women to have their deliveries in health facilities (as we described in Paragraph 41).²⁰⁶ **We applaud DFID for its contribution to the Nepal Safe Motherhood Project and Support to Safe Motherhood Programme, which have included a range of interventions relevant to maternal health in Nepal over a decade that has witnessed progress in reducing maternal mortality. We urge DFID to support independent comprehensive evaluations of this experience, with a view to sharing lessons in the region and globally.**

96. Another DFID-supported project in Nepal highlighted to us was the ‘women’s group’ approach, conducted as a research study, whereby groups were supported at village level to carry out advocacy for safer births, build awareness of maternal complications, promote hygiene and prevent delays in seeking care.²⁰⁷ Evaluations of the approach suggest that neonatal survival benefits will be significant, with the possibility also of a direct effect on maternal survival (although this was not the main outcome being measured).²⁰⁸

97. Possibilities for replication of the ‘women’s group’ approach appear high and trials to assess this are being conducted in Bangladesh, India, Pakistan and Malawi.²⁰⁹ The Towards 4+5 Research Programme Consortium stated:

“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.”²¹⁰

98. Dr Gill Greer, Director General of IPPF, was cautiously optimistic that the DFID-supported wider programme in Nepal had potential for replication.²¹¹ However, YozuMannion criticised DFID for not already taking the opportunity to replicate successes from Nepal elsewhere.²¹² Dr Stewart Tyson from DFID was wary about replicating “too much” and thought that many of the innovative approaches used “may or may not be

204 Ev 208-210

205 Ev 95

206 Ev 152

207 Ev 155 and Anthony Costello et al, ‘An alternative strategy to reduce maternal mortality’, *The Lancet* maternal Survival Series (September 2006), p.10

208 Ev 154

209 Ev 154

210 Ev 155

211 Q 245 [Dr Gill Greer]

212 Ev 227

transferable.”²¹³ Baroness Vadera underlined the need to show caution in attempting to reproduce context-specific approaches.²¹⁴ **We urge DFID to look closely at options for replicating successful approaches from Nepal where appropriate, and to identify factors relevant to scaling-up and transference. We appreciate that success is often context-dependent, but believe the DFID-funded approach to supporting women’s groups, as in Nepal, is worthy of particular consideration wherever relevant.**

What works in strengthening health systems

Boosting human resources

99. ‘Health systems’ encompass infrastructure and equipment, human resources, financing and the various processes that enable staff to work with a system, such as communication.²¹⁵ Aspects of health systems strengthening that are particularly significant for maternal health relate to how the coverage and quality of skilled birth attendance at delivery and emergency obstetric care can be best improved. This often comes down to the issue of increasing the availability of skilled human resources.²¹⁶ In its written submission, the Royal College of Obstetricians and Gynaecologists identified the management of skilled human resources as “the most challenging aspect of MDG 5”.²¹⁷

100. Evidence we received welcomed the focus on health system strengthening within DFID’s health strategy.²¹⁸ Immpact’s written evidence stated that “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.”²¹⁹

101. Several inter-related aspects of human resources issues struck us as needing urgent attention if progress is to be made on maternal health. The first concerns the sheer numbers of health professionals needed if more women are to deliver with a skilled attendant and to have ready access to emergency care should the need arise. There is an estimated global deficit of 2.4 million health workers, including 700,000 midwives alone.²²⁰ Midwives are crucial to the achievement of MDG 5 as they provide both skilled birth attendance and some aspects of emergency obstetric care, if the right equipment and supplies are present. Dr Nynke van den Broek of the Liverpool School of Tropical Medicine told us that seven out of the eight key functions of obstetric care could be performed by midwives, including caesarean sections and blood transfusions.²²¹

213 Q 308 [Dr Stewart Tyson]

214 Q 308 [Baroness Vadera]

215 Sanders D. and Haines A., ‘Implementation Research is Needed to Achieve International Health Goals’, *Public Library of Science Medicine* Vol 3, Issue 6 (2006), online at <http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0030186> (cited Ev 152)

216 Ev 152-153

217 Ev 184

218 Ev 136

219 Ev 152

220 Q 10 [Thoraya Obaid]

221 Q 12 [Dr Francisco Songane]

102. However, the quality of care that a midwife is able to provide will depend on their training and the wider health system in which they are working.²²² Using unqualified staff can worsen many obstetric complications.²²³ In many regions, especially rural areas, training opportunities are sparse and of poor quality: Dr Monir Islam from WHO told us of a midwifery training school he had recently visited in Zimbabwe that had just one book and three teachers between 120 students.²²⁴ Evidence from the Royal College of Obstetricians and Gynaecologists stated that “countries where progress towards MDG 5 has been achieved are those where midwifery as well as medicine is highly professionalised and well-recognised, including at government level.”²²⁵

103. One written submission suggested that action-oriented research is needed into where staff shortages are most acute, what training is available and how midwives are paid and employed.²²⁶ This would help target policies to address the human resource crisis. Similar research on clinical officers and medical assistants would also be helpful. The Peoples’ Health Movement and Global Health Watch Secretariat suggested that DFID should consider working with the Global Health Workforce Alliance and the Alliance for Health Policy and Systems Research to help fill such a knowledge gap.²²⁷ **We were concerned to learn the extent of the global shortfall in health workers, particularly the lack of midwives. Boosting the numbers of midwives worldwide will be central to the achievement of MDG 5. Increasing the availability and quality of training opportunities for midwives is therefore of paramount importance. DFID should consider supporting action-oriented research into where human resource shortages and training needs are particularly acute and the options for addressing them in the short, medium and long term.**

104. As Thoraya Obaid of UNFPA told us, health professionals should not only be well-trained but enjoy good working conditions, not least so that trained medical and midwifery staff do not migrate to more financially rewarding and satisfying jobs outside their home country (the so-called ‘brain drain’).²²⁸ The UK Government has recently implemented a policy of avoiding the active recruitment of health care workers from developing countries for the NHS and this step was applauded in written evidence.²²⁹

105. Persuading staff not only to stay in their home country but to work in rural and remote areas is a key issue for donors and governments. In south and south-east Asia, the key human resources issue is not primarily one of absolute shortages but of poor distribution. In India, for example, a national assessment found that just 6% of the required obstetricians and 27% of the required nurses and midwives are currently deployed in rural

222 Q 101 [Dr Nynke van den Broek]

223 Q 102 [Dr Monir Islam]

224 Q 97 [Dr Monir Islam]

225 Ev 184

226 Ev 173

227 Ev 173

228 Q 7 [Thoraya Obaid]

229 Ev 138

settings.²³⁰ Brigid McConville from the White Ribbon Alliance told us of a successful five-year advocacy campaign in Tanzania to persuade the Government to deploy more skilled birth attendants in rural areas. This has resulted in a doubling of health workers in some areas.²³¹ Ms McConville believed that DFID should support civil society to lobby governments for better salaries and incentives to work in rural areas.²³² The Royal College of Obstetricians and Gynaecologists said that DFID should fund projects that encourage health professionals to work in rural areas by offering financial, social and professional support.²³³ **We believe that DFID and other donors should find new ways to help governments encourage health professionals to provide quality services in remote and rural areas. This should include supporting civil society to lobby for better salaries and conditions for doctors and midwives working outside urban areas and to ensure the necessary infrastructure, supplies, transport and equipment are in place to enable these professionals to provide prompt and effective care.**

106. Recruitment, the brain drain and training and deployment of staff are all addressed under DFID's Emergency Human Resources Programme (EHRP) in Malawi (funded with £55 million over six years, 2005–2011). Malawi's human resources crisis is acute, partly because of the HIV/AIDS epidemic. The country's maternal mortality ratio (MMR) is estimated as 1,100 deaths per 100,000 births, making it one of only 11 countries worldwide with an MMR of over 1000.²³⁴ The EHRP has several main elements:

- improving incentives for recruitment and retention of Malawian staff (including salary top-ups);
- using international volunteer staff in the interim whilst more Malawians are being trained;
- expanding domestic training capacity for doctors and nurses/midwives by over 50%; and
- strengthening Ministry of Health capacity to manage, monitor and evaluate human resources.

The programme specifically addresses career development and incentives for deploying staff to under-served areas.²³⁵

107. DFID says that since the programme began in 2005, provisional results are promising. Staff across the cadres of health professionals increased by 450 in the first 9 months, 60 volunteers have been recruited to fill gaps, training schools have increased intakes and there has been a significant decline in the number of nurses leaving the country to work

230 Malay Kanti Mridha and Marge Koblinsky, 'Shortages and shortcomings: the maternal health workforce crisis' in *Id21 Insights Health* no.11, August 2007

231 Q 125 [Brigid McConville]

232 Q 125 [Brigid McConville]

233 Ev 186

234 UNDP *Human Development Report 2007-2008*

235 Ev 172-173

abroad.²³⁶ Whilst several witnesses cautioned that it was too early to show confirmed results,²³⁷ the Peoples' Health Movement and Global Health Watch were impressed with the Programme and were keen to replicate it elsewhere:

“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 human resources plan for the health sector, many problems will be resolved.”²³⁸

Other evidence questioned why the EHRP is not being replicated by DFID elsewhere.²³⁹ **DFID deserves credit for its support to the Emergency Human Resources Programme in Malawi, for which initial results show expanded staff numbers and better uptake of training. We recommend that DFID move swiftly to support the replication, where appropriate, of efforts to address human resources problems as soon as conclusive results are available.**

Increasing the availability of equipment and supplies

108. The effective delivery of maternal health care relies on access to essential supplies and equipment, yet major shortages of even the most basic drugs, commodities and medical apparatus exist in many developing countries. The reality of giving birth in a facility with empty blood banks, no saline solution for drips and no routine medicines for complications was vividly conveyed by Dr Grace Kodindo, an obstetrician from Chad, in evidence to us and in her BBC Panorama film, *Dead Mums Don't Cry*.²⁴⁰

109. At the time of filming the Panorama programme, one very basic drug—magnesium sulphate, used to treat eclampsia—was not available anywhere in Chad. Given that the drug is extremely cheap—“cheaper than table salt” as Brigid McConville told us—yet also highly effective we could not understand why access is so limited in some developing countries.²⁴¹ Magnesium sulphate is not on the Essential Drugs Lists of many African countries and Dr Kodindo thought it vital that it be included.²⁴² **We were concerned to hear about the lack of even very basic supplies and medicines in many developing countries. We recommend that donors, including DFID, work with the World Health Organization to advocate with national governments for national Essential Drugs Lists to contain drugs such as magnesium sulphate, which are crucial to maternal survival.**

110. IPPF’s evidence explained that the reasons for the shortages of basic drugs and supplies largely stemmed from insufficient funding, but also included: inadequate

236 DFID, *Maternal Health Strategy – Reducing maternal deaths: evidence and action, Second Progress Report* (April 2007), p.11

237 Ev 189 and 152

238 Ev 173

239 Ev 170 and Ev 113

240 Q 23 [Dr Grace Kodindo] and BBC Panorama, *Dead Mums Don't Cry* (2005)

241 Q 129 [Brigid McConville]

242 Q 23 [Dr Grace Kodindo]. Essential Drugs Lists are formularies used by many countries to set out what are considered essential medicines.

forecasting of supply needs; weak distribution systems within countries; and regulatory, tariff and tax barriers that hinder importation and provision.²⁴³ Dr Kodindo explained that blood shortages were often due to a lack of appropriate storage and refrigeration—also a problem for some major obstetric drugs, including oxytocin—and also to cultural beliefs discouraging blood donation.²⁴⁴ In rural areas, few hospitals will have blood banks.²⁴⁵ Yet women with anaemia—a very common condition amongst poor rural communities—can deteriorate or die very quickly even after minor bleeding.²⁴⁶

111. Achieving the additional MDG 5 target of “universal access to reproductive health” will be dependent on addressing shortages of modern contraceptives and reproductive health commodities. Marie Stopes International said that many of their partner organisations are often forced to turn away a large proportion of clients at public clinics simply because they have run out of the basic contraceptive supplies.²⁴⁷ Addressing such shortfalls will also make a direct contribution to reducing maternal deaths, since unwanted and unplanned pregnancies contribute to high levels of unsafe abortion, as described earlier.²⁴⁸

112. DFID is a member of the Reproductive Health Supplies Coalition which was set up to provide global leadership in increasing the availability of reproductive health products.²⁴⁹ DFID admitted that family planning supplies are inadequately financed, both by national governments and global financing initiatives.²⁵⁰ Of 16 countries receiving DFID support in Africa, for example, only 10 have specific budget lines for sexual and reproductive health supplies. Further, direct donor support for family planning supplies and services fell from \$590 million in 1995 to \$460 million in 2003.²⁵¹ In October 2007, DFID did, however, announce an additional £100 million for UNFPA, to be spent on family planning.²⁵² **In addition to insufficient quantities of essential drugs, many countries have widespread shortages of other pre-requisites for maternal health and services, including adequate blood and family planning supplies. We believe that DFID should seek to build political commitment within countries to ensure that these crucial supplies are appropriately funded within national health plans and budgets. The Department should also campaign internationally for a reversal in declining budgets for family planning supplies and services.**

243 Ev 142

244 Qq 38 – 45 [Dr Grace Kodindo]

245 Q 41 [Dr Grace Kodindo]

246 Q 87 [Dr Sam Adjei]

247 Ev 159

248 See Paragraph 52

249 Ev 217

250 Ev 98

251 Ev 98

252 DFID Press Release, 18 October 2007, ‘UK Pledges £100 Million and Calls on World Leaders to Cut Maternal Deaths’ and Ev 229

Balancing the demand and supply-side of care

113. As *The Lancet's* series on Maternal Survival in 2006 made clear, the supply-side approaches described above need to be balanced with demand. The key constraints to maternal health vary significantly depending on the context and thus the challenge for donors lies in supporting the most appropriate configurations of care for the specific country or region. For example, where sufficient health care facilities are available but are under-used, demand-side approaches need to address issues such as transport and cultural barriers. However, where under-use is primarily due to supply-side constraints such as lack of drugs and supplies, insufficient health personnel and poor quality care, improvements in the supply-side need to be the priority.²⁵³

114. A well-performing health system will have an effective balance of demand and supply-side interventions. Countries which are struggling to meet MDG 5 often have an imbalance between the two and hence, in order to catalyse progress, governments and donors need to ensure that their assistance helps redress this imbalance, rather than making it worse.²⁵⁴ As Richard Horton of *The Lancet* emphasised to us: “You need dual approaches. You are not going to solve this by a purely top-down building of clinics and facilities. You have got to mobilise the grass-root support in villages.”²⁵⁵

115. In Chapter 5, we will address DFID’s use of budget support and other modes of financing for maternal health. But the importance of donors retaining oversight of programmes when using budget support for maternal health is worth noting. This is necessary to ensure that balance between supply- and demand-side interventions is achieved. **In order to achieve efficiently functioning health systems, there needs to be a balance of demand- and supply-side approaches. We believe that DFID needs to ensure that its support for demand- and supply-side approaches is flexible and reflects the needs of specific contexts, and that it is consistent with broader health systems strengthening in countries. Where budget support is being used, DFID and other donors should retain oversight of national programmes to ensure this balance is achieved. Monitoring systems need to be capable of tracking this balance.**

Working in conflict-affected and fragile states

116. In fragile states, many of which are affected by conflict, maternal mortality ratios can be 2.5 times higher than in more stable countries at similar levels of development and income.²⁵⁶ According to DFID, fragile states are those which have governments that cannot or will not deliver core functions to the majority of its people, including the poor.²⁵⁷ Fragile

253 Marge Koblinky et al, ‘Going to scale with professional skilled care’, *The Lancet* Maternal Survival Series (September 2006), pp.44-45

254 Lynn Freedman, ‘Health system strengthening: new potential for public health and human rights collaboration’, *Reproductive Health Matters* 2007, Vol 15 (30), pp.219-220

255 Q 128 [Richard Horton]

256 Q 158 [Giorgio Cometto] and Ev 201

257 DFID, ‘Why we need to work more effectively in fragile states’ (January 2005), online at <http://www.dfid.gov.uk/Pubs/files/fragilestates-paper.pdf>

states comprise 14% of the world's population but account for an estimated third of maternal deaths and almost half of all child deaths.²⁵⁸

117. There are both demand and supply aspects to poor maternal health in fragile and conflict settings.²⁵⁹ Women are often exposed to greater risk of sexual violence—and therefore sexually transmitted infections and unwanted pregnancies.²⁶⁰ It is estimated that in Liberia, for example, 60–75% of women of child-bearing age were forced into sex during the conflict between 1989 and 2003.²⁶¹ Conflict also constrains the supply-side of reproductive and maternal health services: health systems often collapse almost completely and geographical access is often more difficult because of insecurity and damaged infrastructure.²⁶² Health workers may move to safer areas.²⁶³ Post-conflict countries, such as Sierra Leone, often find it can take many years to re-build infrastructure and develop sufficient human resources to provide maternal health care.

118. DFID supports maternal health care in such settings in a number of ways. It funds NGOs and other organisations working on maternal health in many conflict-affected countries, including Somalia, Sudan, Liberia, DRC, Sierra Leone and Burundi.²⁶⁴ Supporting civil society organisations is important in fragile states because they often provide health services themselves where governments do not exist or are unable to provide services.²⁶⁵ DFID also supports multilateral agencies working in conflict settings, including WHO, UNFPA and UNICEF.²⁶⁶

119. The UN recently introduced a “cluster approach” for emergency responses that aims to enhance co-ordination between different humanitarian actors and strengthen service delivery on the ground.²⁶⁷ WHO is the lead agency for the cluster on health. Aasha Pai, Acting Regional Director for Africa and Latin America for Marie Stopes International broadly welcomed the cluster initiative as a serious attempt to improved co-ordination between different agencies.²⁶⁸ Co-ordination is crucial given the presence of multiple partners in emergency situations.²⁶⁹

258 IDS Health Systems Reporter, 'Contracting for health service delivery in fragile states' (January 2007). Online at www.eldis.org/go/topics/resource-guides/health-systems/health-systems-reporter

259 Q 158 [Aasha Pai]

260 Ev 102 and Q 157 [Aasha Pai]

261 Q 158 [Giorgio Cometto]

262 Q 158 [Giorgio Cometto]

263 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), p.VI

264 Ev 103

265 Ev 202

266 Ev 102-103

267 For further discussion of the UN cluster approach, see Seventh Report by the Committee, Session 2005–06, *Humanitarian Response to Natural Disasters*, HC 1188

268 Q 169 [Aasha Pai]

269 Q 161 [Giorgio Cometto]

120. However, evidence from the RAISE initiative²⁷⁰ expressed concern that the cluster approach fails to integrate sexual and reproductive health services as a core part of humanitarian responses.²⁷¹ Marie Stopes International (MSI) also acknowledged this, saying that family planning provision, in particular, was neglected within the cluster system and that donors needed to support humanitarian agencies to improve this.²⁷² Other witnesses believed that DFID could use its influence within the cluster system and strengthen its role at country level to help prioritise maternal, reproductive and sexual health within humanitarian responses.²⁷³ **We believe that maternal health should be an essential and integral part of all humanitarian responses. Women in conflict settings are more at risk of poor maternal health and have fewer—or no—services available to them. We recommend that DFID advocate within the UN cluster system—both amongst other donors and the lead agency, the World Health Organization—for maternal, sexual and reproductive health to be prioritised in humanitarian emergencies.**

121. Aasha Pai of MSI thought that, as well as working to improve multilateral responses, DFID should do more at programme level to raise the profile of maternal health in conflict settings:

“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 [...] At the programming level DFID could do more to bring [the two] together also through specific mechanisms, like through DFID’s Conflict, Humanitarian and Security Department, CHASE.”

Ms Pai said that it was important to include maternal health care—for instance, emergency obstetric services—as part of the “basic health package” and in the health system right from the beginning in emergency and conflict settings.²⁷⁴ She also emphasised the need to address the particular needs of individual maternal health programmes; for instance, in Afghanistan the cultural requirement to have only women doctors treating women.²⁷⁵ Programme level work will often involve building up health systems from a state of collapse and this will require long-term political and financial commitment.²⁷⁶ Save the Children UK recommended a twin-track approach that combined health systems building and the continuation of emergency relief until alternative structures are in place.²⁷⁷

122. Baroness Vadera told us that she believes that DFID has a comparative advantage in working on “difficult” issues such as safe abortion.²⁷⁸ DFID’s ability to work on these issues

270 The Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative was launched in 2006 by Marie Stopes International and Columbia University.

271 Ev 178

272 Ev 158

273 Q 169 [Aasha Pai and Giorgio Cometto]

274 Qq 159 and 170 [Aasha Pai]

275 Q 159 [Aasha Pai]

276 Ev 202

277 Ev 205

278 Q 258 [Baroness Vadera]

marks them out from NGOs and donors who cannot or will not give support to family planning or abortion services. Capitalising on this comparative advantage in conflict-affected and fragile settings would help ensure the necessary support for services that are essential to women at risk of forced sex, such as abortion and family planning services. **We believe that DFID should go beyond immediate emergency relief and build on its ability to work on sensitive issues such as abortion, for which there is greater demand in conflict-affected and fragile settings and which urgently needs support. Efforts should be made to ensure that maternal care is a core part of both DFID's and national health programmes from the outset. A long-term dual approach that seeks to strengthen or rebuild systems whilst continuing some aspects of emergency care is likely to work best.**

123. Giorgio Cometto, Health Adviser for Save the Children UK, highlighted several examples of good practice of maternal health provision in fragile contexts, some of which had DFID involvement. One was in Afghanistan, where a relatively quick improvement in health outcomes had been achieved by sub-contracting the provision of health services to non-state providers.²⁷⁹ This had boosted take-up of health services enormously, and there had been an increase in skilled birth and antenatal care attendance, and a decrease in child mortality from 257 per 1000 to just over than 190 per 1000 in five years (although thus far there had been no such dramatic reduction in maternal mortality).²⁸⁰ Another example of good practice was in South Sudan, where Giorgio Cometto thought DFID had bridged the gap well between the winding-down of emergency funding and the establishment of health systems with a 'basic services fund' that addressed health care needs immediately.²⁸¹ DFID was also credited for its support to the development of a sexual and reproductive health policy in Sierra Leone.²⁸²

124. Baroness Vadera told us that DFID had benefited from its previous experience in Nepal, where DFID's maternal health programme had continued throughout a decade of conflict. She was keen to do more of this systematic programme work—work that went beyond emergency relief—in conflict and post-conflict situations.²⁸³ **We believe that DFID should learn from what has worked in terms of supporting maternal health programmes in fragile, conflict and post-conflict settings and share this knowledge appropriately elsewhere. This should include successful examples from DFID's own programmes, such as recent experiences in Nepal, Sudan and Afghanistan.**

The need for improved health information systems to monitor progress

125. Seven years on from the launch of MDG 5, implementing accurate methods to measure maternal mortality remains a major challenge.²⁸⁴ The fact that only 30% of countries have routine death and birth registration indicates the challenges in routinely

279 Fourth Report from the Committee, Session 2007-08, *Reconstructing Afghanistan* HC 65-I

280 Q 170 [Giorgio Cometto]

281 Q 159 [Giorgio Cometto]

282 Ev 203

283 Qq 290-292 [Baroness Vadera and Dr Stewart Tyson]

284 Abdo Yazbeck, 'Challenges in measuring maternal mortality', *The Lancet* Vol 370 (13 October 2007)

collecting accurate data about maternal health and maternal deaths.²⁸⁵ Maternal deaths are often not recorded, let alone investigated.²⁸⁶ This means that official maternal mortality data are unreliable in many countries: a recent study conducted by Médecins Sans Frontières in the Democratic Republic of Congo estimated maternal death rates to be 10 times higher at 5,200 deaths per 100,000 live births than the national reported average of 520 deaths per 100,000 live births.²⁸⁷ As we said in Paragraph 8, because of the absence of data from countries with some of the worst maternal mortality ratios, it is hard accurately to assess either progress in reducing deaths or the most effective strategies to improve maternal health.

126. One approach to addressing the difficulties in measuring maternal mortality is to help countries to develop reliable information systems, which are often weak due to financial constraints and skills shortages.²⁸⁸ Accurate data are also crucial to ascertaining which national policies work most effectively.²⁸⁹ Boosting national capacity to gather and use statistics can also strengthen advocacy for maternal health within countries: Richard Horton from *The Lancet* said that in Guatemala a mortality survey amongst women of child-bearing age had been a major factor in driving improvements in maternal health.²⁹⁰

127. DFID told us that it was “the biggest funder of statistics”.²⁹¹ But Baroness Vadera recognised the difficulties in getting maternal health data: she said that lack of data was “possibly one of the reasons we have not been as effective as we could have been on maternal health.”²⁹² DFID currently funds several initiatives working to improve maternal health data. The Health Metrics Network is a global partnership working from the premise that health information is not an end in itself, but a route towards better health.²⁹³ DFID is providing £500,000 to the Network between 2007 and 2010. Dr Stewart Tyson highlighted the work being done by the Network to build the foundation for a comprehensive health information system, for instance by addressing registration of births and deaths.²⁹⁴

128. DFID is also funding the Immpact project, an international research initiative co-ordinated by the University of Aberdeen, with £7.5 million awarded for the period 2002–08. Other funders include the Gates Foundation, USAID and the European Commission. Through, for example, its ‘Sampling at Service Sites’ methodology, Immpact has pioneered a simple, low-cost way of estimating the levels of maternal mortality within countries. This method collects data from women respondents where they gather in large numbers (for example, markets and clinics) and typically costs much less than traditional house-to-house type surveys.²⁹⁵ The studies conducted by Immpact have found that mortality levels

285 Q 114 [Monir Islam]

286 Q 34 [Dr Grace Kodindo]

287 Ev 114

288 Wendy Graham and Julia Hussein, ‘The right to count’, *The Lancet* Vol 363, 3 January 2004

289 Q 279 [Baroness Vadera]

290 Q 137 [Richard Horton]

291 Q 276 [Baroness Vadera]

292 Q 276 [Baroness Vadera]

293 See <http://www.who.int/healthmetrics> for further information.

294 Q 278 [Dr Stewart Tyson]

295 Ev 88

are often considerably higher than officially recorded.²⁹⁶ Alec Cumming of Immpect told us that the aim now was to offer this and other evaluation tools developed by the project as global “public goods” and that training courses in developing countries were about to begin.²⁹⁷ DFID funding for the project will expire in August 2008.²⁹⁸

129. We received evidence which proposed that in-country data collection should be nationally ‘owned’ and locally relevant and that DFID should help build up in-country capacity to collect and use data on maternal health.²⁹⁹ The Royal College of Obstetricians and Gynaecologists said a good starting point would be to seek the compulsory registration of all births and deaths in all countries.³⁰⁰ **Supporting improved health information systems in developing countries is of crucial importance to identifying and sustaining successful policies for maternal health. We believe that DFID should continue to support initiatives addressing weak information systems, such as the Health Metrics Network and Immpect. DFID should ensure that its programmes include a focus on strengthening national capacity to collect, analyse and use maternal health data.**

130. More could be done to emphasise the importance of more accurate data within global financing and advocacy networks such as the International Health Partnership. As we said in Paragraph 22, maternal health can be viewed as a barometer of a nation’s development and accordingly the use of maternal health data as a ‘yardstick’ for financing decisions by donors may act as an additional incentive for countries to improve maternal health itself. Baroness Vadera told us that DFID is encouraging the IHP to use maternal mortality as one of their key indicators for success.³⁰¹ **The opportunities to highlight and address the urgent need for improved data that arise through various international initiatives, such as the International Health Partnership, should be seized and championed by DFID. The use of maternal indicators as a basis for financing decisions, for example, is likely to be a powerful stimulus to countries to improve maternal health itself.**

131. Evidence from the Royal College of Obstetricians and Gynaecologists (RCOG) suggested that auditing the quality of maternal care and the reasons for deaths was also important. This is also true for other adverse outcomes, such as stillbirths. The RCOG pointed out that audit systems had been successfully developed in Sri Lanka and South Africa, where the system has helped to identify the nature of maternal health problems and where interventions and budgets have been adjusted accordingly.³⁰² **Helping countries to monitor maternal deaths and the quality of care through routine audit systems will help to focus policies. We believe that DFID should help share lessons from developing countries that have successfully implemented audit systems of maternal deaths.**

296 Q 92 [Alec Cumming]

297 Q 91 [Alec Cumming]

298 Q 93 [Alec Cumming]

299 Q 221 [Dr Gill Greer] and Ev 186

300 Ev 186

301 Q 253 [Baroness Vadera]

302 Ev 184 and Q 114

5 The challenge for DFID

132. This chapter will consider the implications for DFID of the challenges and opportunities for maternal health discussed above. This will include a focus on how DFID funds and administers its country programmes that address maternal health, and how effectively the Department deploys its own human resources on maternal health issues. Finally, the chapter will examine DFID's work in relation to other international agencies, and assess whether the Department prioritises and harmonises its work on maternal health effectively.

DFID's current mix of aid instruments and policies

Financing strategies

133. As we stated in Paragraph 11, DFID spent £16 million on maternal and newborn health in 2005–06 (within a £385 million total spend on health),³⁰³ a figure which we were told had since “doubled and will double again [...] to over £50 million by next year [2008].”³⁰⁴ However, the share of international aid for health directed towards maternal health is relatively small. Globally, Official Development Assistance (ODA) for maternal, newborn and child health represented approximately 16% of total global ODA to health, and approximately 2.5% of total global ODA, in 2004. As we said earlier, the majority of funds are provided by a handful of donors: 14 donors contributed 90% of total ODA to maternal, newborn and child health in 2004, and just four donors accounted for 51%—the World Bank, USAID, DFID and UNFPA.³⁰⁵

134. Baroness Vadera told us that a significant portion of DFID's increasing maternal health budget would be directed to major reproductive and maternal care programmes in India and Pakistan. Ghana would also benefit through a Sector Wide Approach (SWAp) for health and Sierra Leone would see extra funds to help re-build its health system.³⁰⁶ Additionally, £100 million for UNFPA was announced by DFID in October 2007, to be spent on family planning.³⁰⁷

135. An aspect of DFID's financing that was welcomed in evidence was its support to research; the Towards 4+5 Research Programme Consortium said that DFID is “one of the biggest bilateral donors (in terms of funds and visibility) for research activities in maternal and neonatal health”, and welcomed the fact that DFID is willing to “take risks with research” by financing research on innovative interventions, for example the women's

303 This figure excludes budget support and contributions to multilateral agencies such as the UN. DFID, *Maternal Health Strategy—Reducing maternal deaths: evidence and action, Second Progress Report* (April 2007), p.8.

304 Qq 271- 272 and Ev 229. DFID spent the following amounts on maternal health: £16.2 million in 2004/05, £18.7 million in 2005/06 and £21.9 million in 2006/07. Projected spending for 2007/08 is £53-54 million (an extrapolated figure based on planned future expenditure as funds begin to be spent under new maternal health projects) (Ev 229).

305 See Paragraph 11 and Ev 151

306 Q 272 [Baroness Vadera]

307 DFID Press Release, 18 October 2007, 'UK Pledges £100 Million and Calls on World Leaders to Cut Maternal Deaths' and Ev 229

group trial in Nepal that we discussed in Paragraphs 96-98.³⁰⁸ **We were pleased to hear that DFID's funding to maternal health will increase to over £50 million in 2008. DFID's additional financing for family planning through UNFPA and its funding for research are particularly welcome.**

136. However, it is clear that overall financing for maternal health is currently insufficient. As we said in Paragraph 18, a further US\$14 billion needs to be found for maternal, newborn and child health if the international community is to reach the US\$25 billion estimated as necessary to ensure that a basic package of health services is available to all.³⁰⁹ Whilst several witnesses perceived DFID's financial contribution to maternal health to be relatively low, and that further funds should be allocated immediately,³¹⁰ more evidence focused on the need for all donors to provide predictable, long-term financing.³¹¹ Predictability of aid is important for strengthening health systems and supporting the costs of health workers' salaries and training.³¹² As we have said, conflict-affected and fragile areas have a particular need for longer-term funding to enable the re-building of systems.³¹³ Baroness Vadera told us that DFID's use of predictable, long-term financing gives it a comparative advantage amongst other donors.³¹⁴ **We reiterate our recommendation from Paragraph 122 that, in order to strengthen health systems, aid to maternal health should be predictable and long-term, especially in fragile and conflict-affected states.**

Budget support and maternal health

137. One approach to improving the predictability of aid is through the use of budget support: direct contributions by donors to national governments that provide long-term and flexible finance. Sometimes funds are paid directly into the budgets of health ministries through health sector budget support. DFID uses budget support in nine of its 16 health programmes in sub-Saharan Africa, and in five programmes in Asia.³¹⁵ DFID's Annual Report 2007 states, "Increasingly, DFID's support to reduce maternal mortality is delivered through general budget support or health sector budget support."³¹⁶

138. For either general or sector budget support, DFID does not earmark funds for sub-sectors such as maternal health: governments themselves make decisions about such allocations. This is, of course, the right approach given that budget support seeks to enable countries to set policies and financing strategies themselves. But as DFID itself admits, the use of budget support

308 Ev 150

309 Ev 113

310 Ev 126; Ev 157; and Q 14 [Dr Francisco Songane]

311 Ev 139; Ev 110; Ev 202; Q 54 [Dr Grace Kodindo]

312 Ev 177

313 See Paragraphs 121-122

314 Q 258 [Baroness Vadera]

315 DFID, *Maternal Health Strategy—Reducing maternal deaths: evidence and action, Second Progress Report* (April 2007), p.9 and DFID, 'A way to help governments reduce poverty', 7 January 2008, online at <http://www.dfid.gov.uk/news/files/prbs-govs-reduce-poverty.asp>

316 DFID, Annual Report 2007, p.326

“makes tracing DFID investment in maternal health and its impact complex ... [it] will help to improve service delivery for the health sector, and create spill-over benefits for maternal health; but it is not possible to identify how much [budget support and sector budget support] directly benefit maternal health programmes within partner countries.”³¹⁷

Thoraya Obaid of UNFPA told us that it was important that maternal health does not “fall between the cracks” when support is given in the form of budget support.³¹⁸

139. The view of Dr Tim Ensor from Immpact was that budget support for maternal health “makes a lot of sense” because maternal health is to a large extent a systems issue that is difficult to address through ‘vertical’ or project-based programming. However, he was concerned that the effectiveness of budget support is dependent on the capacity of governments and civil society to track expenditure and ensure funds are allocated to specified sectors. He said:

“there are challenges with implementing systems of budget support, particularly with regards to the monitoring [...] the systems with the governments that we are working with are just not adequate to deliver the kind of broad monitoring of independent indicators required to provide the information on how the money is being used.”³¹⁹

Dr Ensor suggested that strengthening the use of public expenditure reviews—especially ones with civil society involvement—would help summarise how public money is spent and thus help ensure the effectiveness of budget support. He highlighted an example in India of civil society involvement in training people to undertake expenditure reviews.³²⁰

140. Baroness Vadera said that one way to make it easier to track budget support and ensure improved maternal health outcomes would be to make maternal health a specific headline indicator for budget support. The Minister highlighted that maternal health is often used as a proxy for measuring the strength of health systems, and thought that it might be “a better tracker of the effectiveness of the health system” than traditional headline indicators such as immunisation rates.³²¹ **We believe that delivering support to maternal health through budget support is appropriate and will assist the predictability of aid. However, better tracking is needed of the extent to which the funds contribute to improved maternal health outcomes. DFID should explore specific mechanisms to ensure this, including giving support to public expenditure reviews of government budgets—especially those involving civil society—and making maternal health a specific headline indicator for budget support. The choice of measures of maternal health will be crucial, in terms of their availability, accuracy and ability to reveal inequities, and we recommend that DFID takes a lead role internationally in ensuring the most appropriate and effective selection.**

317 Ev 104-105

318 Q 7 [Thoraya Obaid]

319 Q 65 [Tim Ensor]

320 Q 84 [Tim Ensor]

321 Qq 277 and 294 [Baroness Vadera]

DFID's human resource capacity

141. Another point raised in evidence in connection with DFID's increasing use of budget support was that it relies on in-country staff for its effective delivery. However, DFID, like all departments, is currently subject to civil service efficiency targets—which have entailed an 11% headcount cut for DFID since 2004 and thus constrained staff numbers within the Department.³²² Catharine Taylor of health consultancy HLSP told us:

“When you are giving budget support there is also a need for very good technical knowledge at a country level so that you can [...] 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.”³²³

Baroness Vadera told us that, whilst DFID's Headquarters is subject to a 5% headcount reduction, in-country programmes will be exempt from restrictions and two-thirds of such programmes will even see a staff increase of 1%.³²⁴ Thirty-nine of DFID's 53 health advisers are currently based in-country.³²⁵ The Minister was confident that DFID had the necessary staff complement to drive forward maternal health in 2008. She said “everybody is always stretched and we are working in a field where the need is, in one sense, endless.”³²⁶

142. Whilst we were reassured to be told that health advisers working in-country will not be subject to reductions, we are concerned by the implication that being “stretched” is acceptable and not counter to the effectiveness of DFID's operations. Immpact told us that DFID staff are already “frequently overstretched by the volume and range of work they must undertake”. Immpact also said that, in Ghana, DFID interests are looked after by another national agency due to capacity constraints.³²⁷ The Towards 4+5 Research Programme Consortium was concerned that high staff workloads could adversely affect the ability of DFID to interact with the academic community, both in developing countries and in the UK.³²⁸ We have already commented that DFID has resigned from the Board of the Partnership for Maternal, Newborn and Child Health partly due to capacity constraints and is now being represented by the Norwegian Government.³²⁹

143. In our report of November 2007 on DFID's 2007 Annual Report, we registered our concern that headcount restrictions will act as a constraint on DFID's work, particularly in the poorest countries and fragile states. We said that we believe DFID needs to make some difficult choices about withdrawing from some countries or sectors so that it can focus development assistance where it will have the greatest effect on poverty reduction. We discussed examples of the options facing DFID, for instance reducing staff in countries which are performing well, so that staff in more challenging countries can be increased or

322 Q 259 [Baroness Vadera]

323 Q 180 [Catharine Taylor]

324 Q 261 [Baroness Vadera]

325 Q 261 [Baroness Vadera]

326 Q 265 [Baroness Vadera]

327 Ev 131

328 Ev 150

329 See Paragraphs 69-70

funding specialist staff within country budgets thus also helping to strengthen capacity. We also highlighted the risks inherent in these options.³³⁰

144. We were reassured to hear that DFID country programmes will be exempt from headcount cuts due to efficiency savings. However, we were concerned to hear the views of a number of witnesses that DFID staff working on maternal health were frequently overstretched. There is evidence that DFID’s human resource capacity to drive the maternal health agenda is constrained, both in-country and within DFID Headquarters. We believe that, as one of the most off-track MDGs—and one needing urgent progress—maternal health should be a priority area for staff resources within DFID. We reiterate our recommendation from our report on DFID’s Annual Report 2007 that, in order to focus development assistance where it will have the greatest effect on poverty reduction, DFID will have to make some difficult decisions about withdrawing from some countries or sectors. We look forward to contributing to this decision-making process as part of our future work.

Managing expectations of DFID’s work and aid harmonisation

DFID’s comparative advantage

145. One route to maximising DFID’s resources for maternal health, both human and financial, is ensuring that they are prioritised and harmonised in line with other donors’ activities. Spending UK aid funds in the most cost-effective manner relies on DFID working to its strengths, seeking to be focused, avoiding duplication and complementing existing international strategies. Integral to this approach is identifying and acting upon DFID’s comparative advantage amongst other donors.

146. As we said in Paragraph 122, Baroness Vadera believes DFID’s comparative advantage is being able to “do and say difficult things: that we are able to champion something that not many countries easily champion” (for instance, access to safe abortion).³³¹ We agree that DFID’s willingness to work on sensitive issues such as abortion places it within a select band of donors. It is also clear that other donors in this grouping—chiefly the Scandinavian and the Dutch agencies—do not have the same reach as DFID in terms of budgets or overseas programmes.³³²

147. As we have made clear, we do not believe that abortion decisions should be imposed on countries from the outside; however, we do believe that DFID—as one of the few donors actively to promote efforts to prevent unsafe abortion—should challenge restricted access to contraception services and safe abortion and encourage governments and donors to think hard about the fact that unsafe abortions are the third highest cause of maternal deaths.³³³ It may be difficult for donors and international agencies to challenge cultural attitudes and gender bias but we who live in more liberal societies must not shy away from

330 First Report from the Committee, Session 2007-08, *Department for International Development Annual Report 2007*, HC 64, Paragraphs 38-40

331 Q 258 [Baroness Vadera]

332 Q 258 [Baroness Vadera]

333 See Paragraphs 50-52

championing fundamental women's rights. **We agree that DFID has a comparative advantage in working on sensitive issues such as unsafe abortion. Whilst we reiterate our view that abortion is a national issue, we believe that DFID should challenge governments which seek to restrict access to contraception services and safe abortion. This should include working with international and national advocacy and rights-based groups to communicate the facts about preventable deaths and disabilities from unsafe abortion.**

148. UNFPA estimates that meeting the existing demand for family planning services would in itself reduce maternal mortality and morbidity by at least 20%.³³⁴ It follows that those who deny women the right to access contraception, whether through negligence or active policy, are effectively condemning millions of women a year to death or disability.³³⁵ This is a fundamental issue of human rights.

149. Identifying where DFID's comparative advantage lies is also about highlighting what DFID cannot do—and that it cannot do everything. If progress towards MDG 5 is to be scaled up over the next 5 to 10 years, DFID must help ensure that all global actors are playing their part. For example, this must include supporting the Japanese to realise their pledge to focus their 2008 G8 leadership on global health. It should also involve helping to streamline the currently fragmented UN approach to improving maternal health.

150. From the evidence we received, it was clear that there is an expectation that DFID can do everything, from publicising good practice to improving monitoring systems to implementing professional development for health workers in developing countries.³³⁶ This is unrealistic. There is a need for DFID to 'manage expectations' and communicate clearly that it cannot single-handedly drive progress on MDG 5 on all fronts. The fact that it has a dedicated maternal health strategy is an asset; when a revised strategy is due—and we think this should be sooner rather than later—DFID should ensure that it sets out a clear and focused approach that highlights the limits of its contribution to maternal health, as well as its current and projected activities. **Identifying DFID's role within the international drive to meet MDG 5 also relies on establishing the limits of the Department's contribution. DFID cannot do everything. Part of its approach should focus on supporting other actors, especially the UN, to play their part. DFID's next maternal health strategy—which we believe should be produced sooner rather than later—should set out a clear and focused approach that seeks to engender more realistic expectations of its work from other aid organisations and sets out what it cannot, as well as what it can, achieve.**

Re-appraising priorities

151. Many witnesses believed that 2008 was a crucial year for maternal health, with over 20 years having elapsed since the launch of the Safe Motherhood initiative, the mid-point to the MDGs just passed and with new leaders in place to galvanise progress.³³⁷ Baroness

334 Cited in written evidence submitted by IPPF, Ev 135

335 Based on the statistic quoted in Paragraph 6 that for each maternal death, an estimated further 30 women will become disabled, injured or ill owing to pregnancy.

336 Q 14 [Thoraya Obaid], Q 97 [Monir Islam] and Q 108 [Dr Nynke van den Broek]

337 See Paragraph 56

Vadera told us of DFID's plans to capitalise on the opportunities in 2008 and have a big "push" on MDG 5 this year.³³⁸ But DFID will only be in a position to do this if it has a clear vision of its priorities and where its contribution is most needed. **We believe that DFID needs to re-assess its work now—whilst reaching MDG 5 by 2015 is still a possibility—and identify specific areas in which it can immediately 'add value'. 2008 is a year of opportunities to catalyse progress on MDG 5 but DFID needs to reflect first on where it can best contribute to global efforts.**

152. This re-appraisal of priorities will require DFID to conduct a robust analysis of other donor efforts and of where the need is greatest. But the 2015 MDG deadline is now very close, and the simple goal should be to identify strategies that will reduce deaths fastest whilst ensuring that changes are sustainable. These strategies are well understood by DFID: family planning, emergency obstetric care and skilled birth attendance. But securing the delivery of this essential package remains elusive for many countries. Just seven years from the MDG deadline, countries such as Nigeria, Lesotho and Zambia are going backwards rather than forwards in terms of the number of births attended by a skilled professional.³³⁹

153. Thus **we believe that the three pre-requisites of family planning, emergency obstetric care and skilled birth attendance must remain at the centre of DFID's work.** Witnesses were clear that establishing basic human and physical health care infrastructure within countries was still at the centre of the challenge facing governments and donors. This will enable more skilled birth attendants to work in adequately equipped health facilities that can provide emergency obstetric care.³⁴⁰

154. Countries such as Honduras show how quickly maternal mortality ratios can be improved when basic maternal health policies are made a national priority. In 1990, the mortality ratio (MMR) was 182 per 100,000 live births. This was addressed through a strong focus on emergency obstetric care, a robust referral system for women with complications and an increase in the number of births with a skilled attendant. Government prioritisation, in combination with donor support, helped bring about a reduction in the MMR to 108, a fall of 38% in 7 years.³⁴¹ **Countries such as Honduras show that when maternal health is made a national priority, and a strong focus is given to emergency obstetric care, skilled birth attendance and family planning, maternal mortality can be reduced substantially in less than a decade. We believe that DFID and other donors should prioritise supporting other countries to emulate this success, which will help ensure MDG 5 is within closer reach by 2015.**

338 Q 268 [Baroness Vadera]

339 DFID Annual Report 2007, p.325

340 Ev 174; Q 3 [Dr Francisco Songane]; Q 96 [Nynke van den Broek]; Q 142 [Richard Horton]

341 Kirrin Gill et al, 'Women Deliver for Development', *The Lancet* Vol 370 (13 October 2007), p.1350

6 Conclusion

155. The Honduras example cited at the end of Chapter 5 brings us back to where we started: the difference that political will can make in improving maternal health. DFID has been a global champion for maternal health. Through its spearheading of international partnerships, its willingness to address sensitive issues, its support to research and its focus on strengthening health systems it has pushed maternal health considerably higher up national and international political agendas.

156. But maternal health has not yet become a political priority, either globally or within developing countries. Conveying this message and advocating successfully for change—both at the international and national levels—has never been more important. At the start of a crucial year for the health MDGs, DFID must reflect on how to move forward. Retaining its role of global champion will depend on whether DFID really can, as it says it can, spend increasing funds and shape strong international partnerships when it has staff headcount restrictions in place. Keeping its leadership position is feasible and desirable but will involve a careful re-examination of priorities within DFID's maternal health strategy and a re-appraisal of how best the Department can play to its strengths and harmonise its work with that of other donors. The Department must focus on ensuring that other aid actors fulfil their part in reaching MDG 5 and that its own efforts complement the work of others: the International Health Partnership provides an excellent framework for ensuring this.

157. Reaching MDG 5 by 2015 will shortly become an impossibility unless urgent action is taken. For millions of women, delivering a child with a midwife in attendance and emergency care at hand if she needs it will remain hopelessly unachievable. As one witness argued, it is a disgrace that astronauts landed on the moon decades ago, but we cannot yet provide women with simple maternity care.³⁴² DFID should put securing this basic package for women at the centre of its approach and campaign for others to do the same. There are real chances in 2008 to reverse the trend of maternal mortality—and they must not be wasted.

Recommendations

The global maternal mortality burden

1. Such is the uncertainty about the real scale of maternal mortality, particularly in sub-Saharan Africa and Asia, that whilst the number of maternal deaths for 2005 is cited as 536,000, the figure could be as high as 872,000. Many studies have found a tendency for maternal deaths to be under-reported and we fear that the higher figure could indeed be nearer the truth. Moreover, using national averages to assess the magnitude of the problem often masks enormous differences between areas and groups of women. (Paragraph 8)

The key bottleneck: a failure of advocacy and political will

2. Over the course of the inquiry, we have been saddened by the stagnancy of MDG 5 and the fact that so many women continue to die during pregnancy and childbirth. A clear message from the evidence we took was that a key bottleneck in securing progress on maternal health is a failure of advocacy and a lack of political will. (Paragraph 14)
3. We believe that lack of progress towards MDG 5 is a global collective failure. Responsibility for this belongs at both international and national levels. Donors and national governments carry a particular responsibility to heighten awareness both of the unacceptability of the situation and of the urgent need for greater political will for progress. The responsibility to act lies not with one sector but across sectors—the Ministry of Finance, for example, as well as the Ministry of Health—and with a whole range of actors, from UN agencies to grassroots groups at village level. (Paragraph 16)

Girls' and women's education

4. Girls who are not in school are having their right to education undermined and are at increased risk of early marriage, domestic violence and HIV/AIDS. We urge DFID to ensure that the interdependency between maternal health, gender inequality and education is acknowledged and acted upon in its own strategies for these three areas as well as in national country development plans. (Paragraph 24)

Gender-based violence

5. The DFID-funded project to address gender-based violence towards pregnant women in Nepal and Bangladesh is achieving promising results and this approach should be communicated, and, where relevant, replicated. Contraceptive services and counselling by trained health workers should be integral parts of such projects. (Paragraph 26)

Socio-economic empowerment

6. Microfinance and microcredit schemes have been shown to work well in empowering women socially and economically and can be used to promote better health and uptake of care. We recommend that DFID build on the success of projects such as the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) in South Africa, which added gender, violence and HIV/AIDS components to existing microfinance schemes and promote relevant opportunities for replication and adaptation to improve maternal health. (Paragraph 29)

Strengthening civil society's capacity to hold governments to account and influence policy

7. DFID deserves credit for its support to strengthening civil society's capacity to hold governments to account for maternal health care. However, we believe that the Department could do more to ensure citizens are appropriately involved in the national policy-making process, including for example appropriate engagement in auditing government statistics and measuring progress on maternal health. (Paragraph 37)

Ensuring pro-poor health financing

8. User fees for maternal health care almost always hit the poorest women hardest and we believe that there is a strong case for their removal in favour of universal free care. We believe that DFID should continue to support countries to abolish user fees. We recommend that, when doing so, DFID and other donors should help ensure that other revenue sources—for instance, the tax base or additional donor funds—are identified in order to support the expanded demand for care. We believe that governments, when considering free care, need to identify the main financial barriers for women (for instance, transport), particularly the poorest, and seek to address these using financing options which are sustainable and most relevant to the country's circumstances. (Paragraph 43)
9. There is evidence that cash transfer or voucher schemes can work in encouraging women, particularly the poorest and those living in remote areas, to give birth in facilities with a skilled attendant, rather than at home. We recommend that DFID prioritise support to efforts to identify, implement and evaluate context-specific options for reducing financial barriers to maternal health care. (Paragraph 44)

A rights-based approach

10. We believe that DFID deserves credit for its rights-based approach to maternal health. However, the Department must ensure that the approach is accompanied by adequate funding and implementation strategies. To ensure that the approach is fully implemented at programme level, we believe that DFID should support monitoring frameworks which assess how effectively country programmes are applying a rights-based perspective. (Paragraph 46)

Unsafe abortion

11. Unsafe abortion is responsible for tens of thousands of women dying each year and is a highly neglected public health challenge. We agree with DFID's approach of not trying to impose abortion decisions on countries but seeking to support civil society where interest in changing the law and improving services already exists. In countries where abortion is illegal, we believe that DFID should continue to look for opportunities to help ensure women are aware both of the circumstances in which abortion is permitted and of the safe services that are available to them. (Paragraph 52)
12. The hugely oversubscribed first call for funding from the Safe Abortion Action Fund (SAAF) demonstrates the size of the need for funds to improve abortion services. We agree that DFID should continue to advocate for new donors to contribute to the Fund and if, following evaluation results, there is sound evidence for the effectiveness of the SAAF, we believe that DFID should also consider a substantial increase in its own support for the Fund. (Paragraph 54)

The UN: challenges and opportunities in its current approach

13. It is far from clear to us how the UN divides up responsibility for different aspects of maternal, newborn and child health. The overlapping remits between agencies has contributed to a lack of confidence in the UN as a global leader. Whilst maternal health is multi-factoral in nature and requires input from several agencies, we believe that a clearer delineation of each UN agency's role needs to be set out and communicated widely (Paragraph 60)
14. Fragmentation amongst UN agencies has slowed progress on MDG 5 and constrained the UN's ability to provide global leadership on maternal health. We urge DFID to continue to press strongly for concrete actions that will sharpen co-ordination between UN agencies, including the rapid roll-out of the 'One UN' programme, and the appointment of official maternal health 'champions' within the UN. (Paragraph 65)

The Partnership for Maternal, Newborn and Child Health

15. Whilst we appreciate the need to balance membership of global partnership boards according to capacity and shifting priorities, we were concerned to hear that DFID has resigned from the Board of the Partnership for Maternal, Newborn and Child Health, particularly at a time when the need to accelerate progress towards MDG 5 is so acute. We urge DFID to return to the Board as soon as staff capacity permits, and in the meantime to work closely with the Norwegian Government to ensure DFID's leverage and push for co-ordination is retained within the Partnership. (Paragraph 70)

The Global Campaign for the Health MDGs

16. DFID deserves credit for spearheading the International Health Partnership. We were pleased to see this practical application of the Paris Declaration on Aid Effectiveness and hope it will help both recipient countries and donors to maximise development assistance for health. DFID must maintain its leadership role and help drive the IHP's implementation phase, ensuring that parallel donor efforts to strengthen health systems are delivered. (Paragraph 74)
17. Greater national ownership of health policies, as envisaged by the IHP, is dependent on effective advocacy for improved health by governments. We recommend that DFID use its leadership role to ensure that governments and both national and international civil society groups are fully involved in the implementation of the IHP so that successful advocacy for improved health takes place in tandem with improved aid effectiveness. (Paragraph 75)
18. We recommend that DFID and the other organisations involved in the IHP take steps to ensure that the process of reviewing pilot countries is managed promptly and efficiently. Assuming successful reviews emerge, the IHP should then be extended to other interested countries as soon as possible. (Paragraph 76)

The Global Fund to Fight AIDS, TB and Malaria

19. We believe that DFID and other donors should build on a series of opportunities at the Global Fund to Fight AIDS, TB and Malaria—its new Director, gender strategy and membership of the International Health Partnership—and should encourage the Fund to support more maternal health care interventions which have direct relevance to these three diseases as well as to health systems strengthening. (Paragraph 83)
20. We believe that the Global Fund needs to communicate more clearly its willingness to accept funding proposals for maternal, sexual and reproductive health programmes—particularly those integrated with HIV/AIDS, TB and malaria interventions—to countries seeking funds. DFID should use its Board membership to help encourage a closer dialogue between the Fund and its recipients so that there is a clearer understanding of how the Fund's resources can be spent. (Paragraph 85)

The Japanese Presidency of the G8

21. We were pleased to hear that DFID is engaging with Japan regarding its Presidency of the G8 in 2008. DFID should support Japan to realise its pledge to make health—and maternal health especially—a key priority for the Presidency. This should include advocating for this prioritisation amongst other G8 members. (Paragraph 87)

The UK's role in stepping up advocacy

22. We are pleased that DFID recognises the need to step up its efforts on international advocacy. We will keep a watching brief on how these efforts are translated into action during 2008, especially at the UN General Assembly meeting on the MDGs in the autumn. (Paragraph 88)
23. We agree that supporting specific maternal health champions and change agents in developing countries is a good idea. We recommend that DFID pursue its discussions about empowering such champions with the Elders Group. (Paragraph 89)
24. The scientific research community is an advocacy mechanism in its own right and should be supported by donors so that it mobilises itself more effectively. This is particularly important within developing countries where research can be applied practically as a way to inform and monitor government policies for maternal health. (Paragraph 90)
25. We agree that focusing intensified global advocacy efforts around existing processes, such as the 2008 Japanese G8 Presidency and the UN General Assembly's meeting on the MDGs in the autumn of 2008, is likely to be more effective than creating a separate global fund for women's health. (Paragraph 91)

What works in preventing maternal deaths: the example of Nepal

26. We applaud DFID for its contribution to the Nepal Safe Motherhood Project and Support to Safe Motherhood Programme, which have included a range of interventions relevant to maternal health in Nepal over a decade that has witnessed progress in reducing maternal mortality. We urge DFID to support independent comprehensive evaluations of this experience, with a view to sharing lessons in the region and globally. (Paragraph 95)
27. We urge DFID to look closely at options for replicating successful approaches from Nepal where appropriate, and to identify factors relevant to scaling-up and transference. We appreciate that success is often context-dependent, but believe the DFID-funded approach to supporting women's groups, as in Nepal, is worthy of particular consideration wherever relevant. (Paragraph 98)

What works in strengthening health systems: boosting human resources

28. We were concerned to learn the extent of the global shortfall in health workers, particularly the lack of midwives. Boosting the numbers of midwives worldwide will be central to the achievement of MDG 5. Increasing the availability and quality of training opportunities for midwives is therefore of paramount importance. DFID should consider supporting action-oriented research into where human resource shortages and training needs are particularly acute and the options for addressing them in the short, medium and long term. (Paragraph 103)

29. We believe that DFID and other donors should find new ways to help governments encourage health professionals to provide quality services in remote and rural areas. This should include supporting civil society to lobby for better salaries and conditions for doctors and midwives working outside urban areas and to ensure the necessary infrastructure, supplies, transport and equipment are in place to enable these professionals to provide prompt and effective care. (Paragraph 105)
30. DFID deserves credit for its support to the Emergency Human Resources Programme in Malawi, for which initial results show expanded staff numbers and better uptake of training. We recommend that DFID move swiftly to support the replication, where appropriate, of efforts to address human resources problems as soon as conclusive results are available. (Paragraph 107)

Increasing the availability of equipment and supplies

31. We were concerned to hear about the lack of even very basic supplies and medicines in many developing countries. We recommend that donors, including DFID, work with the World Health Organization to advocate with national governments for national Essential Drugs Lists to contain drugs such as magnesium sulphate, which are crucial to maternal survival. (Paragraph 109)
32. In addition to insufficient quantities of essential drugs, many countries have widespread shortages of other pre-requisites for maternal health and services, including adequate blood and family planning supplies. We believe that DFID should seek to build political commitment within countries to ensure that these crucial supplies are appropriately funded within national health plans and budgets. The Department should also campaign internationally for a reversal in declining budgets for family planning supplies and services. (Paragraph 112)

Balancing the demand and supply-side of care

33. In order to achieve efficiently functioning health systems, there needs to be a balance of demand- and supply-side approaches. We believe that DFID needs to ensure that its support for demand- and supply-side approaches is flexible and reflects the needs of specific contexts, and that it is consistent with broader health systems strengthening in countries. Where budget support is being used, DFID and other donors should retain oversight of national programmes to ensure this balance is achieved. Monitoring systems need to be capable of tracking this balance. (Paragraph 115)

Working in conflict-affected and fragile states

34. We believe that maternal health should be an essential and integral part of all humanitarian responses. Women in conflict settings are more at risk of poor maternal health and have fewer—or no—services available to them. We recommend that DFID advocate within the UN cluster system—both amongst other donors and the lead agency, the World Health Organization—for maternal, sexual and reproductive health to be prioritised in humanitarian emergencies. (Paragraph 120)

35. We believe that DFID should go beyond immediate emergency relief and build on its ability to work on sensitive issues such as abortion, for which there is greater demand in conflict-affected and fragile settings and which urgently needs support. Efforts should be made to ensure that maternal care is a core part of both DFID's and national health programmes from the outset. A long-term dual approach that seeks to strengthen or re-build systems whilst continuing some aspects of emergency care is likely to work best. (Paragraph 122)
36. We believe that DFID should learn from what has worked in terms of supporting maternal health programmes in fragile, conflict and post-conflict settings and share this knowledge appropriately elsewhere. This should include successful examples from DFID's own programmes, such as recent experiences in Nepal, Sudan and Afghanistan. (Paragraph 124)

The need for improved health information systems to monitor progress

37. Supporting improved health information systems in developing countries is of crucial importance to identifying and sustaining successful policies for maternal health. We believe that DFID should continue to support initiatives addressing weak information systems, such as the Health Metrics Network and Immpact. DFID should ensure that its programmes include a focus on strengthening national capacity to collect, analyse and use maternal health data. (Paragraph 129)
38. The opportunities to highlight and address the urgent need for improved data that arise through various international initiatives, such as the International Health Partnership, should be seized and championed by DFID. The use of maternal indicators as a basis for financing decisions, for example, is likely to be a powerful stimulus to countries to improve maternal health itself. (Paragraph 130)
39. Helping countries to monitor maternal deaths and the quality of care through routine audit systems will help to focus policies. We believe that DFID should help share lessons from developing countries that have successfully implemented audit systems of maternal deaths. (Paragraph 131)

DFID's current mix of aid instruments and policies: financing strategies

40. We were pleased to hear that DFID's funding to maternal health will increase to over £50 million in 2008. DFID's additional financing for family planning through UNFPA and its funding for research are particularly welcome. (Paragraph 135)
41. We reiterate our recommendation from Paragraph 122 that, in order to strengthen health systems, aid to maternal health should be predictable and long-term, especially in fragile and conflict-affected states. (Paragraph 136)

Budget support and maternal health

42. We believe that delivering support to maternal health through budget support is appropriate and will assist the predictability of aid. However, better tracking is needed of the extent to which the funds contribute to improved maternal health

outcomes. DFID should explore specific mechanisms to ensure this, including giving support to public expenditure reviews of government budgets—especially those involving civil society—and making maternal health a specific headline indicator for budget support. The choice of measures of maternal health will be crucial, in terms of their availability, accuracy and ability to reveal inequities, and we recommend that DFID takes a lead role internationally in ensuring the most appropriate and effective selection. (Paragraph 140)

DFID's human resource capacity

43. We were reassured to hear that DFID country programmes will be exempt from headcount cuts due to efficiency savings. However, we were concerned to hear the views of a number of witnesses that DFID staff working on maternal health were frequently overstretched. There is evidence that DFID's human resource capacity to drive the maternal health agenda is constrained, both in-country and within DFID Headquarters. We believe that, as one of the most off-track MDGs—and one needing urgent progress—maternal health should be a priority area for staff resources within DFID. We reiterate our recommendation from our report on DFID's Annual Report 2007 that, in order to focus development assistance where it will have the greatest effect on poverty reduction, DFID will have to make some difficult decisions about withdrawing from some countries or sectors. We look forward to contributing to this decision-making process as part of our future work. (Paragraph 144)

DFID's comparative advantage

44. We agree that DFID has a comparative advantage in working on sensitive issues such as unsafe abortion. Whilst we reiterate our view that abortion is a national issue, we believe that DFID should challenge governments which seek to restrict access to contraception services and safe abortion. This should include working with international and national advocacy and rights-based groups to communicate the facts about preventable deaths and disabilities from unsafe abortion. (Paragraph 147)
45. Identifying DFID's role within the international drive to meet MDG 5 also relies on establishing the limits of the Department's contribution. DFID cannot do everything. Part of its approach should focus on supporting other actors, especially the UN, to play their part. DFID's next maternal health strategy—which we believe should be produced sooner rather than later—should set out a clear and focused approach that seeks to engender more realistic expectations of its work from other aid organisations and sets out what it cannot, as well as what it can, achieve. (Paragraph 150)

Re-appraising priorities

46. We believe that DFID needs to re-assess its work now—whilst reaching MDG 5 by 2015 is still a possibility—and identify specific areas in which it can immediately 'add value'. 2008 is a year of opportunities to catalyse progress on MDG 5 but DFID needs to reflect first on where it can best contribute to global efforts. (Paragraph 151)

47. We believe that the three pre-requisites of family planning, emergency obstetric care and skilled birth attendance must remain at the centre of DFID's work. (Paragraph 153)
48. Countries such as Honduras show that when maternal health is made a national priority, and a strong focus is given to emergency obstetric care, skilled birth attendance and family planning, maternal mortality can be reduced substantially in less than a decade. We believe that DFID and other donors should prioritise supporting other countries to emulate this success, which will help ensure MDG 5 is within closer reach by 2015. (Paragraph 154)

List of acronyms

DFID	Department for International Development
GBV	Gender Based Violence
GNP	Gross National Product
IDS	Institute of Development Studies
IHP	International Health Partnership
IMMPACT	Initiative for Maternal Mortality Programme Assessment
IPPF	International Planned Parenthood Federation
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MSI	Marie Stopes International
NGO	Non-Governmental Organisation
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
PMNCH	Partnership for Maternal, Newborn and Child Health
RCOG	Royal College of Obstetricians and Gynaecologists
SAAF	Safe Abortion Action Fund
SSMP	Support for Safe Motherhood
SWAp	Sector Wide Approach
UNFPA	UN Population Fund
UNICEF	The United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Formal Minutes

Wednesday 6 February 2008

Members present:

Malcolm Bruce, in the Chair

Richard Burden
Mr Stephen Crabb

Sir Robert Smith

Draft Report (Maternal Health), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 157 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Fifth Report of the Committee to the House.

Ordered, That the Chairman make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report, together with written evidence reported and ordered to be published on 12 October and 13 December.

Several papers were ordered to be reported to the House for placing in the Library and Parliamentary Archives.

[Adjourned till Tuesday 26 February at 10.00 am

Witnesses

Tuesday 16 October 2007

Page

Mrs Thoraya Ahmed Obaid, Executive Director, United Nations Population Fund (UNFPA) and UN Under-Secretary-General; **Dr Francisco Songane**, Director, Partnership For Maternal, Newborn and Child Health Ev 1

Dr Grace Kodindo, Assistant Professor of Emergency Obstetrics Care, Mailman School of Public Health, Columbia University Ev 10

Tuesday 13 November 2007

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 Ev 18

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 Organisation, and **Dr Nynke van den Broek**, Senior Clinical Lecturer in Reproductive Health, Liverpool School of Tropical Medicine and Director, RCOG International Office Ev 25

Thursday 22 November 2007

Mr Richard Horton, Editor, The Lancet, and **Ms Brigid McConville**, White Ribbon Alliance Ev 35

Ms Aasha Pai, Acting Regional Director, Africa and Latin America, Marie Stopes International, and **Mr Giorgio Cometto**, Health Adviser, Save the Children UK Ev 44

Wednesday 5 December 2007

Professor Charlotte Watts, London School of Hygiene and Tropical Medicine, **Ms Catharine Taylor**, Lead Specialist for Maternal Health, HLSP, and **Professor Peter Godfrey-Faussett**, Chair, Technical Review Panel, Global Fund to Fight AIDS, TB and Malaria Ev 51

Dr Gill Greer, Director-General, International Planned Parenthood Federation (IPPF) Ev 60

Tuesday 18 December 2007

Baroness Vadera, a Member of the House of Lords, Parliamentary Under Secretary of State, **Dr Stewart Tyson**, Head of Profession for Health, Human Development Group (Policy and Research Division), and **Mr Andrew Rogerson**, Head of Human Development Group, Policy and Research Division, Department for International Development Ev 67

List of written evidence

	<i>Page</i>
Department for International Development	Ev 83; 229
All Party Parliamentary Group on Population, Development and Reproductive Health	Ev 108
Cara International Consulting Ltd.	Ev 110
Columbia University, Mailman School of Public Health	Ev 121
IMMPACT, University of Aberdeen	Ev 126
Institute of Development Studies	Ev 131
International Planned Parenthood Federation (IPPF)	Ev 133
International Rescue Committee UK	Ev 149
London School of Hygiene and Tropical Medicine	Ev 149
Marie Stopes International	Ev 156
Maternity Worldwide	Ev 161
Merlin	Ev 164
Nestlé UK	Ev 168
Peoples Health Movement and Global Health Watch	Ev 170
Plan UK	Ev 174
Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative	Ev 178
Royal College of Obstetricians and Gynaecologists (RCOG) International Office	Ev 181
Save the Children UK	Ev 201
Stop the Traffik	Ev 205
Support to Safe Motherhood in Nepal	Ev 207
Tadeyose Belay	Ev 210
UK Network on Sexual and Reproductive Health and Rights Maternal Health Working Group	Ev 214
World Vision UK	Ev 224
YozuMannion Limited	Ev 226

List of unprinted written evidence

The following written evidence has been reported to the House, but to save printing costs it has not been printed and copies have been placed in the House of Commons Library, where it 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

List of Reports from the Committee during the current Parliament

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2007-08

First Report	DFID Departmental Report 2007	HC 64 (HC 329)
Second Report	Development and Trade: Cross-departmental Working	HC 68 (HC 330)
Third Report	Work of the Committee 2007	HC 255
Fourth Report	Reconstructing Afghanistan	HC 65

Session 2006-07

First Report	DFID Departmental Report 2006	HC 71 (HC 328)
Second Report	HIV/AIDS: Marginalised groups and emerging epidemics	HC 46-I&II (HC 329)
Third Report	Work of the Committee in 2005-06	HC 228
Fourth Report	Development Assistance and the Occupied Palestinian Territories	HC 114-I&II (HC 430)
Fifth Report	EU Development and Trade Policies: An update	HC 271 (HC 622)
Sixth Report	Sanitation and Water	HC 126-I&II (HC 854)
Seventh report	Fair Trade and Development	HC 356-I&II (HC 1047)
Eighth report	DFID's Programme in Vietnam	HC 732 (HC 1062)
Ninth report	Prospects for sustainable peace in Uganda	HC 853 (HC 1063)
Tenth report	DFID Assistance to Burmese Internally Displaced People and Refugees on the Thai-Burma Border	HC 645-I&II (HC 1070)

Session 2005-06

First Report	Delivering the Goods: HIV/AIDS and the Provision of Anti-Retrovirals	HC 708-I&II (HC 922)
Second Report	Darfur: The killing continues	HC 657 (HC 1017)
Third Report	The WTO Hong Kong Ministerial and the Doha Development Agenda	HC 730-I&II (HC 1425)

Fourth Report	Private Sector Development	HC 921-I&II (HC 1629)
Fifth Report	Strategic Export Controls: Annual Report for 2004, Quarterly Reports for 2005, Licensing Policy and Parliamentary Scrutiny	HC 873 (Cm 6954)
Sixth Report	Conflict and Development: Peacebuilding and post-conflict reconstruction	HC 923 (HC 172)
Seventh Report	Humanitarian response to natural disasters	HC 1188 (HC 229)