

# Choices for women: planned pregnancies, safe births and healthy newborns

The UK's Framework for Results for improving reproductive,  
maternal and newborn health in the developing world



# **Choices for women: planned pregnancies, safe births and healthy newborns**

The UK's Framework for Results for improving reproductive, maternal and newborn health in the developing world

December 2010

# Contents

Foreword	1
Summary	2
<b>Vision and Rationale</b>	<b>4</b>
1.1 Vision.....	5
1.2 The case for investment.....	7
1.3 Value for money.....	10
1.4 Challenges and opportunities .....	12
<b>Framework for Results</b>	<b>18</b>
2.1 Pillar One: Empower women and girls to make healthy choices .....	21
2.2 Pillar Two: Remove barriers that prevent access to quality services.....	24
2.3 Pillar Three: Expand the supply of quality services.....	27
2.4 Pillar Four: Enhance accountability for results at all levels.....	32
<b>Achieving Results</b>	<b>35</b>
3.1 Implementing through country programmes.....	36
3.2 Improving the effectiveness of the global response.....	41
3.3 Investing in global public goods.....	45
3.4 Harnessing UK expertise.....	46
<b>Annex: Monitoring and Evaluation Framework</b>	<b>47</b>
Glossary	53

# Foreword

One thousand women will die today in pregnancy or childbirth, the vast majority of them in low and middle income countries. For them, pregnancy has been a death sentence, a morbid lottery of chance. They die not from incurable disease or chronic illness but from conditions and complications that we have the power to prevent.

When a mother dies the loss to her family is immediate and tragic but the impact continues long-term. When a mother dies her family, community and society lose their future. The Prime Minister has therefore made it clear that this Coalition Government will place women at the heart of our development efforts. We have promised to save the lives of at least 50,000 women during pregnancy and childbirth and 250,000 newborn babies by 2015.



Equally importantly, since women and girls should be able to exercise choice over whether, when and how many children to have, we have also committed to making family planning available to at least another 10 million couples. In all of this, we will place a particular emphasis on reaching those who often find it hardest to access services – the poorest and most marginalised women and girls.

Improving reproductive, maternal and newborn health is one of the most cost-effective ways to empower women and accelerate development progress. Building on the unprecedented levels of political will that characterised the UN Summit in September 2010, this document sets out a clear and logical framework for achieving our goals. It blends experience of what works with fresh-thinking and a new focus on innovation and results, recognising that success will depend on committed action at all levels, by all stakeholders.

The Framework emphasises forging fresh partnerships as well as strengthening existing ones and makes the vital link between a woman's reproductive health and broader development outcomes. Crucially, it also contains a series of results and indicators against which we and others will monitor our performance and hold ourselves to account. This transparency will allow others to learn from our experience while also demonstrating whether we are achieving results and value for money.

We have a unique opportunity to improve the life chances of women and girls and their babies in some of the world's poorest countries. If we succeed we can leave this world a better place for generations to come. I believe that this Framework is a crucial step to achieving that goal. And I hope others will join us on this journey.

Andrew Mitchell  
Secretary of State for International Development

# Summary

## Vision and rationale

Our vision is a developing world where all women are able to exercise choice over the size and timing of their families, where no woman dies giving birth and where all newborns survive and thrive. This Framework for Results is an important way in which women and girls are being placed at the heart of the UK's development assistance.

The UK has two strategic priorities, to:

- i. **prevent unintended pregnancies** by enabling women and adolescent girls to choose whether, when and how many children they have
- ii. **ensure pregnancy and childbirth are safe** for mothers and babies.

Investing in reproductive, maternal and newborn health is highly cost effective and has far-reaching returns for women, families, societies, economies and the environment.

## Results by 2015

We will double our efforts<sup>i</sup> for women's and children's health to:

- **save the lives** of at least 50,000 women during pregnancy and childbirth and 250,000 newborn babies by 2015
- **enable at least 10 million more women to use modern methods of family planning** by 2015, contributing to a wider global goal of 100 million new users
- **prevent more than 5 million unintended pregnancies**
- **support at least 2 million safe deliveries**, ensuring long lasting improvements in quality maternity services, particularly for the poorest 40%.

## Framework for results

The UK will do more of what works, focusing on value for money, but also innovate, evaluate and continue to learn. As summarised in table 2 in chapter 2, there are four pillars for action:

- **empower** women and girls to make healthy reproductive choices and act on them
- **remove barriers** that prevent access to quality services, particularly for the poorest and most at risk
- **expand the supply of quality services**, delivering cost effective interventions for family planning, safe abortion, antenatal care, safe delivery and emergency obstetric care, postnatal and newborn care – delivered through stronger health systems with public and private providers
- **enhance accountability** for results at all levels with increased transparency.

<sup>i</sup> The UK will double its efforts in terms of the numbers of women's and babies' lives saved and women using family planning, backed by a doubling in investment in women and children's health from 2008 to 2012, sustained at that level to 2015. These are the high-level results that seek to illustrate far greater and wider improvements in reproductive, maternal and newborn health and women's empowerment achieved by the UK's investments and action.

## Achieving results

The UK will:

- **scale up action through country programmes**, giving increased resources and greater attention to the geographical areas within DFID's portfolio and to the women and babies with the greatest need, focusing where the UK considers it has a comparative advantage
- **improve the effectiveness of the global response** through our engagement with international institutions, partnerships and global civil society
- **invest in global public goods** including market efficiencies, research and evidence
- **harness UK expertise** through better partnerships with academics, professional bodies and other UK government departments to help deliver this Framework.

## Core indicators for tracking progress

We will track a core set of indicators as part of a wider relevant set across our programmes. These are:

- **women's lives saved during pregnancy and childbirth** – calculated from changes in maternal mortality rates
- **newborn lives saved** – calculated from changes in neonatal death rates
- **number of women using family planning** – calculated from change in contraceptive prevalence rate (CPR) for women of reproductive age (15–49) using modern methods; for all women, the poorest 40% and young women aged 15–19
- **number of unintended pregnancies prevented** – calculated from couple years of protection supported
- **number and percentage of safe deliveries** – births with skilled attendance for all women and the poorest 40%.

The UK will invest in stronger monitoring systems and robust evaluation and help strengthen the capacity of partner countries to track their progress.



# Chapter 1

## Vision and Rationale

*'The choices [a woman or adolescent girl] can make for herself and her child... make a fundamental difference to current and future generations across the developing world.'*

Partnership for Maternal, Newborn and Child Health and University of Aberdeen, 2010



# Vision and Rationale

## 1.1 Vision

1. **Our vision is a developing world where all women are able to exercise choice over the size and timing of their families, where no woman dies giving birth and where all newborns survive and thrive.** Recent data have demonstrated that progress towards this vision is possible but there is still a long way to go. The UK has played a significant role in getting this far. The UK will accelerate action to 2015 through this Framework for Results for reproductive, maternal and newborn health.

2. **The UK has two strategic priorities:**

- i. **prevent unintended pregnancies** by enabling women and adolescent girls to choose whether, when and how many children they have
- ii. **ensure pregnancy and childbirth are safe** for mothers and babies.

Box 1 below outlines the high-level results by which success will be measured.

3. **This Framework outlines why prioritising reproductive, maternal and newborn health is important and why it is excellent value for money.** It sets out how the results will be achieved. It will guide DFID's country programmes, in line with national health plans and the wider health priorities of our partner countries. It will guide how the UK government will work with international organisations and other partners to leverage greater results. The monitoring and evaluation framework (See Annex) is critical, not only to track progress but to enable us to continually strengthen interventions and improve outcomes.

4. **The Framework is informed by evidence, expert and public opinion, and a process of country level planning.** The UK government has compiled a series of evidence papers that summarise the vast and growing body of evidence available. Extensive online consultations were carried out with the public and with experts across the world and meetings were held in the UK, India, Kenya and South Africa. Through DFID's Bilateral Aid Review, country offices set out country-specific outline plans. DFID's Multilateral Aid Review is informing the UK's engagement with international partners. Both processes will report in 2011.

### Box 1: Results by 2015<sup>a</sup>

The UK's support will have saved the lives of at least 50,000 women during pregnancy and childbirth and 250,000 newborn babies:

i) Preventing unintended pregnancies:

- At least 10 million more women can use modern methods of family planning, contributing to a global total of 100 million through partnerships
- Up to 1 million young women aged 15–19 to access family planning with action for adolescent girls that enable them to delay their first pregnancy
- More than 5 million unintended pregnancies prevented.

(ii) Ensuring pregnancy and childbirth are safe for mothers and babies:

- At least 2 million safe deliveries, with long lasting improvements in access to quality maternity services, particularly for the poorest 40%.

<sup>a</sup> These are the key results expected (expanded in the Annex); they reflect greater and wider improvements in reproductive, maternal and newborn health and women's empowerment achieved by the UK's investments and action.



**Box 2: What reproductive, maternal and newborn health seeks to address**

Women and men should have the capability to reproduce, the freedom to choose whether, when and how many children to have and be able to enjoy a healthy sex life. This means ensuring access to comprehensive sexual and reproductive health services and being able to realise their rights. Family planning services help women plan their pregnancies, avoid abortions and achieve their desired family size. If a woman seeks abortion, for example when these services fail, safe abortion saves women's lives.

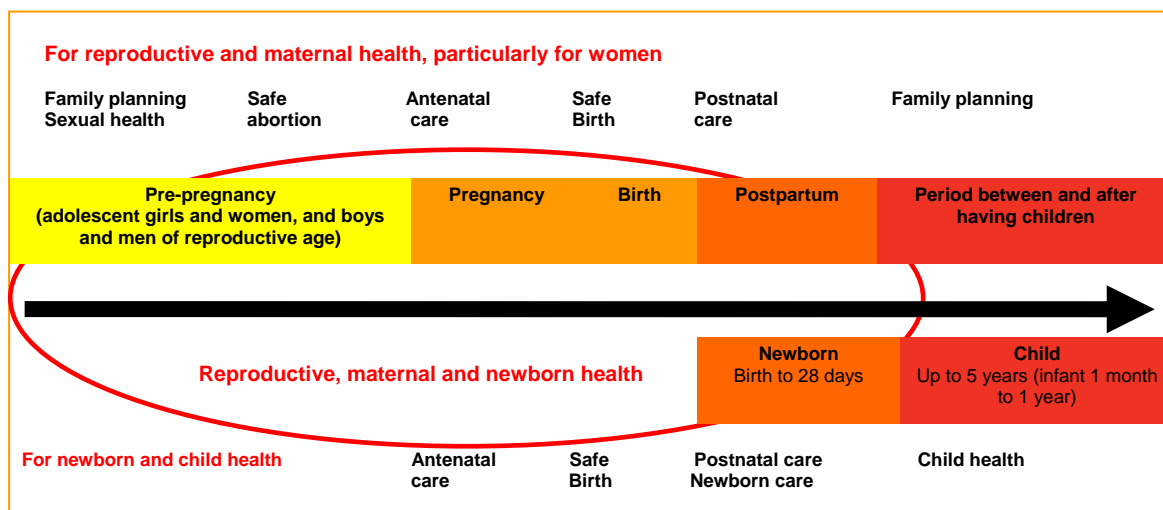
Women and girls need educational, nutritional and psychological support before they become pregnant. Good nourishment and regular antenatal care throughout pregnancy help ensure a healthy mother and baby. At childbirth, and soon after, skilled care for mother and baby is crucial, because the risks of death and serious complications are greatest at that time. The health of mothers and babies has to be monitored and they must be cared for for at least six weeks after childbirth to prevent, detect and treat problems.

An early start to breastfeeding is very important and babies should be breastfed exclusively during the first six months. Adequate nutrition, immunisation, good hygiene and other health care for babies are essential from birth and throughout childhood. A healthy start ensures a healthy future.<sup>b</sup>

<sup>b</sup> Source: Partnership for Maternal, Newborn and Child Health (PMNCH) and University of Aberdeen, *Sharing Knowledge for Action on Maternal, Newborn and Child Health*. Geneva, Switzerland: PMNCH; 2010.

5. **The scope of this Framework is outlined in Box 2 and Figure 1 overleaf.** This Framework for Results forms an important part of the UK government's support to women and children's health, wider health, broader poverty reduction and the achievement of the Millennium Development Goals (MDGs).
6. **The focus is on adolescent girls and women of reproductive age and their newborn babies.** Critically, this focus is part of the 'continuum of care' that extends into childhood (see Figure 1). The UK continues to support infant and child health through a range of actions on nutrition, immunisation, malaria and the management of childhood illness as well as wider determinants of child health such as sanitation, water and hygiene. Although the Framework focuses primarily on the health of women and girls, it recognises that men and boys have sexual and reproductive health needs and rights as well; and that working with men and boys is critical to achieving outcomes for women and girls. Whilst this Framework focuses on reproductive, maternal and newborn health, the UK supports broader women's health issues, including non-communicable diseases, tuberculosis, HIV, malaria and undernutrition, some of which are included in the Framework. The Framework is clear that strong health systems are needed to deliver reproductive, maternal and newborn health services.
7. **Responsibility for delivering the Framework does not lie with the health sector alone.** There are also social, economic, political and environmental drivers of better health.

**Figure 1:** Reproductive, maternal and newborn health within women and children's health and 'continuum of care' from pre-pregnancy to childhood



## 1.2 The case for investment

### The need is great

8. **Despite many commitments and 'safe motherhood' initiatives since the late 1980s, the number of women and babies at risk of death or illness remains unacceptably high.** Of the 8 Millennium Development Goals, Goal 5 to improve maternal health is one of the most off-track.<sup>1,2</sup>

9. **Globally, 215 million women who want to delay or avoid a pregnancy are not using an effective method of family planning.**<sup>3</sup> Each year there are 75 million unintended pregnancies and 44 million end in induced abortion.<sup>4</sup> According to new WHO data, in 2008 an estimated 22 million unsafe abortions took place.<sup>5</sup> Unsafe abortion results in about 70,000 deaths of women and girls each year, although many go unreported.<sup>6</sup> Each year there are many as 340 million new cases of common curable sexually transmitted infections (STIs).<sup>7</sup> Some, such as syphilis, have serious effects on health – including the survival chances of unborn babies – and on fertility.<sup>8</sup> HIV is now the major cause of maternal death in South Africa and Zimbabwe.<sup>9,10</sup>

10. **Each year, more than one third of a million women and girls die in pregnancy or childbirth.**<sup>11</sup> Some 60 million women give birth not in a health facility. 50 million of them give birth without skilled care.<sup>12</sup> The likelihood of a woman dying from pregnancy- and childbirth-related causes is 1 in 14 in Chad and Somalia, compared with 1 in 4,700 in the UK.<sup>13</sup> The most common causes of death are bleeding (post-partum haemorrhage), high blood pressure (eclampsia) and infection (sepsis). Most deaths in pregnancy or childbirth in developing countries are entirely avoidable. Yet these deaths are only the tip of the iceberg. For every woman who dies, up to 30 more suffer a debilitating illness or permanent disability. This can be accompanied by stigma and social exclusion, as is often the case with untreated obstetric fistula that affects more than 2 million girls and women.<sup>14</sup> Undernutrition contributes to one in five maternal deaths and leads to poor foetal and early childhood growth which can be irreversible and have life-long effects.<sup>15</sup> Infections, such as malaria, HIV, TB and hookworm, and practices such as female genital mutilation/cutting (FGM/C) increase risk to women and babies.<sup>16</sup>

**11. Intrinsically linked to their mothers' health, the chances of a newborn baby dying remain stubbornly high.** This is despite the achievement of significant reductions in infant and child deaths. Every year, 3.6 million babies die before they are a month old – some 41% of all deaths in children under 5 years of age. The three major causes of neonatal deaths in settings where newborn deaths are high are: infections (sepsis); complications of preterm birth; and lack of oxygen at birth (birth asphyxia) – these account for over 80% of all newborn deaths globally. In addition, around 3 million stillbirths were reported globally in 2000, a third of which occur during birth, mainly due to their mother's high blood pressure or obstructed labour.<sup>17</sup> The minutes and hours around childbirth is the time when the risk of death is greatest for women and babies. About 2 million lives a year are lost due to complications occurring in labour and birth.<sup>18</sup>

### The benefits are far reaching

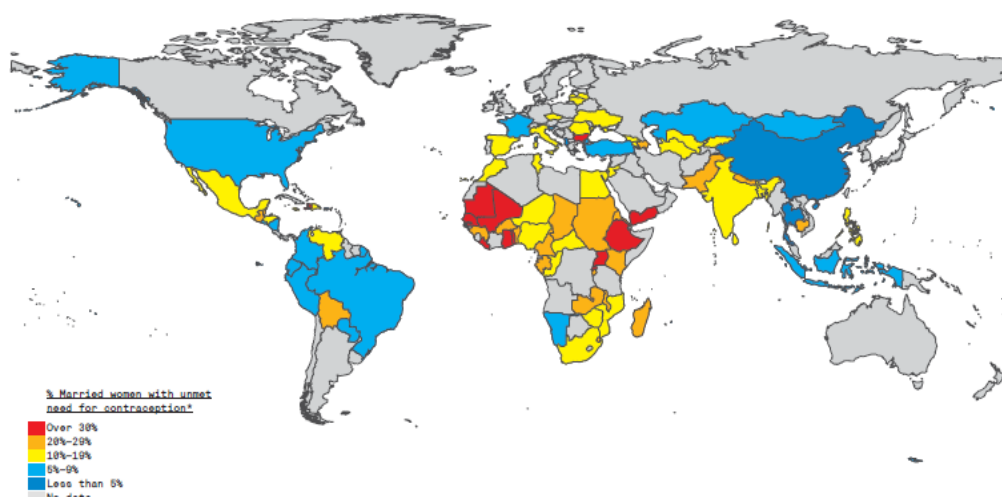
**12. Improved reproductive and maternal health can improve the status of women and strengthen equality between men and women.**<sup>19</sup> A woman's social, economic and other opportunities in life are enhanced by being able to make fertility and other health choices.<sup>20</sup> They are increased further by her ability to live free from pregnancy- and childbirth-related disability and the stigma that can accompany it. Preventing pregnancy in young adolescents makes a particularly significant difference to girls' life chances. Gender equality and women's empowerment are both a means to and an end of improved reproductive, maternal and newborn health.<sup>21</sup>

**13. Investment saves lives, particularly when those most at risk, including the youngest and oldest women, are reached.** Maternal and newborn services include proven life-saving interventions such as emergency obstetric care. Saving mothers' lives increases children's chances of survival.<sup>22</sup> Globally, meeting the unmet need for family planning alone could avoid around a third of maternal deaths and a fifth of newborn deaths.<sup>23,24</sup> Birth spacing saves babies and infants: international survey data show that babies born less than two years after their next oldest sibling are twice as likely to die in the first year as those born after an interval of three years.<sup>25</sup> Family planning also reduces mother to child transmission of HIV by preventing unintended pregnancies, and, when condoms are used by men and women, prevents HIV transmission. Improved maternal nutrition prevents women from suffering iron deficiency anaemia and other micronutrient deficiencies that increase risk of complications, for example severe haemorrhage in childbirth.

**14. The health and population benefits of reproductive, maternal and newborn health investments bring wider benefits to poor families, societies and economies with added intergenerational benefits.** The life chances of children are in part determined by the health and nutrition of their mothers before and during pregnancy. Household poverty can be mitigated by improving women's health and survival; women are the sole income earners in up to a third of all households. Services and programmes that remove or reduce costs of commodities, care or referrals to poor women can prevent families spiralling into debt. Health care costs can be catastrophic and a major cause of deepening and persistent poverty. National economies benefit when mothers and babies are healthy and when high fertility rates fall.<sup>26,27</sup>

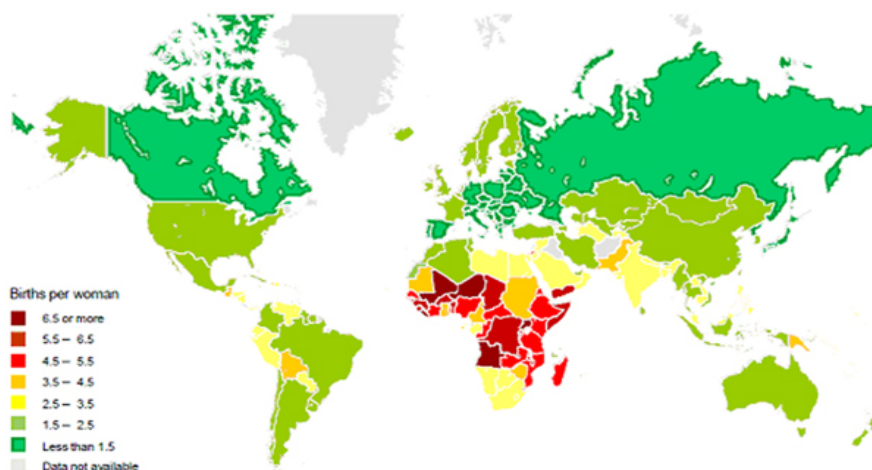
**15. Meeting the unmet need for family planning services, together with wider investment in girls' education and empowerment, will reduce unwanted fertility and slow population growth.** Most rapid population growth (greater than 2% a year) will take place in the poorest countries, where current fertility rates mean that populations are expected to double or triple by 2050. The largest generation of adolescents in history is entering their reproductive years, with growing demand for education and health services.<sup>28</sup> For example, in Kenya there will be a 60% rise in the number of school children aged between 5 and 14 by 2050.

Figure 2a: Unmet need for family planning



Source: Neal et al. *White Ribbon Alliance Atlas of Birth*. WRA, GHP3 (University of Southampton) and Impact (University of Aberdeen). London: 2010.<sup>29</sup>

Figure 2b: Total Fertility Rate



Source: Population and Sustainability Network from World Bank Development Indicators, 2006/ accessed 2008.

16. **Countries with high fertility and rapid population growth also tend to have high proportions of women and girls who want to delay or avoid a pregnancy** (see Figure 2a and 2b).<sup>30</sup> In countries such as Rwanda and Uganda, with high levels of unmet need for family planning, national efforts are scaling up to address reproductive health needs and rights and in recognition of the implications of population growth for food security and basic services.

17. **Reduced unwanted fertility and smaller families can reduce vulnerability to the effects of climate change and lessen pressure on scarce natural resources.** Some 37 of the 41 national plans for climate change adaptation recognise that rapid population growth exacerbates harmful impacts on water and land availability and food security.<sup>31</sup> Recent evidence, whilst not dismissing the urgent need to cut carbon emissions in the developed world, suggests reduced population growth will also reduce climate change in the medium to long term.<sup>32</sup>

## The UK has made international commitments

**18. Prioritising reproductive, maternal and newborn health is important for meeting our commitments to the MDGs**, particularly those for child and maternal health. In 2010, the UK government committed to double its efforts for women and children's health to 2015, in order to save 50,000 lives of women during pregnancy and childbirth and 250,000 newborn lives, and to enable at least 10 million couples to use family planning by 2015.<sup>ii</sup>

**19. This Framework is one important element of the UK's commitment to put women and girls at the heart of our international development assistance<sup>iii</sup> and fulfil the UK's commitments to women's rights.** These include commitments made in: the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) signed in 1981; the Program of Action of the 1994 International Conference for Population and Development (ICPD) and subsequent agreements; the 1995 Commission on the Status of Women's Beijing Declaration and Platform for Action; and the UN Human Rights Council's 2010 Resolution on Maternal Health.

### 1.3 Value for money

**20. Most interventions offer excellent value for money.** For example:

- Family planning is considered a 'best buy' in global health and in development more broadly due to its low cost and far reaching benefits. Costs vary across the world but in 2008 it was estimated that meeting all the need for contraception in the developing world would cost an average of \$1.20 per person per year or \$8 per year per woman using modern contraception.<sup>33</sup> It costs an estimated \$28 to avert an unintended pregnancy and \$62 to save a DALY.<sup>iv</sup>
- Maternal and newborn care interventions are high impact and generally very low cost. Table 1 below shows how costs per healthy life year saved range from just \$1 to \$36 for individual interventions.

**21. Packages of interventions are cheaper than the sum of their parts.** These can be built up incrementally according to local context and resources available. Table 1 also shows that a mix of both preventative and clinical services, including the treatment of severe pre-eclampsia and emergency neonatal care, costs \$73 per healthy life year saved.<sup>34</sup> To actually avert a maternal death through 'improved overall quality of care and coverage with nutritional supplements' is estimated to be approximately \$3,000 in Africa and \$5,000 in south Asia but this will vary depending on context and over time.<sup>35</sup>

**22. For a clinic, a hospital and the wider health service, it is far cheaper to prevent rather than treat complications of an unintended pregnancy.** The cost per woman to health systems for the treatment of abortion complications in Tanzania was more than seven times the overall Ministry of Health budget per head of population in 1999.<sup>36</sup> In one district in Maputo in Mozambique, post-abortion care admissions represented more than 55% of obstetric complications treated.<sup>37</sup>

<sup>ii</sup> The commitment to double our efforts for women and children's health was made by the Deputy Prime Minister at the launch of the UNSG's Global Strategy for Women and Children's Health in September 2010, building on an earlier announcement by the Prime Minister in relation to the G8 Muskoka Initiative in June 2010.

<sup>iii</sup> In line with DFID's Departmental Business Plan, published in late 2010.

<sup>iv</sup> A Disability Adjusted Life Year (DALY) can be thought of as one lost year of healthy life due to disease or injury.



**23. Implementing reproductive health services and maternal and newborn care at the same time in the same place saves lives and saves money.** The cost of meeting the need for both modern family planning and maternal and newborn health services is \$4.50 per capita per year.<sup>38</sup> Globally, an estimated \$5.1 billion that would otherwise be required for maternal and newborn care can be saved by meeting the unmet need for family planning.<sup>39</sup> Substantial savings can be made across other sectors as well. In Zambia, by reducing fertility and pressure on services, one dollar invested in family planning saved \$4 in health, education and other sectors.

**24. Failure to invest in systems underpinning the delivery and/or regulation of services and to remove wider barriers to services can place investments at risk.** DFID's Health Portfolio Review noted that underwriting the salaries of health workers in both Malawi and in Zimbabwe prevented a collapse of the health system.<sup>40</sup> Equally, failure to reach the poorest and most vulnerable can undermine progress.

**Table 1:** Cost-effectiveness of maternal and newborn health interventions on an optimal expansion path in African countries with high child and very high adult mortality, in 2000 (Source: WHO-CHOICE published in the BMJ, 2005).<sup>41</sup>

	Intervention package	Average cost per DALY averted (\$)	Incremental cost per DALY averted when package built up (\$)
A1	Community-based management for neonatal pneumonia	1	1
A2	A1+ Community newborn care package (breastfeeding, support low birth weight babies)	7	8
A3	A2+ Tetanus Toxoid for mothers	11	22
A4	A3+ Antenatal care screening for pre-eclampsia, asymptomatic bacteriuria and screening and treatment of syphilis	12	27
A5	A4+ Skilled maternal and immediate care of newborn care	18	40
A6	A5+ Treatment of severe pre-eclampsia	19	42
A7	A6+ Management of emergency neonatal care (facility based care of very low birth weight babies, severe neonatal infections, severe asphyxia and neonatal jaundice)	25	61
A8	A7+ Management of obstructed labour, breech position and foetal distress	28	73
A9	A8+ steroids for pre-term birth	32	117
A10	A9+ management of maternal sepsis	34	125
A11	A10+ antibiotics for pre-term premature rupture of membranes	35	178
A12	A11+ referral for post partum haemorrhage	36	223

## 1.4 Challenges and opportunities

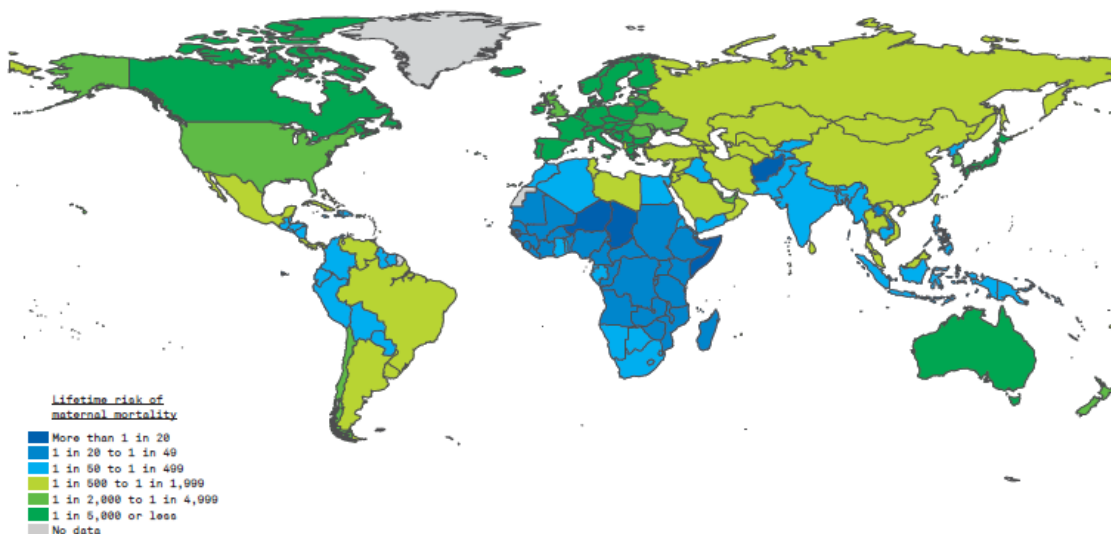
**25. Globally, we have a unique opportunity to make real and lasting progress by 2015 and beyond, with political commitment, common priorities and national level action.** But there are a range of challenges facing countries aiming to improve reproductive, maternal and newborn health, including: a changing global economy; growing population and pressure on services particularly in urban areas; a changing climate; and insecurity and conflict.

### Reaching those left behind

**26. Persistent inequalities exist in reproductive, maternal and newborn health, between and within countries.**<sup>42</sup> Within countries, these can be between different socio-economic groups, rural and urban areas and different age groups. Marginalised women include those living with HIV or a disability, or those affected by conflict and crises.

**27. Additional efforts are required to accelerate progress in regions, countries and sub-national areas with high burdens and with little or no progress.** Globally, the numbers of maternal and newborn deaths remain concentrated. Eleven countries account for 65% of all maternal deaths.<sup>v,vi</sup> Over half of these countries are showing little or no progress in improving maternal health.<sup>43</sup> A woman's risk of dying during pregnancy or in childbirth remains very high in sub-Saharan African countries and in Afghanistan – where women face the highest lifetime risks (Figure 3a). Newborn deaths are concentrated in a similar group of countries (Figure 3b).<sup>44</sup> Although globally contraceptive use has increased, it remains low in West, Central and East Africa, especially West Africa, where acceptability and use are both low. Some 35 of the 43 countries with high fertility, with an average of 4 or more births per woman, are in sub-Saharan Africa.<sup>45</sup>

**Figure 3a:** Lifetime risk of maternal death

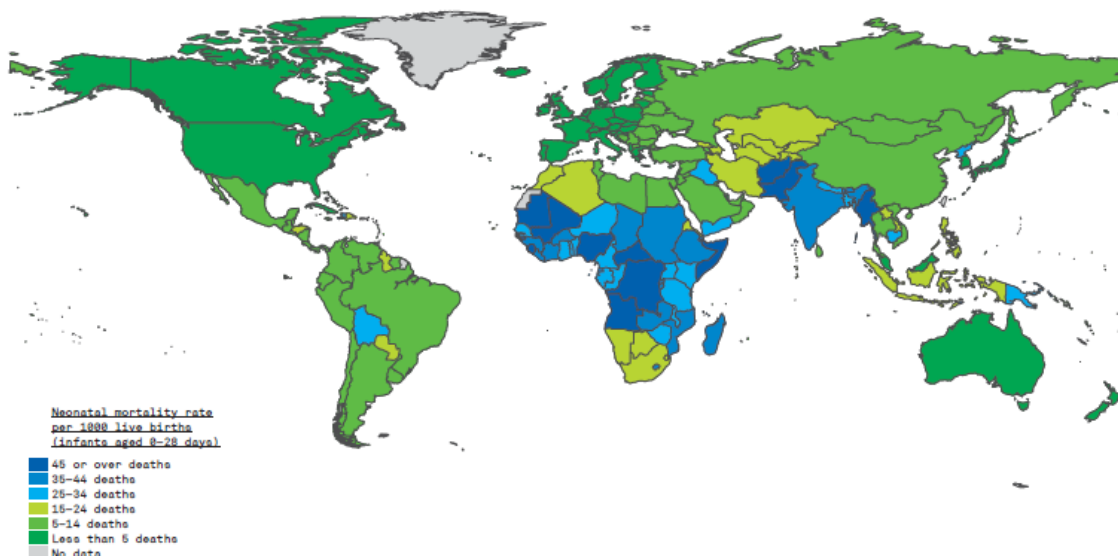


Source: Neal et al. *White Ribbon Alliance Atlas of Birth*. WRA, GHP3 (University of Southampton) and Immpact (University of Aberdeen). London: 2010.<sup>46</sup>

<sup>v</sup> Where both numbers of births and risk of dying are high.

<sup>vi</sup> 11 countries - India, Nigeria, DRC, Afghanistan, Pakistan, Ethiopia, Tanzania, Bangladesh, Indonesia, Sudan and Kenya – account for 65% of maternal deaths; 50% of maternal deaths occur in the first six.

Figure 3b: Newborn deaths



Source: Neal et al. *White Ribbon Alliance Atlas of Birth*. WRA, GHP3 (University of Southampton) and Immpact (University of Aberdeen). London: 2010.<sup>47</sup>

**28. Progress has generally been slowest where health systems are weak, often due to conflict and/or chronic underinvestment, or where the burden of disease has increased or persisted.** Little progress has been made in conflict-affected countries such as the Democratic Republic of Congo (DRC) and Somalia. HIV has significantly slowed progress in reducing maternal deaths in sub-Saharan Africa, even reversing progress in Southern Africa. Low birth weight and anaemia in girls are pervasive in South Asia.

**29. The poorest women have the greatest need but are being left behind.** Women in the poorest 20% of households are more than five times less likely to give birth with a skilled attendant than women in the richest 20%<sup>48</sup> and are less likely to get good quality care. In most developing countries, the use of modern methods of contraception is lowest among poorer women and highest among the rich. For example in Uganda, it is only 7% among the poorest fifth compared to 38% in the wealthiest.<sup>49</sup> Progress is greater for richer groups, widening inequalities. In each country, a better understanding is needed of who are benefiting least and why so programmes and interventions can be better designed.

**30. The poor are being left behind in both rural and, increasingly, in urban areas.** The majority of future births will be in towns and cities as rural dwellers seek a better life by migrating. Climate change is predicted to exacerbate migration rates, as people seek viable livelihoods in a changing environment and as areas (including major cities) vulnerable to sea level rise become uninhabitable. Urbanisation can open up opportunities for improved standards of living, economic growth, economies of scale for information and services, and increasing demand for family planning to limit family size. But the poorest migrants and low-income peri-urban dwellers can have maternal and child death rates as high as or even higher than the rural poor.<sup>50</sup> A study of urban slums in Nairobi in Kenya estimated a maternal mortality ratio 25% higher than the national rate.<sup>51</sup>

**31. Adolescent sexual and reproductive health remains a neglected and sensitive issue in many contexts despite the following facts:**

- Adolescent girls are less likely to be able to choose whether and when to have a child than older women, and have a much higher unmet need for family planning<sup>52</sup>; there are 6.1 million unintended pregnancies each year among 15-19 year olds.
- Almost half of all maternal deaths from unsafe abortion in Africa are in women under 25.<sup>53</sup>
- Young people account for 40% of new HIV infections. And in Sub-Saharan Africa, adolescent girls have higher infection rates than their male counterparts.<sup>54</sup>
- In 2008, there were 14 million births to adolescent women aged 15-19; 5 million (16% of all births) in Africa and 6 million (12% of all births) in Asia.<sup>55</sup> Young women aged 15-19 are twice as likely to die in pregnancy and childbirth than older women and starting childbearing at a young age means a woman's risk of dying from pregnancy- and childbirth- related causes in her lifetime is increased.
- Nearly 10% of all adolescent girls in low and middle income countries become mothers before they are 16.<sup>56</sup> In sub-Saharan Africa, majority are married.<sup>57</sup> Girls aged 10-15 are five times more likely than women aged 20-24 to die in pregnancy or childbirth.<sup>58</sup>

**We know much of what needs to be done – and context is crucial**

**32. There is now a much stronger consensus as to what needs to be done, agreed by a range of actors.**<sup>vii</sup> Strategies for scaling up must be tailored to context.

**33. There is no single fix for saving the lives of women and babies during pregnancy and childbirth, one important reason why progress has been slow.** Systemic changes are needed. Bringing down the numbers of unintended pregnancies will make an important difference. But to save lives, women also need quality care during pregnancy, birth and in the critical first days after birth, including emergency care. Changes are needed in both the supply and in tackling the wider barriers to the uptake of services.

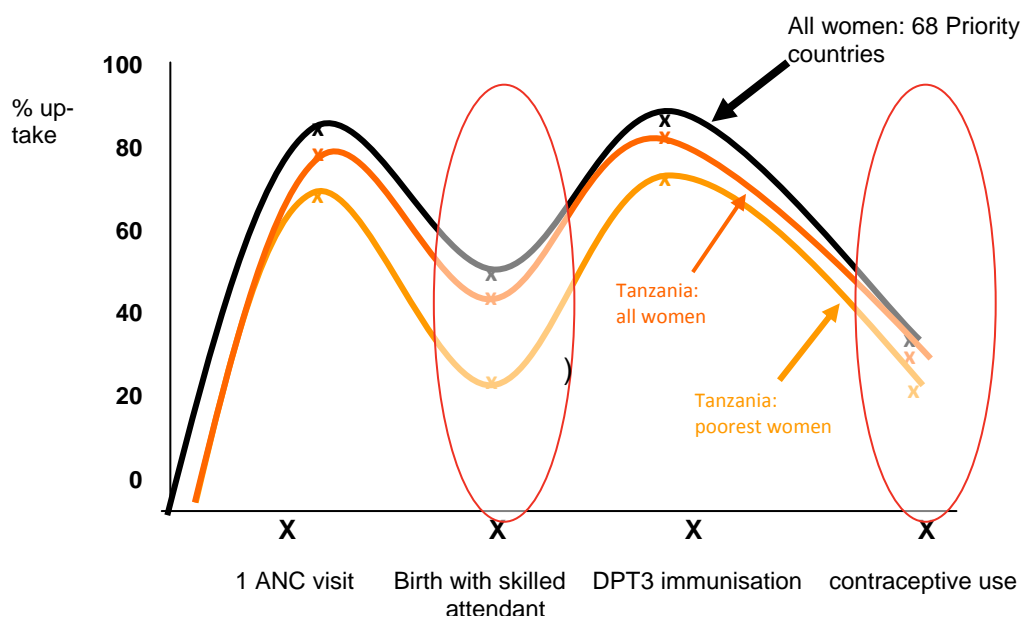
**34. Reproductive and maternal health are indivisible from the deep socio-cultural and political issues that surround women's empowerment.** Lack of investment in the wider determinants of poor health has constrained progress. A woman's status is often determined from birth when the value given to a girl child and her health and survival is often lower than for boys. A woman's or girl's relations with the men and boys around her and her status within a family and wider society will determine the importance given to her health, her ability to make decisions, and her call on household and other resources to access services.

**35. Globally there are important gaps in availability and utilisation of services for reproductive, maternal and newborn health.**<sup>59</sup> Figure 4 takes the example of Tanzania. Gaps are found particularly around family planning for spacing and limiting pregnancies safe births and post birth care. Coverage of these services is often low,

<sup>vii</sup> The 'Global Consensus on Maternal, Newborn and Child' outlines 5 priorities for action: (i) political leadership, community engagement and mobilisation; (ii) delivering high-quality services across the continuum of care (family planning, care for women and newborns during and after pregnancy and childbirth, safe abortion services (when legal), improved child nutrition and prevention and treatment of major diseases); (iii) removing barriers to access, with services for women and children being free at the point of use where countries choose; (iv) skilled and motivated health workers in the right place at the right time, with the necessary infrastructure, drugs, equipment, and regulation; (v) accountability at all levels for credible results. See [www.who.int/pmnch/topics/part\\_publications/2009\\_mnchconsensus/en/](http://www.who.int/pmnch/topics/part_publications/2009_mnchconsensus/en/) Our Framework for Results (Chapter 2 draws heavily on this).

especially in sub-Saharan Africa. Opportunities are being missed to increase uptake by providing services together, including family planning after childbirth and abortion.

**Figure 4:** ‘Dipping-in-and-out of the health system’, important gaps in service provision.



Source: Graham, 2009, unpublished; Data sources: ‘Countdown to 2015 (2008) Report’; Tanzania Demographic and Health Surveys 2004-2005

**36. There are well-tested, effective and safe drugs, commodities and procedures required for reproductive, maternal and newborn health.** And there is continuing biomedical and technological innovation. But these must all reach the women who need them. Whether it is ‘uniject’ syringes for injectable contraceptives, magnesium sulphate for eclampsia, antenatal steroids for preterm labour,<sup>60</sup> ‘kangaroo mother care’ for newborns,<sup>61</sup> the drugs misoprostol and oxytocin to prevent or treat postpartum haemorrhage, or the range of more widely established interventions, these need to be reliably available at scale, as appropriate. Innovation, and implementation research, are needed for *how* to do this.

**37. After years of often donor-driven disease-specific programmes, there is now a stronger consensus that investment in health systems underpins the achievement of all health MDGs.** This includes reproductive, maternal and newborn health.

### Resources and unprecedented political will to accelerate progress

**38. National level responses have varied but collective investments are paying off.** In Nepal, Rwanda and Bangladesh strong political commitment coupled with evidence-based health and broader development policies have led to significant reductions in the risks of maternal deaths. There is an opportunity to learn lessons from these and other countries, and apply them, as appropriate, to different contexts. A focus at the local level is critical for real and lasting change.

**39. At the international level, the response has often been fragmented, unpredictable and ideologically-driven.** Progress in family planning, in particular, has stalled in the last decade as donor investment shifted to HIV and AIDS.<sup>62</sup> However, with international consensus on evidence-based priority policies, new mechanisms to promote harmonisation and alignment to country plans and strong international partnerships, there is a real opportunity to better support developing



countries' priorities for long-lasting change. Wider development agendas, including climate change, now explicitly recognise the importance of population growth and need for voluntary reproductive health services.

**40. Accountability has been a missing ingredient.** Global and national commitments need to deliver change on the ground for poor families but it has proven difficult to hold countries and development partners to account, largely owing to weak information flows. But commitments made in 2010 to strengthen accountability, including from the African Union and the UN Secretary General's Global Strategy for Women's and Children's Health, plus an increasingly mobilised and well organised civil society, provide opportunities to ensure that countries and development partners deliver on their promises.

**41. The UK has played a leading role in efforts to date but more needs to be done, and more effectively.** A review carried out in 2009 to assess the value for money of DFID's investments in health, and to identify ways to get even better value for money, indicated that interventions to improve reproductive, maternal and newborn health are highly cost effective and recommended DFID should increase spend on child and maternal health (MDGs 4 and 5).<sup>63</sup> The UK's direct funding for family planning has been particularly low to date.

## Chapter references

- <sup>1</sup> WHO. Trends in maternal mortality 1990 – 2008. Geneva; 2010.  
[http://whqlibdoc.who.int/publications/2010/9789241500265\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf).
- <sup>2</sup> The Countdown to 2015 Initiative. Countdown to 2015 Decade Report. Geneva; 2010.  
<http://www.countdown2015mnch.org/reports-publications/2010-report/2010-report-downloads>
- <sup>3</sup> Singh S et al (a). *Adding it Up: the costs and benefits of investing in family planning and maternal and newborn health*. Guttmacher Institute and UNFPA; 2009.
- <sup>4</sup> *Ibid*.
- <sup>5</sup> WHO and HRP. *Unsafe abortion in 2008: Global and Regional Levels and Trends*. 2010.
- <sup>6</sup> Singh S et al (b). *Abortion Worldwide: A decade of uneven progress*. Guttmacher Institute; 2009.
- <sup>7</sup> WHO. Global prevalence and incidence of selected curable sexually transmitted infections: overview and estimates. Geneva; 2001.
- <sup>8</sup> WHO. Global elimination of congenital syphilis: rationale and strategy for action. Geneva; 2007.
- <sup>9</sup> UNAIDS. Global Report. UNAIDS report on the global AIDS epidemic 2010.
- <sup>10</sup> Munjanja, SP. *Maternal and Perinatal Mortality Study 2007*. Ministry of Health and Child Welfare, Zimbabwe; 2009.
- <sup>11</sup> WHO, 2010. *op.cit*.
- <sup>12</sup> Blencowe H, et al. *Clean birth kits – potential to deliver? Evidence, experience, estimated lives saved and cost*. 2010.
- <sup>13</sup> WHO, 2010. *op.cit*.
- <sup>14</sup> WHO. *Obstetric fistula: Guiding principles for clinical management and programme development*. WHO: 2006.
- <sup>15</sup> Black R et al. Maternal and child undernutrition: global and regional exposures and health consequences, *Lancet*, 2008, 371(9608): 243-260.
- <sup>16</sup> WHO. *Female genital mutilation and obstetric outcome: WHO collaborative prospective study in 6 African countries*. WHO: 2006  
[www.who.int/reproductivehealth/publications/fgm/fgm-obstetric-outcome-study/en/](http://www.who.int/reproductivehealth/publications/fgm/fgm-obstetric-outcome-study/en/).
- <sup>17</sup> Lawn et al. Global report on preterm birth and still birth (1of7): definitions, description of the burden and opportunities to improve data. In *Global report on preterm birth and still birth: the foundation for innovative solutions and improved outcomes*. BMC Pregnancy and Childbirth 2010, 10 (suppl 1).
- <sup>18</sup> The Countdown to 2015 Initiative, 2010, *Op Cit*.
- <sup>19</sup> Gill K, Pande R and Malhotra A, Women deliver for development, *Lancet*, 2007, 370(9595):1347–1357.

- <sup>20</sup> Women's Studies Project. [www.fhi.org/en/RH/Pubs/wsp/index.htm](http://www.fhi.org/en/RH/Pubs/wsp/index.htm).
- <sup>21</sup> Commission on Social Determinants of Health, WHO, *Achieving Health Equity: From Root Causes to Fair Outcomes*, WHO, 2007.
- <sup>22</sup> Ronsmans C, et al. Effect of parent's death on child survival in rural Bangladesh: a cohort study. *Lancet* 2010; 375:2024–31.
- <sup>23</sup> WHO (2009). 'Women and health: today's evidence tomorrow's agenda.' [http://whqlibdoc.who.int/publications/2009/9789241563857\\_eng.pdf](http://whqlibdoc.who.int/publications/2009/9789241563857_eng.pdf).
- <sup>24</sup> Rutstein SO. Effects of preceding birth intervals on neonatal, infant and under-five years mortality and nutritional status in developing countries: evidence from the demographic and health surveys. *International Journal of Obstetrics and Gynaecology* 2005;89 (suppl. 1):S7-S24.
- <sup>25</sup> Macro International Inc., Demographic and Health Surveys, various years. In Smith R et al, *Family Planning Saves Lives: 4<sup>th</sup> Edition*. Population Reference Bureau: 2009.
- <sup>26</sup> Dalggaard C J, Hansen H. *Evaluating Aid effectiveness in the aggregate, a critical assessment of the evidence*. DANIDA; January 2010.
- <sup>27</sup> Bloom DE, Williamson JG. Demographic transitions and economic miracles in emerging Asia. *World Bank Econ Rev.* 1998; 12: 419–455.
- <sup>28</sup> Guttmacher Institute and UNFPA, *Contraception: an Investment in lives, health and development* New York: 2008.
- <sup>29</sup> Data source: UNSTATS Millennium Development Indicator Database (most recent data 1995–2007) and DHS Statcompiler.
- <sup>30</sup> Cleland J et al. Family Planning: the unfinished agenda. *The Lancet* 2006; 368(9549): 1810-1827
- <sup>31</sup> Mutunga C, Hardee, K. *Population and Reproductive Health in National Adaptation Programmes of Action (NAPAs) for Climate Change, Working Paper WP 09-04*. Population Action International 2009
- <sup>32</sup> O'Neill, BC et al. Global demographic trends and future carbon emissions. *PNAS*; 2010; 107 (41); 17521–17526 [www.pnas.org/cgi/doi/10.1073/pnas.1004581107](http://www.pnas.org/cgi/doi/10.1073/pnas.1004581107).
- <sup>33</sup> Singh S et al (a) *op. cit.*
- <sup>34</sup> Adam, T et al. Cost effectiveness analysis of strategies for maternal and neonatal health in developing countries. *British Medical Journal*; 2005; 331:1107 (PDF). [www.bmj.com/content/331/7525/1107.full.pdf](http://www.bmj.com/content/331/7525/1107.full.pdf). WHO CHOICE seminal work 2005.
- <sup>35</sup> Graham, WJ et al, Maternal and Perinatal Conditions. In: Jamison, DT et al, ed. *Disease Control Priorities in Developing Countries*, 2<sup>nd</sup> edition; Oxford: OUP/World Bank; 2006 pp499-530.
- <sup>36</sup> Mapangile, G, Leshabari MT, and Kihwele, D.J., 1999. Induced abortion in Dar es Salaam, Tanzania: The plight of adolescents. In: Mundigo, A.L., Indiso, C., eds. *Abortion in the developing world*. New Delhi: WHO, pp.387-403
- <sup>37</sup> Jamisse et al, 2004, Averting maternal death and disability Reducing maternal mortality in Mozambique: challenges, failures, successes and lessons learned, *International Journal of Gynecology and Obstetrics* 85 (2004) 203–212
- <sup>38</sup> Guttmacher Institute, special analyses, In Singh S et al. (a) *op cit.*
- <sup>39</sup> Singh S et al (a) *op cit.*
- <sup>40</sup> DFID *Health Portfolio Review*. 2009
- <sup>41</sup> Adam, T et al. Cost effectiveness analysis of strategies for maternal and neonatal health in developing countries. *British Medical Journal*; 2005; 331:1107 (PDF). [www.bmj.com/content/331/7525/1107.full.pdf](http://www.bmj.com/content/331/7525/1107.full.pdf). WHO CHOICE seminal work 2005.
- <sup>42</sup> Marmot, M. on behalf of the Commission on Social Determinants of Health, *Achieving Health Equity: from root causes to fair outcomes*, *Lancet*, 2007, 370: 1153-63
- <sup>43</sup> WHO, 2010. *opc.it*
- <sup>44</sup> Lawn et al. *op. cit*
- <sup>45</sup> Cleland, J. DFID presentation, 21 September 2010.
- <sup>46</sup> Data source: WHO, UNICEF, UNFPA and World Bank (2010). Trends in Maternal Mortality 1990–2008
- <sup>47</sup> Data source: World Health Statistics 2010 (estimates for 2008)
- <sup>48</sup> O'Donnell, O. Access to health care in developing countries: breaking down demand side barriers *Cadernos de Saúde Pública* vol.23 no.12 Rio de Janeiro Dec. 2007 doi: 10.1590/S0102-311X2007001200003.
- <sup>49</sup> Macro International DHS Analysis 2003 –2006. In Smith R et al, *Family Planning Saves Lives: 4<sup>th</sup> Edition*. Population Reference Bureau: 2009.
- <sup>50</sup> Matthews Z, et al. Examining the "Urban Advantage" in Maternal Health Care in Developing Countries. *PLoS Med* 7(9) 2010: e1000327. doi:10.1371/journal.pmed.1000327 (accessed 17 Dec 2010)
- <sup>51</sup> National Coordinating Agency for Population and Development, Ministry of Health, Central Bureau of Statistics, ORC Macro *Kenya Service Provision Assessment Survey 2004*. Nairobi, Kenya: National Coordinating Agency for Population and Development, Ministry of Health, Central Bureau of Statistics, and ORC Macro; 2005.
- <sup>52</sup> UNFPA. *How universal is access to reproductive health? A review of evidence*. UNFPA; 2010. [www.unfpa.org/webdav/site/global/shared/documents/publications/2010/universal\\_rh.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/universal_rh.pdf)
- <sup>53</sup> WHO. *Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003. Fifth Edition*. 2007.
- <sup>54</sup> UNAIDS, 2010, *op cit.*
- <sup>55</sup> Guttmacher Institute and IPPF. *Facts on the Sexual and Reproductive Health of Adolescent Women in the Developing World*. 2010
- <sup>56</sup> WHO. Why is giving special attention to adolescents important for achieving Millennium Development Goal 5? Factsheet. Geneva: WHO; 2008.
- <sup>57</sup> Neal S, Very Early Adolescent Motherhood in Sub-Saharan Africa, Southampton: GHP3; 2010. [www.norad.no/attachment/142502/binary/76958?download=true](http://www.norad.no/attachment/142502/binary/76958?download=true)
- <sup>58</sup> Neal S et al. *White Ribbon Alliance Atlas of Birth*. WRA, GHP3 (University of Southampton) and Immpect (University of Aberdeen). London: 2010
- <sup>59</sup> Partnership for Maternal, Newborn and Child Health (PMNCH) and University of Aberdeen, *Sharing Knowledge for Action on Maternal, Newborn and Child Health*. Geneva, Switzerland: PMNCH; 2010.
- <sup>60</sup> Mwansa-Kambafwile J, et al. Antenatal steroids in preterm labour for the prevention of neonatal deaths due to complications of preterm birth. *Int J Epidemiol* 2010; 39 Suppl 1:i122-i133. doi: 10.1093/ije/dyq029
- <sup>61</sup> Lawn JE, et al. 'Kangaroo mother care' to prevent neonatal deaths due to preterm birth complications. *Int J Epidemiol* 2010; 39 Suppl 1:i144-i154.
- <sup>62</sup> UNFPA *op.cit.*
- <sup>63</sup> DFID *op.cit.*

Chapter 2

# Framework for Results

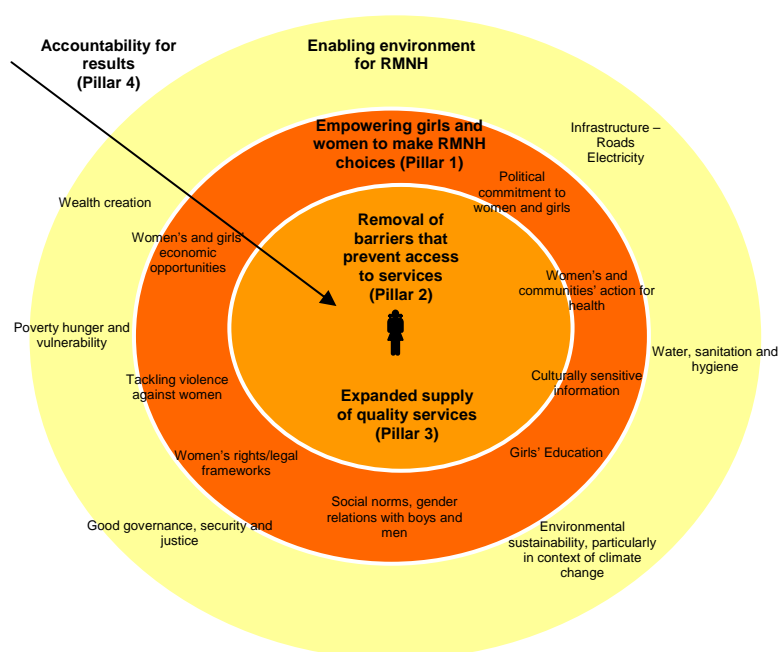


# Framework for Results

42. This chapter outlines the ‘Framework for Results’ (Table 2). The four pillars in this Framework and the priority actions within them are based on an understanding of the drivers of poor reproductive, maternal and newborn health, and evidence of what works and where the UK considers it can add most value to global and country level efforts. In any country, the prioritisation of action across pillars depends on the context, the UK’s comparative advantage and the objective.

43. The UK’s guiding principles for implementing the Framework will be to:

- **Demonstrate results, value for money, accountability and transparency.** Scale up what works; innovate and learn lessons wherever possible
- **Achieve objectives by reaching those not currently benefiting from progress.** Especially the poorest women and girls, young women under 20 and those affected by conflict and crises
- **Ensure action is context specific.** Base programmes on robust analysis that enable us to understand underlying causes and identify drivers for progress
- **Respond to national priorities.** Embed the UK’s support in national plans, programmes and budgets wherever possible to ensure a coordinated, locally relevant response
- **Use appropriate and effective aid instruments for the context.** Reduce transaction burdens and provide long term predictable funding, which are particularly important for the delivery of services
- **Work to ensure reproductive, maternal and newborn health outcomes are delivered by efficient, effective, sustainable and accountable health services.** Build national systems rather than deliver vertical programmes. These should be financed using equitable systems, delivered by both public and private providers
- **Support action to overcome a range of demand-side (Pillars 1 and 2) and supply-side (Pillar 3) barriers** to health care, addressing high impact, neglected issues that other donors will not or cannot address
- **Take a multi-sectoral approach to create an enabling environment for reproductive, maternal and newborn health** (Figure 5) in order to empower women and girls (Pillar 1) and address wider determinants of ill-health.



**Figure 5:** Putting the Framework for Results in the context of a wider multi-sectoral response



Preventing unintended pregnancies		Safe pregnancy and childbirth	
<b>Women and newborn lives saved [target at least 50,000 women during pregnancy and childbirth and 250,000 newborns by 2015]</b>			
<b>Numbers of women/couples using modern methods of family planning</b> calculated from Contraceptive Prevalence Rate – for all, poorest 40% of women, those aged 15-19; <b>Number of unintended pregnancies prevented</b> – modelled from Couple Years of Protection of family planning		<b>Number and percentage of births attended by a skilled birth attendant</b> - for all women and the poorest 40%	
<b>Target groups:</b> Those at greatest risk, especially growing numbers of young people, the poorest, those affected by conflict and natural disaster. <b>Programme focus:</b> Based on comparative advantage, where short, medium and long term impact can be delivered, on budget, with demonstrable results and value for money			
Framework for results			
Pillar 1 Empower women and girls to make healthy reproductive choices	Pillar 2 Remove barriers that prevent access to services, particularly for the poorest and most at risk.	Pillar 3 Expand the supply of quality services	Pillar 4 Enhance accountability for results at all levels
<b>Political commitment</b> to girls and women and their health at all levels <b>Legal frameworks</b> for girls' and women's rights and protection	<b>Financial barriers to services removed</b> , increasing purchasing power, choice and incentives where appropriate through services free at point of use, cash transfers, vouchers, cash incentives, social health insurance ( <i>see para 55 for important considerations</i> ).. Including for family planning.	<b>Increased coverage and integration of health services that provide high impact, cost effective interventions</b> for family planning, safe abortion, antenatal care, safe birth, emergency obstetric care, postnatal care, newborn care, with PMTCT, HIV prevention, nutrition, malaria, water, sanitation and hygiene	<b>Data and information systems</b> for registering births/deaths, better planning and tracking of results
<b>Girls' education</b> , including to lower secondary level	<b>Innovative approaches to referrals and transport</b> (to emergency obstetric care)	<b>Health workers</b> –especially midwives/equivalent and community health workers – trained, deployed, motivated, managed and supervised	<b>Enhanced accountability and transparency</b> between citizens, communities, civil society and providers
<b>Economic opportunities</b> including employment, income, assets, financial education and savings	<b>Tackling discrimination</b> and treatment of women in services. <b>Services that are appropriate for adolescents</b> , including married and unmarried girls at risk.	<b>Commodities</b> – product innovation (eg for long acting and reversible methods of family planning), getting supplies in the right place at the right time, making them affordable and available, social marketing	<b>Accountability for better performance</b> in RMNH services
<b>Locally-led social change</b> of norms that constrain women's choice, control over resources and body (eg early marriage, FGM/C, violence, cultural preferences for sons); working with men and boys	<b>Action for those affected by conflict and natural disaster</b> to improve reproductive, maternal and newborn health  <i>(Note: action to remove many social and cultural barriers is covered in Pillar 1)</i>	<b>More efficient and effective delivery of quality services by public or private providers</b> through quality assurance, management, regulation, performance based funding  <b>Delivery through a range of non state providers (private and NGOs) whenever appropriate</b> , cost effective and pro-poor - through social marketing, accreditation, innovation.	<b>International agencies</b> more accountable for better reproductive, maternal and newborn health outcomes
<b>Girls', womens' and wider communities' action</b> for RMNH  <b>Culturally sensitive information</b> especially about family planning, to meet unmet need and stimulate demand			

**Table 2:** Framework for results for reproductive, maternal and newborn health



## Pillar 1: Empower women and girls to make healthy choices

*“Women... are not dying because of conditions we cannot treat... they are dying because their societies have yet to make the decision that their lives are worth saving. The inconvenient truth ... is that the health scandal of maternal deaths is ... a question of how much the life of a ... woman is considered worth”.*

Professor M.F. Fathalla, Former President of the International Federation of Gynecology and Obstetrics

**44. Evidence shows that a girl’s or woman’s power to make informed choices about whether and when she becomes pregnant, to avoid unwanted sexual contact, violence and infection, to face fewer risks in the course of pregnancy and childbirth and to access services, depends on her ability to negotiate and control these issues.**<sup>64,65</sup> Reaching adolescent girls early in life and before they become pregnant prevents unintended pregnancies, complications, ill-health and poverty in adolescence and later life. Girls’ and women’s empowerment can be enhanced by policies and interventions within the health sector and across other sectors. These can work at individual level to increase girls’ and women’s capability and assets, at community and local levels, and at national level. Emerging evidence indicates the benefits of combining approaches.<sup>viii</sup> Overall, the strength of the evidence on what works is mixed and there is scope for innovation.

**45. There was a strong call in the consultation for the UK to champion women’s and girls’ reproductive and wider human rights.** Many felt the UK government should prioritise girls’ education and equality, and tackle violence against women and girls.

**46. Fundamentally, sustained political commitment at all levels to girls and women and their health is required.** This underpins the priority given to reproductive and maternal health in laws, policies and budgets at national, state and local levels.<sup>66,67</sup> It shapes the social and economic context within which girls and women live. Legal frameworks are an important way of enshrining these rights and political commitments. When strong, these can enable judicial recourse for violations where justice systems allow. The UK will champion reproductive, maternal and newborn health and the rights of women and girls, including the ICPD Programme of Action and the Beijing Declaration and Platform for Action commitments.

### Box 3: Political commitment across Africa

The Africa Union (AU) has the potential to catalyse commitment across the continent. The Campaign for the Reduction of Maternal Mortality in Africa (CARMMA), launched regionally and nationally, is bringing greater focus and political accountability to reproductive and maternal health. The AU has extended the Maputo Plan of Action on Sexual and Reproductive Health and Rights through to 2015. The UK welcomes renewed and strengthened commitment on these issues, and will work with national governmental partners, civil society and others to support these efforts.

<sup>viii</sup> For example, combining micro-credit and gender training in South Africa (see Box 4). The need for a ‘combination’ approach is recognized by those working on sexual and reproductive health in the context of HIV and AIDS (eg UNAIDS Outcome Framework 2009-2011, [http://data.unaids.org/pub/report/2009/jc1713\\_joint\\_action\\_en.pdf](http://data.unaids.org/pub/report/2009/jc1713_joint_action_en.pdf)).

**47. For girls' and women's empowerment, their education is critical, particularly through to lower secondary level.** Women with more years of schooling have better maternal health, fewer and healthier children and increased economic opportunities. Adolescent girls who are in school are likely to marry later, less likely to have premarital sex and more likely to use contraception. The proportion of girls who do not finish primary school in countries where DFID works ranges from between 15% and 65% and there is a lack of affordable options for mass progression to secondary education in most countries. Quality, comprehensive life skills and sexual health education, grounded in gender and relationship issues, are most effective in giving girls and boys the knowledge and skills they need to help them make healthier and more informed choices.<sup>68</sup>

**48. Girls and women with economic literacy, opportunities and assets can have a greater ability to negotiate and control resources and freedom to make choices.** These opportunities and assets could be gained through cash assistance, jobs, financial services, property and other productive assets, savings, skills development and market information. For adolescent girls, this process can begin with financial education, savings and opportunities for economic activity.<sup>69</sup> Enabling girls and women to benefit from economic progress often requires social change and legal reform, including changes in society's reliance on their unpaid work.

**49. Locally-driven social change activities can challenge and change norms that prevent girls and women from being able to take opportunities and to control their own bodies.** These include those working with religious and community leaders, men and boys, influential women and marginalised women and girls themselves. For example, in Senegal, communities have stopped female genital mutilation/cutting following community, rights-based education and declarations.<sup>70</sup> Emerging evidence from Ethiopia indicates that a combination of community interventions with the transfer of an asset and support to girls' education can reduce early marriage.<sup>71</sup> Combining social change and economic support can reduce violence against women (see Box 4). Civil society plays an important role in these activities.

#### Box 4: The importance of tackling rape and violence against women

There are limited data on the prevalence of violence against women and girls. But survey findings in a number of developing countries show a high level of tolerance of husbands beating their wives. Violence against women and girls (VAWG) is related to gynaecological disorders, unplanned pregnancy, the spread of sexually transmitted infections, pregnancy complications and abortion. As is the case in the UK, violence is more likely to occur when a woman is pregnant. Adolescent girls are particularly vulnerable – in both Malawi and Ghana around a third of girls reported that they were 'not willing at all' at their first sexual experience. In addition to the pervasive existence of violence in homes, it is also common in conflict affected areas where rape is a weapon of war.

It is possible to tackle violence. For example, in South Africa, two programmes, one using the Stepping Stones participatory social change methodology and one combining micro-finance with gender training, both decreased violence against women by their partners.<sup>c,d</sup> Across the UK government, work to tackle violence against women and girls will be increased.

<sup>c</sup> Jewkes, R et al, Impact of stepping stones on HIV and HSV2 and sexual behaviour in rural South Africa: cluster randomised control trial, *BMJ* 2008;337:a506 doi:10.1136/bmj.a506

<sup>d</sup> Kim JC et al, Understanding the impact of a microfinance based intervention on women's empowerment and the reduction of intimate partner violence in South Africa, *American Journal of Public Health* 2007; 97 (10): 1794-1802.

**50. Empowerment can be collective; supporting adolescent girls and women to mobilise, organise and take action for their own health has positive impacts.** Community action complements health services by increasing demand, participation and preventative action for better health, for example through improved hygiene during births at home and newborn care practices. This can be particularly important where services are weak, as is the case in post-conflict areas. In Nepal and India, strong evidence shows that women's groups have had demonstrable impacts on maternal and, particularly, newborn survival.<sup>72</sup> Emerging evidence shows that reaching marginalised girls (including married ones), and enabling them to meet in a safe place and engage with a mentor, can allow them to share ideas and information and support each other to make healthy choices.

**51. To make healthy choices, women, and their partners, need culturally sensitive and accurate information.** Mass media and community interventions can improve access to information about available services and preventative healthy action, and can increase wider social acceptance of interventions.<sup>73</sup> This is especially where both demand and unmet need for contraception are low. There is limited evidence for the impact of male involvement on preventing unwanted pregnancy and its effect on women's decision making and power. However, well targeted mass media campaigns in countries such as Zimbabwe have increased men's knowledge and acceptance of contraception.<sup>74</sup> There is scope for exploring the possibilities offered by new media technologies. Information alone is not enough to increase uptake of services: other barriers must be overcome and services must be readily available (Pillars 2 and 3).



Information about choice of contraceptives © Jenny Matthews / IPPF

## Pillar 2: Remove barriers that prevent access to quality services

**52. Evidence shows that inequality in access and use is markedly greater for reproductive, maternal and newborn interventions than for other health interventions.** However, countries like Brazil and Bangladesh show it is possible to change this.<sup>75</sup> Increasing the coverage of information, products and services (Pillar 3) is important but not sufficient. Informal and formal payments for health both constrain access and are a major cause of household debt, particularly ‘catastrophic’ payments for emergency obstetric care.<sup>76</sup> Although surveys indicate finance is not reported to be a major barrier to accessing contraception, in poorer countries, and for poorer women, access can be limited by cost (especially for long acting methods), not least the time and money spent travelling to a clinic.<sup>77</sup> Transport and socio-cultural barriers are also major constraints to access to services, often overlooked and poorly understood in service delivery.

**53. There was a strong call in the consultation for the UK to lead efforts to achieve equitable access to health services and ‘universal coverage.’**<sup>78</sup> This was particularly in relation to countries making their health services free at the point of use.

**54. Ultimately, the UK government will judge the success of this Framework by whether the poorest are reached in the countries we work in.** Disaggregated data, that track changes in the lives of poor and marginalised groups, are important. Analysis of who has poor reproductive, maternal and newborn health, and why, is critical.

**55. Removing financial barriers increases poor women’s uptake of reproductive, maternal and newborn health services.** This includes making essential health services free at the point of use<sup>79,ix</sup> and supporting the poorest women to meet the indirect costs of health care by piloting innovative approaches like cash transfer programmes.<sup>80</sup> Importantly, meaningful, sustained progress on removing financial and other barriers to access will have to be met with improvements in health service performance and quality to maximise health outcomes.<sup>81,82,83</sup> This applies to both public and private sector delivery (see Chapter 3 on Achieving Results).

**56. Countries and service providers need to consider a relevant mix of complementary, equitable health financing mechanisms and social assistance measures that improve health outcomes and enable poor women and children to access reproductive, maternal and newborn health services** (see Table 3). Where appropriate, we will support countries that wish to remove fees at the point of use of services and replace them with more equitable health financing systems. Social assistance programmes like unconditional and conditional cash transfers also have the potential to reduce women’s heavy workloads during pregnancy, support dietary improvements and enable women to spend more time caring for infants. Often broader acceptance, coverage and greater efficiency are achieved using a wider approach. Sometimes, instruments (such as incentives or vouchers) targeted at certain services and groups can be appropriate. For example:

- The Janani Suraksha Yojana (JSY), India’s conditional cash transfer scheme that gives women a cash incentive to give birth in a clinic, has increased the rate of institutional delivery from 41% to 73% between 2005 and 2009 and shown

<sup>ix</sup> Fees need to be replaced by equitable mechanisms for prepayment and pooling risk, such as tax funding, social health insurance or a combination of the two. To benefit reproductive, maternal and newborn health for the poorest, insurance schemes need to cover these services and to subsidise the poorest families’ participation using tax revenues or donor funds

promising health outcomes. It also highlights the need to ensure targeting enables the poorest women to benefit and to pay attention to the quality of obstetric care in health facilities.<sup>84</sup>

- In Bangladesh, early data from a pilot voucher programme that enables poor women to access maternal health services (delivered under the ongoing Health, Nutrition and Population Sector Programme) indicates that deliveries attended by skilled staff and referrals for women with complications both increased, and maternal mortality dropped. Globally, evidence on vouchers is still emerging.<sup>85</sup>

The UK will support robust analysis of what works to improve health outcomes for poor families.

**Table 3:** Instruments for removing financial barriers to access to services and products

Instrument	Link to reproductive, maternal and newborn health results for the poorest	Some examples in evidence
<b>Making services free at point of use</b>	Can be for all essential services or those for certain groups (eg for pregnant women and young children) or particular services (eg antenatal care and/or Emergency Obstetric Care). For reproductive health, the services that are free need to include at least certain contraceptives and other interventions. To improve health outcomes, often also requires the removal of social and transport barriers for the poorest and improved quality of services.	Sierra Leone, Ghana, Malawi, Zambia, Burundi
<b>Cash transfers</b>	Increase purchasing power and so enables poor households to afford a better diet and cover a range of health costs (transport, drugs, consultation as required) with direct and indirect benefits for health and nutrition. With or without conditions that require attendance at health clinics.	South Africa, Zambia, Malawi, Mexico, Brazil
<b>Cash incentives</b>	Payments to women when they have used the services: provides an incentive for use and enables women to recuperate costs.	Promising evidence from India, Nepal
<b>Vouchers for use of particular services</b>	Vouchers exchanged in place of payment for particular, or a package of, services delivered by an accredited provider (either public or private) that is then reimbursed. Vouchers have so far been used for family planning, safe delivery and safe abortion, and for services for marginalised groups.	Bangladesh, Pakistan, Kenya, Nicaragua
<b>Subsidised family planning products</b>	Approaches such as social marketing get contraceptives nearer to women who need them, including to remote areas, at reduced prices. Can reach remote areas but often don't reach the poorest 20%.	Ethiopia, Cameroon

**57. Effective referral systems, including affordable transport, save lives but there is no easy solution to geographic disadvantage, particularly in remote rural areas and where the terrain is difficult.** Studies from Tanzania and Nepal indicate transport costs can form 50% or more of the total costs of care.<sup>86</sup> Innovative approaches to scaling up referrals to emergency care are required, including transport, transport management and new technologies for planning. An increased number of well distributed clinics providing emergency obstetric care and a more extensive rural road network can also be important. The private sector can play an important role (see Box 5), so long as the models developed enable the poorest to benefit.



### Box 5: Private sector innovation in India

In Andhra Pradesh, an innovative Public Private Partnership (PPP) for emergency transportation works with the non-profit Emergency Management and Research Institute. The service has responded to more than 4 million emergencies since 2007, about 25% of which related to maternal and newborn health, and has been adopted by nine more Indian states.

**58. Stigma and discrimination – due to poverty, ethnic group, age, marital status, disability, sexuality, HIV status and other factors – exclude women and girls from services.** This is often overlooked yet significantly affects the quality of care. The health system reflects the society in which it operates but could be a model for equity and social change.<sup>87</sup> Approaches to overcome stigma and discrimination include: training of health workers; tailored services; accountability mechanisms and quality assurance; behaviour change communications strategies; and community engagement. Approaches that are friendly to adolescents are particularly important to encourage their use of information and services.

**59. Women and babies affected by crises, including conflict and natural disaster, often lack access to essential information and services.** Support to reproductive, maternal and newborn health during crises is an important but relatively neglected aspect of any humanitarian response. Relevant needs assessment is a critical first step, followed by sufficient supplies and relevant services. This includes supporting access to family planning, including emergency contraception, and access to safe abortion and other care as a response to rape.



Removing financial barriers and improving health service delivery in Sierra Leone © DFID

### Pillar 3: Expand the supply of quality services

60. **Evidence shows which interventions and approaches improve reproductive, maternal and newborn health.** There is a strong evidence base on the interventions and approaches but evidence on what works where and why is more limited. Exactly how to scale up depends on context.<sup>88,89</sup>

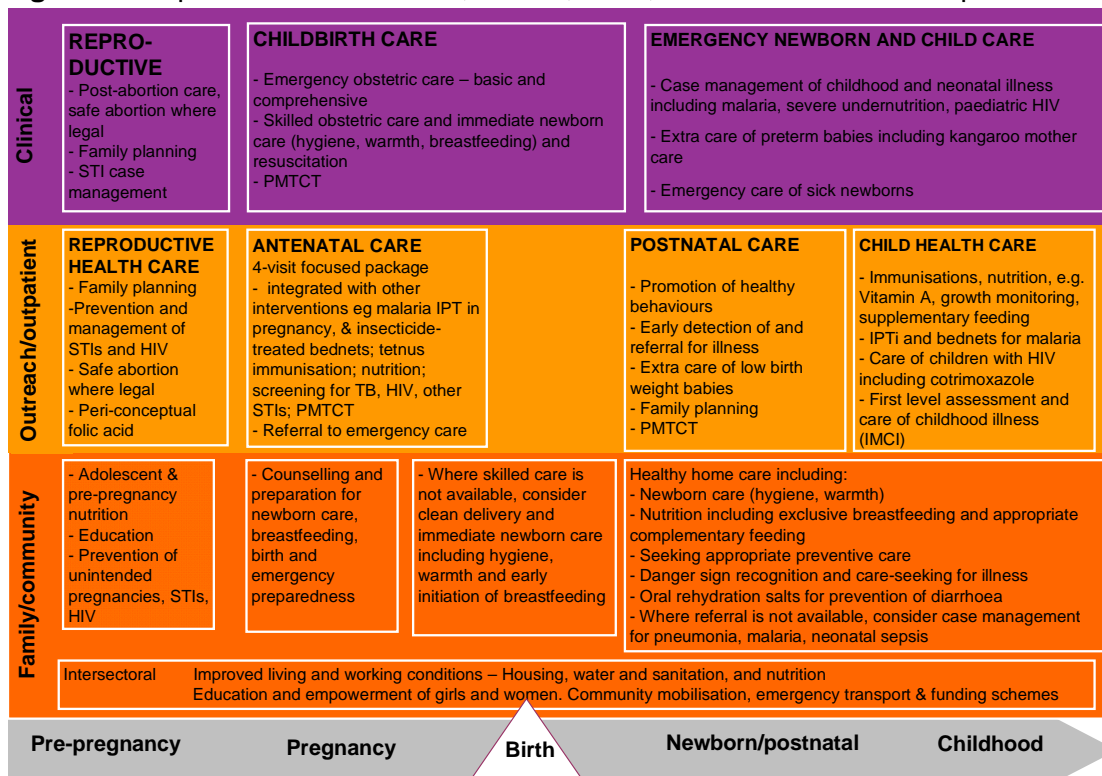
61. **There was a strong call in the consultation for the UK to continue to play a critical role in tackling neglected issues.** This included safe abortion and services for marginalised groups. Respondants thought that with a strong systems approach and relatively predictable funding instruments, the UK's development assistance is well placed to tackle the shortage of skilled health workers and improve commodity security.

#### Expanding coverage of services for women and newborns

62. **Expanding coverage of the proven interventions and services that women and newborns need is a priority.<sup>x</sup>** (Figure 7). Tried and tested, high impact, cost effective interventions improve health outcomes, save lives and prevent illness and disability. Families and the health sector save money when the interventions are delivered together as 'packages' through existing health services.<sup>90,91,92,93,94,95,96</sup>

63. **Women will be at the centre of the UK's approach.** A woman or adolescent girl should be able to get the information, services and supplies she needs when and where she needs them for herself and her child. When pregnant, she needs a wider range of health interventions. To save her and the health services time and money, she should be able to access these without having to move between multiple clinics and providers. See Box 6.

Figure 7 Adapted from Kerber et al, *Lancet*, 2007, Women Deliver 2007 special issue



<sup>x</sup> The UK government recognises that the 'continuum of care' includes child health. We will continue to promote the full range of services that women and children need in our policy dialogue and increase our investment in child health in line with our G8 and MDG commitments, including through support to immunization, nutrition, malaria and health systems.

**Box 6: Delivering services that women need, together**

*“Women and children aren’t pre-eclampsia or malnutrition or neonatal malaria. They aren’t emergency obstetric care or community-based care. They aren’t conditions or procedures or treatment models. They are human beings ... the same woman who is nervous about giving birth is also desperate to feed her starving two-year-old.”*

Melinda Gates at the Women Deliver conference 2010

- **Family planning with other reproductive and maternal care.** When a woman has given birth or had an abortion, she needs contraception to be available to enable her to prevent an unintended pregnancy. Action is needed to integrate maternal and newborn health care and comprehensive family planning wherever appropriate and to address gaps in availability.
- **Sexual health with reproductive and maternal health services.** This includes: the promotion of dual protection (including male and female condoms); services that reach adolescents, and those to diagnose and treat STIs such as congenital syphilis.
- **HIV services with reproductive, maternal and newborn health services.** Particularly in countries and areas with high HIV prevalence, the prevention of mother-to-child transmission (PMTCT) of HIV should be part of routine antenatal, delivery and postnatal care and family planning services. Sexual and reproductive health services should ensure couples can protect themselves from HIV and other STIs as well as prevent unintended pregnancy. Screening for tuberculosis is an important intervention within antenatal care.
- **Nutrition for adolescents, pregnant women and babies.** More support needs to be given to proven interventions including support to early and exclusive breastfeeding, iron folate supplementation, universal salt iodisation, as well as multi-sectoral interventions to tackle the underlying causes of malnutrition.
- **Malaria as part of antenatal and postnatal care.** 10,000 pregnant women die of malaria each year.<sup>6</sup> Action is needed to support more effective prevention, diagnosis and treatment of malaria in pregnancy. See the UK’s Framework for Results on Malaria.
- **Responding to survivors of sexual and other violence, particularly but not only in conflict affected areas.** If raped or abused, a girl or woman needs health care that includes emergency contraception, HIV and STI diagnosis, treatment, and counselling.

Some groups, such as young women, sex workers and those requesting a safe abortion, will also need tailored approaches, particularly due to stigma and discrimination in health care settings and in society more generally.

<sup>6</sup> The Countdown to 2015 Initiative, 2010

**64. Reproductive, maternal and newborn health services need to be scaled up through stronger over-arching health systems, from community level<sup>97</sup> through to 24 hour functioning health facilities.** As Figure 7 shows, a woman should have information and services close by at the community level, through outreach services and clinical care, with a referral process that enables her to access hospital care when needed. For a woman’s life to be saved, and debilitating disabilities such as fistula prevented, during pregnancy and childbirth, she needs the health workers, clinics and district level hospitals to be functioning 24 hours a day. These need enough medicines, equipment, clean water, sanitation, good hygiene and power supplies. As the scale-up

of services increases, including to remote rural areas, providers need to ensure that the major causes of maternal death, such as pre-eclampsia and post-partum haemorrhage, are managed with appropriate protocols. Ensuring all these elements are in place and in line with WHO standards<sup>98</sup> requires strong management, quality assurance and the regulation of the different providers. Best practice and innovative approaches will be learnt from, including those from India and Nepal where access to life saving emergency care has been expanded.

## Renewed focus on quality of care

**65. The UK will work with partners at national and global levels to agree and implement effective approaches to improving and assuring a better quality of care.** Quality has a significant impact on uptake of services as well as health outcomes; achieving good quality services requires both commitment and investment.<sup>99</sup> For example, in family planning services, women need appropriate and accurate counseling and information, and a greater mix of contraceptive methods available to them to delay, space and then limit pregnancies as they choose and to enable them to switch methods if they experience side effects or other problems. One-third of developing countries have a very skewed method mix, in which a single method accounts for more than half of contraceptive use.<sup>100</sup> For all aspects of health, but particularly reproductive and maternal health, health workers need to adopt a supportive and non-discriminatory approach to all women and girls. Indicators that track quality are needed, including women's experience of the service and the choices available to her, and the cleanliness of the facility.

**66. To expand quality services, a particular focus is required on ensuring there are sufficient and motivated health workers with the right skills, in the right place, at the right time, particularly midwives and others with midwifery skills.** WHO estimates an additional 341,000 midwives, nurses and doctors are required by 2015.<sup>101</sup> Emerging evidence shows task-shifting to different skilled staff has strong potential for expanding the pool of health workers and coverage of essential services.<sup>102,103</sup> See Box 8. Strengthened data at national level on the availability, use, pay and motivation of healthworkers are urgently needed.<sup>104</sup> More female nurses and midwives are required – reinforcing the need for girls' education – to facilitate more local recruitment and the professionalisation of these cadres, with increased recognition from (often male) doctors.<sup>105,106,107</sup> Where appropriate, DFID works with the Department of Health to directly transfer skills, for example in midwifery and quality assurance.

### Box 7: Tackling unsafe abortion

Support for safe abortion reduces recourse to unsafe abortion and prevents girls and women from dying or suffering serious health problems. Maternal death from unsafe abortion is rare where abortion is permitted and quality, affordable services are available. DFID does not support abortion as a method of family planning. Where abortion is permitted, we can support services that make abortion more accessible.<sup>f</sup>

In Nepal, prior to safe abortion legislation, 20% of maternal deaths in health facilities were estimated to be caused by unsafe abortion but this excludes maternal deaths outside health facilities that are very hard to estimate. Abortion laws were finally passed as part of wider laws on women's rights in 2002. Services are now available across the country with private providers playing a strong role. It is estimated that since 2004, these efforts have resulted in more than 153,000 unsafe abortions avoided and 1,600 maternal deaths being averted.<sup>g</sup>

<sup>f</sup> See [www.dfid.gov.uk/abortion](http://www.dfid.gov.uk/abortion) <sup>g</sup> Source: MSI Nepal, 2010.

### Box 8: Expanding the health workforce in Ethiopia

Over the last five years, supported by the UK and other donors, more than 34,000 health workers have been trained and deployed across Ethiopia's population of around 80 million people. These workers, who are mostly women, are delivering a package of basic services to their communities including family planning, immunisation, nutrition and malaria prevention and treatment.



Image of woman receiving contraceptive injection in Ethiopia © DFID Ethiopia.

The latest data from the Ethiopian Ministry of Health suggests that in the last five years the proportion of women seeking antenatal care has increased from 50% to 71%, the proportion seeking postnatal care has more than doubled (from 16% to 36%) and contraceptive acceptance rate has increased from 37% to 62%.<sup>h</sup>

<sup>h</sup> Federal Democratic Republic of Ethiopia Ministry of Health (2010) Health Sector Development Programme III. Annual Performance Report.

**67. At global and country levels, health workers need reliable and affordable supplies of quality medicines and equipment, including contraceptives.** Funding constraints, combined with a weak commitment in national budgets to prioritise the purchase of reproductive health supplies and a limited capacity for distribution, have created an unstable environment for supplies worldwide.<sup>108</sup> The UK will invest in continued innovation in products and support stronger procurement and supply chains to prevent stock outs and increase availability of essential commodities (e.g. contraceptives, medicines and supplies for maternity care). Increasing global and national market efficiencies make quality products cheaper to developing countries and increase value for money.

### Delivery through the public and private sectors

*'Private sector engagement in maternal and newborn health is happening and happening on a large scale. Pregnant women are choosing private sector sources of care in developing countries across the globe every day. Given this fact, a concerted effort must be made by the safe motherhood community, by donors and by governments to engage in meaningful ways with the private sector to ensure that its contribution to MNH is effective, based on science and practicable.'*

Madhavan S., et al 2010<sup>109</sup>

**68. Both public and non-state providers (including NGOs) are important for delivering quality products and services.** In many developing countries, when people first seek diagnosis and treatment for any illness they often visit a private pharmacist, nurse, midwife, doctor, drug seller or traditional practitioner. The non-state sector is particularly significant in Asia.<sup>110</sup>

**69. Strengthening district health services and national capacity to plan, budget, manage and deliver health services more efficiently and effectively is a priority.** In many countries, these systems are weak and chronically under-resourced, seriously undermining progress. The public sector also has an important role in



stewardship of the overall health system and reaching the poorest. Ministries of Health and decentralized authorities need the capacity to play their stewardship role in overseeing the provision of services including accreditation processes, quality assurance, contracting and regulation of non-state providers. Very few studies on the role of the private sector consider equity and whether the poorest or marginalised benefit.<sup>111</sup> The public sector has a critical role in ensuring services reach poor people. Public subsidy, accreditation and regulation are generally all critical factors to enable the poorest to benefit from affordable, good quality services when delivered by non-state providers.

**70. The UK will support the scale up of services by non-state providers, where they will reach poor people, are of good quality and are cost-effective, ideally as part of a well coordinated and regulated health system.**<sup>112,113</sup> Social franchising can expand access to family planning for the poor.<sup>114</sup> In fragile states (see Box 9), non-state providers play a significant role but robust evaluations of their work are few.

**71. Social marketing and franchising can be an effective approach to increasing the coverage of affordable, good quality family planning commodities by both increasing demand and making products and services more affordable and accessible.** Target groups may be given or sold a voucher to cover the cost of buying the product or service from the accredited provider (see Pillar 2), or the prices charged by providers may be directly subsidised.

**72. Overall, context determines priorities and strategies to address these issues in any country, particularly the strength of the health sector and services.** In a country with a reasonably well functioning health system, with reasonable coverage of interventions, it is important to increase the quality and range of services, working with both the public and private sector and addressing inequality in access. Where health systems are in crisis, where there is a serious shortage of health workers, where quality obstetric care facilities are a distant reality and where most women are still giving birth at home, a pragmatic approach is often required. This might mean support to preventing unintended pregnancies to avoid deaths or strengthening community action to save lives and prevent illness, whilst building up the system to deliver reproductive, maternal and newborn care and working through non-state providers to reach those in greatest need.

### Box 9: Scaling up service delivery in fragile contexts

Strengthening health service delivery in fragile and conflict-affected states provides an opportunity to build accountability and transparency within new or renewed state structures. In any context, service delivery is often political and, whether public or private, can be used to reinforce elite power-bases and discriminatory systems – this is particularly the case in fragile and conflict affected states. But improved health service delivery is a tangible area around which communities and poor people can engage. If this engagement is well designed it can be an empowering process in which citizens influence decision-making processes at a local level and begin to engage with the state in a constructive process for change.

## Pillar 4: Enhance accountability for results at all levels

**73. There is general consensus within the reproductive, maternal and newborn health community that accountability holds the key to progress.** <sup>115,116,117</sup>

Accountability can push all partners to deliver on their commitments and responsibilities, demonstrate how actions and investment translate into tangible results and better long term outcomes, and tell us what works, what needs to be improved and what requires more attention. Accountability mechanisms that give women, girls and wider communities the ability and channel through which to challenge and demand change, can be empowering.

**74. There was a strong call in the consultation for the UK to lead by example in delivering on our commitments and to ensure greater transparency and accountability.** Our technical capacity and work on empowerment and accountability, combined with a strong focus on evidence and results, makes us well placed to make an important contribution, both internationally and at country level.

**75. Better data are essential for planning, management and reporting progress.** <sup>118,119</sup> Priorities vary from country to country but might include filling gaps in essential data (e.g. birth and death registration, indicators of quality care), tracking resources and expenditure more effectively, and disaggregating data. Improving data quality in the following is also important:

- Surveys: In the absence of vital events data and routine health information systems, or where they are weak, population level surveys are vital for both tracking progress to drive delivery and for analysing trends and underlying causes of poor health. Demographic and Health Surveys (DHS) are the most widely used and provide an important entry point to consider additional data needs.
- Health management information systems: These gather important metrics for planning and reporting but are often overloaded with data of varying quality. Where appropriate, support will be given to countries to improve their routine data collection and use for improving health outcomes.
- Participatory analysis and evaluation – with women and girls in particular: This is important to build into planning and review, including as part of routine data collection. For example, this should ask women about their experience of the services they receive.

**76. Enhanced domestic accountability is required between both state and non-state providers and women and wider communities, and between governments and Parliaments and their citizens and civil society.** There is a range of tools and approaches, working at individual, institutional and community level, which can be employed to give women and girls and wider communities a voice including public hearings, check lists, maternal death audits, and more (see Box 10). The media can play an important role here.

**77. There is plenty of scope to explore the use of new technologies and innovative approaches.** For example, mobile phones can be used to give women a way to feed back their views on the services they receive or on the lack of availability of medicines and contraceptives at their local clinic.

**78. Stronger accountability within the health system for better performance is also important.** Action is required on the barriers to, and incentives for, national and local level providers and health workers to deliver on policies and plans that improve reproductive, maternal and newborn health, including for the poorest. Quality assurance, clinical supervision and performance monitoring processes are examples of action that can enhance accountability within the health sector.

**79. Results-based approaches show potential to increase performance but more and better evaluation is required.** A range of results-based approaches exist, including conditional cash transfers and vouchers (covered in Pillar 2) and wider performance based aid mechanisms used by donors. Within the health system, a results/performance based approach can: effectively identify results achieved; create more incentives to deliver results; improve value for money; and contribute to improved accountability to service users. There is some evidence of effectiveness. In Rwanda, a rigorously evaluated scheme improved the quality of antenatal care, increased the number of mothers giving birth in health facilities and increased preventive care visits for young children.<sup>120</sup> But the number of schemes is growing much faster than the evidence base. Priority must be given to evaluation to establish what works in which situations and at what cost.<sup>121,122</sup>

**80. The aid architecture for health, and for women and children's health in particular, needs to be more accountable and transparent.**<sup>123,124</sup> As part of wider work to improve how the international system delivers for reproductive, maternal and newborn health (see Chapter 3.2), the UK will use funding instruments and policy dialogue to ensure multi-lateral partners and others are even more accountable and transparent.

## Chapter references

- <sup>64</sup> Sen G, Ostlin P. *Unequal, Unfair, Ineffective and Inefficient Gender Inequity in Health: Why it exists and how we can change it. Final report to the WHO Commission on Social Determinants of Health. 2007.* [www.who.int/social\\_determinants/resources/csdh\\_media/wgekn\\_final\\_report\\_07.pdf](http://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf) (accessed 17 Dec 2010)
- <sup>65</sup> Jones N et al. *Stemming girls' chronic poverty: catalysing development change by building just social institutions.* CPRC; 2010
- <sup>66</sup> Shiffman J, Smith S. Generation of political priority for global health initiatives: a framework and case study of maternal mortality. *Lancet* 2007; 370: 1370–79.
- <sup>67</sup> Lee K et al, Family planning policies and programmes in eight low-income countries: A comparative policy analysis *Social Science & Medicine* 1998; vol 47(7):pp 949-959.
- <sup>68</sup> Haberland N, Rogow, D, *Sexuality and HIV education: Time for a paradigm shift*, Transitions to Adulthood, Brief No 22; New York: Population Council; 2007
- <sup>69</sup> Baldwin W, Diers, J, Population Council, presentation to DFID, 2010. For resources see: [http://www.popcouncil.org/projects/164\\_DevCapProgramAdolGirls.asp#/Resources](http://www.popcouncil.org/projects/164_DevCapProgramAdolGirls.asp#/Resources) (accessed December 2010).
- <sup>70</sup> UNICEF. (2008). *Long-term evaluation of the Tostan Programme in Senegal: Kolda, Thies and Fatik Regions*. New York, NY: UNICEF. <http://www.tostan.org/web/page/599/sectionid/548/parentid/548/pagelevel/2/interior.asp>
- <sup>71</sup> Erulkar A, Muthengi, E, An evaluation of Evaluation Of Berhane Hewan A Pilot Program To Promote Education and Delay Marriage in Rural Ethiopia, New York: Population Council; 2007.
- <sup>72</sup> Tripathy P, Effect of a participatory intervention with women's groups on birth outcomes and maternal depression in Jharkhand and Orissa, India: a cluster-randomised controlled trial. *The Lancet* 2010; Vol. 375 (9721): pp1182-1192.
- <sup>73</sup> Smith, R. et al. *Family Planning Saves Lives, 4th edition 2009.* Population Reference Bureau: P19. 2009
- <sup>74</sup> Peter Sternberg; John Hubley Evaluating men's involvement as a strategy in sexual and reproductive health promotion. *Health Promot. Int.* (2004) 19 (3): 389-396. doi: 10.1093/heapro/dah312
- <sup>75</sup> The Countdown to 2015 Initiative, 2010, *op cit.*
- <sup>76</sup> Paruzzolo, S. et al. *Targeting poverty and gender inequality to improve maternal health, Executive Summary.* [www.womendeliver.org/assets/Targeting\\_poverty.pdf](http://www.womendeliver.org/assets/Targeting_poverty.pdf). (accessed 17 Dec 2010)
- <sup>77</sup> Singh, S. et al (a) *op. cit.*
- <sup>78</sup> The World Health Report. Health systems financing: the path to universal coverage. Geneva: WHO; 2010. <http://www.who.int/whr/2010/en/index.html>
- <sup>79</sup> Lagarde, M. and Palmer, N. The impact of user fees on health service utilization in low and middle income countries: how strong is the evidence? *WHO Bull* 86(11) 839-48. 2008
- <sup>80</sup> Lagarde M, Haines A, Palmer N. The impact of conditional cash transfers on health outcomes and use of health services in low and middle income countries. *Cochrane Database of Systematic Reviews* 2009, Issue 4. Art. No.: CD008137.
- <sup>81</sup> Lagarde, M. and Palmer, N. *op.cit.*
- <sup>82</sup> LSHTM, University of Zambia, Ministry of Health, University of Cape Town. Removing user fees: what matters in making it work. Briefing paper 1, May 2010.
- <sup>83</sup> Carasso B et al. *Evaluation of the impact of the abolition of user fees – a case study approach in five districts in Zambia.* Summary of preliminary findings (unpublished). LSHTM, UNZA, MoH; 2009
- <sup>84</sup> Lim SS et al, India's Janani Suraksha Yojana, a conditional cash transfer programme to increase births in health facilities: an impact evaluation, *Lancet* 2010; 375: 2009-2023. doi:10.1016/S0140-6736(10)60744-1.
- <sup>85</sup> Bellows NM, Bellows BW, Warren C. The use of vouchers for reproductive health services in developing countries: systematic review, *Trop Med Int Health*; 2010 Nov. doi: 10.1111/j.1365-3156.2010.02667.x. [Epub ahead of print]
- <sup>86</sup> Ensor, T, Ronoh J Effective financing of maternal health services: a review of literature. *Health Policy* 2005, 75(1):49-58

- <sup>87</sup> Freedman LP, Achieving the MDGs: health systems as core social institutions <http://ipsnews.net/indepth/MDGGoal5/MDG5%20Freedman.pdf>
- <sup>88</sup> McCoy, D. et al. Maternal, neonatal and child health interventions and services: moving from knowledge of what works to systems that deliver *International Health* - June 2010 (Vol. 2, Issue 2, Pages 87-98. DOI: 10.1016/j.inhe.2010.03.005)
- <sup>89</sup> Freedman, L.P., et al. 'Practical lessons from global safe motherhood initiatives: time for a new focus on implementation.' *Lancet*; 370:1383–91. 2007
- <sup>90</sup> Darmstadt, GL et al. Evidence-based, cost-effective interventions: how many newborn babies can we save? *Lancet*; 365: 977–88. 2005
- <sup>91</sup> Bhutta, ZA, et al. What works? Interventions for maternal and child undernutrition and survival. *Lancet*; 371: 417–40. 2008
- <sup>92</sup> Friberg, IK, et al. Sub-Saharan Africa's Mothers, Newborns, and Children: How Many Lives Could Be Saved with Targeted Health Interventions? *PLoS Med* 7(6):e1000295. 2010
- <sup>93</sup> Darmstadt G L, et al. Saving newborn lives in Asia and Africa: cost and impact of phased scale-up of interventions within the continuum of care. *Health Policy and Planning* 2008;23:101–117. 2008.
- <sup>94</sup> Goldie SJ, et al. 'Alternative Strategies to Reduce Maternal Mortality in India: A Cost-Effectiveness Analysis.' *PLoS Med* 7(4): e1000264. (2010)
- <sup>95</sup> Kerber KJ, et al. 'Continuum of care for maternal, newborn, and child health: from slogan to service delivery.' *Lancet* 2007; 370: 1358–69
- <sup>96</sup> WHO. *Packages of interventions for family planning, safe abortion care, maternal, newborn and child health*. 2010 [http://whqlibdoc.who.int/hq/2010/WHO\\_FCH\\_10.06\\_eng.pdf](http://whqlibdoc.who.int/hq/2010/WHO_FCH_10.06_eng.pdf). (accessed 17 Dec 2010)
- <sup>97</sup> Lassi ZS, et al. Community-Based Intervention Packages for Preventing Maternal Morbidity and Mortality and Improving Neonatal Outcomes. *The International Initiative for Impact Evaluation (3ie) Synthetic Review 005*. 2010
- <sup>98</sup> Including "Recommended Interventions for Improving Maternal and Newborn Health" 2009 and "Packages of Interventions for Family Planning, Safe Abortion care, Maternal, Newborn and Child Health" 2010.
- <sup>99</sup> Althabe F, et al. Strategies for improving the quality of health care in maternal and child health in low- and middle-income countries: an overview of systematic reviews. *Paediatric and Perinatal Epidemiology*, 22 (Suppl. 1): 42–60. 2008
- <sup>100</sup> Harbison S. *Completing the demographic transition in developing countries: what does quality have to do with it?* Office Pop and RH, USAID 2005
- <sup>101</sup> to reach 95% coverage targets of skilled attendance at birth in the 68 countries covered in 'Countdown to 2015' monitoring
- <sup>102</sup> The Global Health Workforce Alliance. *Catalyst for Change: The 2009 Annual report*. [http://www.who.int/workforcealliance/knowledge/resources/ghwa\\_annualreport\\_2009.pdf](http://www.who.int/workforcealliance/knowledge/resources/ghwa_annualreport_2009.pdf)
- <sup>103</sup> Fauveau V, et al. Human resources for maternal health: multipurpose or specialists? *Human Resources for Health*, 6 (21). doi:10.1186/1478-4491-6-21. 2008
- <sup>104</sup> McCoy D, et al. Salaries and incomes of health workers in sub-Saharan Africa. *Lancet*; 371: 675–81.2008 doi:10.1016/S0140-6736(08)60306-2
- <sup>105</sup> McCoy D et al, *op.cit.*.
- <sup>106</sup> Willis-Shattuck M, et al. Motivation and retention of health workers in developing countries: a systematic review. *BMC Health Services Research*, 8(247). doi:10.1186/1472-6963-8-247. 2008.
- <sup>107</sup> Fauveau V et al., *op.cit.*
- <sup>108</sup> Leahy E. Reproductive health supplies in six countries. *Population Action International*. 2009.
- <sup>109</sup> Madhavan S et al. 'Engaging the private sector in maternal and neonatal health in low and middle income countries.' Future Health Systems Working Paper 12 2010
- <sup>110</sup> Mavalankar D, *op cit.*. (2009). Saving mothers and newborns through an innovative partnership with private sector obstetricians: Chiranjeevi scheme of Gujarat, India. *International Journal of Gynaecology & Obstetrics Volume 107, Issue 3, December 2009, Pages 271-276* [doi:10.1016/j.ijgo.2009.09.008](https://doi.org/10.1016/j.ijgo.2009.09.008)
- <sup>111</sup> Madhavan S and D Bishai, *Private Sector Engagement in Sexual and Reproductive Health and Maternal and Neonatal Health: A Review of the Evidence*, Department of Population, Family, and Reproductive Health, Johns Hopkins Bloomberg School of Public Health, forthcoming.
- <sup>112</sup> Madhavan S et al. 2010, *op. cit.*.
- <sup>113</sup> Haji M et al (2010). 'Emerging opportunities for recruiting and retaining a rural health workforce through decentralized health financing systems.' *Bull World Health Organ*; 88:397–399. [www.who.int/bulletin/volumes/88/5/09-072827.pdf](http://www.who.int/bulletin/volumes/88/5/09-072827.pdf) . doi:10.2471/BLT.09.072827
- <sup>114</sup> Madhavan S and D Bishai, *op cit.*.
- <sup>115</sup> Rosato M et al (2008). Community participation: lessons for maternal, newborn and child health. *Lancet*, 372 (9642),p962–971.
- <sup>116</sup> Inter-Parliamentary Union/Partnership for Maternal, Newborn and Child Health. *Taking the lead: Parliamentarians engage with maternal, newborn and child health*. [www.who.int/pmnch/topics/part\\_publications/20100716\\_takingthelead/en/index.html](http://www.who.int/pmnch/topics/part_publications/20100716_takingthelead/en/index.html)
- <sup>117</sup> Greco G et al (2008). 'Countdown to 2015: assessment of donor assistance to maternal, newborn, and child health between 2003 and 2006.' *Lancet*; 371: 1268–75.
- <sup>118</sup> Lewin S. Supporting the delivery of cost-effective interventions in primary health-care systems in low-income and middle-income countries: an overview of systematic reviews. *Lancet*; 372: 928–39. 2008
- <sup>119</sup> UNICEF. *Strengthening birth registration in Africa: opportunities and partnerships*. [www.unicef.org/esaro/Technical\\_paper\\_low\\_res\\_.pdf](http://www.unicef.org/esaro/Technical_paper_low_res_.pdf) (accessed 17 Dec 2010)
- <sup>120</sup> Gertler, P "Paying health care providers for performance: evidence from Rwanda," presentation, 3ie, 2009. [http://www.3ieimpact.org/userfiles/file/5\\_13%20Impact%20of%20PBF%20in%20Rwanda\\_Cairo.ppt#256,1](http://www.3ieimpact.org/userfiles/file/5_13%20Impact%20of%20PBF%20in%20Rwanda_Cairo.ppt#256,1), Paying Health Care Providers for Performance: Evidence from Rwanda (accessed 16 Dec 2010).
- <sup>121</sup> Taskforce on Innovative International Financing for Health Systems. *Raising & Channeling Funds* 2009 [www.internationalhealthpartnership.net/CMS\\_files/documents/working\\_group\\_2\\_report\\_raising\\_and\\_channeling\\_funds\\_EN.pdf](http://www.internationalhealthpartnership.net/CMS_files/documents/working_group_2_report_raising_and_channeling_funds_EN.pdf)
- <sup>122</sup> Oxman AD, Fretheim A. 'An overview of research on the effects of results-based financing.' Report from Norwegian Knowledge Centre for the Health Services. Systematic Review, Report Nr 16 –2008, Oslo: Nasjonalt kunnskapssenter for helsetjenesten, [www.kunnskapssenteret.no/Publikasjoner/3219.cms?threepage=1](http://www.kunnskapssenteret.no/Publikasjoner/3219.cms?threepage=1) (accessed 17 Dec 2010). 2008
- <sup>123</sup> WHO Maximizing Positive Synergies Collaborative Group. An assessment of interactions between global health initiatives and country health systems. *Lancet*; 373: 2137–69. 2009
- <sup>124</sup> International Budget Partnership. *Ask Your government How Much It's Spending On Development Commitments*. 2010. <http://www.internationalbudget.org/cms/index.cfm?fa=view&id=3653> (accessed 17 Dec 2010)



## Chapter 3

# Achieving results





# Achieving Results

**81. The priorities, budgets and results to be achieved for each country programme and each of our international partners will be agreed in 2011.** These will be detailed in forthcoming Country Operational Plans and other documents. This chapter outlines which countries and partners the UK government is likely to work with and give illustrative examples of action. It also shows how UK support is already achieving results.

**82. The Annex outlines the indicators against which our progress will be tracked.** They rely on global and national data systems and existing surveys wherever possible. It outlines the Monitoring and Evaluation framework; this forms part of a wider approach to monitoring results in health. Continuing to improve monitoring and evaluation at all levels is critical (see Pillar 4 above, and Chapter 3.3 below).

**83. The UK's G8 and UN commitments will be tracked.** OECD-DAC data will be used to track progress on women's and children's health to meet the UK's commitment to "double our efforts, backed by a doubling of expenditure".<sup>xi</sup> The Annex includes the internationally agreed methodology for tracking expenditure.

## 3.1 Implementing through country programmes

**84. A significant proportion of results will be delivered through the bilateral programme.** At country level, our strong advisory capacity enables us to support cost effective, context specific health programmes – capacity will be expanded where necessary. To accelerate progress, efforts will be scaled up where need is greatest and where the UK considers it can add the most value, within the portfolio of UK focus countries. Action will be embedded in national health plans, programmes and/or budgets, wherever possible.

**85. In line with DFID's Departmental Business Plan, all relevant country offices will support action to enable women and girls to choose whether, when and how many children they have.** Most country offices will also scale up support to wider reproductive, maternal and newborn health and address broader determinants of health.

**86. For monitoring purposes, particular emphasis will be placed on 8–12 focus countries** with high need which will deliver the most significant results and where the UK government is a major donor for reproductive, maternal and newborn health. These countries will be determined as operational planning progresses in 2011.

<sup>xixi</sup> In September 2010, the UK committed to double its annual support for women and children's health by 2012 and sustain that level to 2015. The UK will provide an annual average of £740 million from 2010-2015, totaling £4.4 billion, meaning that over this period the UK will spend an additional £2.1bn on women and children's health. This commitment added to the one made at the Muskoka G8 Summit in July 2010. Reproductive, Maternal and Newborn Health is a subset of this commitment. Child health investments, including some malaria spend, and some investments in wider women's health account for the rest.

## Achieving results in Africa

87. **Sub-Saharan Africa has seen the least progress in reducing maternal death.** A woman's chance of dying in pregnancy and childbirth is highest in sub-Saharan Africa, particularly in conflict affected states. Progress in reducing newborn death has been particularly slow. Skilled birth attendance is relatively weak in sub-Saharan Africa but importantly, is linked to a reduction in maternal death when the poorest benefit. Quality of care is often poor. Sub-Saharan Africa has seen the slowest improvements, and in some countries stagnation and reversal, in contraceptive use by women and girls.

88. **The UK government plans to support the achievement of reproductive, maternal and newborn health results in more than 11 countries in sub-Saharan Africa.** Table 5 shows which countries are planning to take action.

**Table 5:** Countries already and/or planning to implement in sub-Saharan Africa

		Action to achieve reproductive, maternal and newborn health results		
		Family Planning & wider reproductive health	Maternal and newborn health	Multi-sector and wider health support
Country (in order of number of maternal deaths a year from higher to lower)	Nigeria	✓	✓	✓
	Democratic Republic of Congo	✓	✓	✓
	Ethiopia	✓	✓	✓
	Kenya	✓	✓	✓
	Somalia	✓	✓	✓
	South Africa	x	✓	✓
	Malawi	✓	✓	✓
	Zimbabwe	✓	✓	✓
	Ghana	✓	✓	✓
	Zambia	✓	✓	✓
	Sierra Leone	✓	✓	✓
	Others likely to include: Tanzania, Sudan, Uganda, Mozambique, Rwanda, Liberia			
	Africa regional	✓	✓	x

89. The following are examples of action underway and planned:

- **Nigeria:** the UK will continue to support the Partnership for Reviving Routine Immunisations in Northern Nigeria and the Maternal, Newborn and Child Health Initiative. Since 2007, this programme has supported 150,000 skilled deliveries, 200 midwives in rural areas, the delivery of 5,000 babies by emergency caesarean section and a 20 % increase in antenatal care. Increased efforts to 2013 include support to family planning.
- **Malawi:** the UK's support to reproductive, maternal and newborn health through the sector programme will continue to invest in increasing the numbers and skills of health staff. An independent evaluation recently confirmed that Malawi's Emergency Human Resources Programme has to date increased the total number of professional health workers by more than 50% from 2004 to 2009 and contributed to an estimated 15% increase in safe deliveries, 18% increase in PMTCT and 49% increase in outpatient visits.

**Box 11: Improving reproductive, maternal and newborn health in the context of high HIV prevalence – Southern Africa**

We will support efforts to reverse the trend of increasing maternal and newborn mortality due to HIV by expanding access to quality reproductive, maternal and newborn health services that include action to tackle HIV. This means: improving access to comprehensive Prevention of Mother to Child Transmission of HIV (PMTCT) in line with WHO guidance through better integrating PMTCT into maternal and child health services; reducing infections among women of reproductive age and preventing unintended pregnancies; tackling the structural drivers of the epidemic (stigma and discrimination, gender based violence); and supporting access to essential medicines for women and children, including anti-retroviral drugs.

In South Africa, where very high HIV prevalence has increased maternal and child mortality since the 1990s, the UK will help improve the quality of and access to maternal and newborn care services in poorer rural districts as part of our support to strengthening the health sector. This will be linked to action on gender based violence, a main driver of HIV.

In Zimbabwe, where HIV prevalence is 14.3% and the leading cause of maternal deaths, the UK will continue to support HIV services. UK funding ensured that over 40,000 people were able to access treatment in 2009. Currently, with USAID, it ensures that over half of all mothers attending antenatal care services have access to PMTCT services.

- **Somalia:** the UK is investing in interventions that save and improve the lives of women and children affected by conflict and instability, responding to a local context where birth spacing through family planning is increasingly acceptable. Results will be delivered through partnerships between private sector and NGO facilities that will increase access. Community based approaches that help develop local stability and accountability will also be supported. Action builds on successes to date in strengthening the capacity of midwives and obstetricians through UK NHS staff who travel to Somaliland to train health workers.
- **Across the region:** The UK will strength empowerment and accountability for reproductive, maternal and newborn health results across six African countries.

## Achieving results in Asia

**90. Countries in Asia account for some of the greatest numbers of maternal deaths.** In South Asia, gender inequality and exclusion has created higher levels of poverty among women and girls and limits their opportunities to access information and services. This has been exacerbated by under-investment in maternal health services especially for the poor. Demand for family planning outstrips availability. High rates of undernutrition and early marriage and adolescent pregnancy increase risks for pregnant women and girls.

**91. The UK government plans to support the achievement of reproductive, maternal and newborn health results in at least 5 countries in Asia.** Table 6 shows which countries are planning to take action.

**Table 6:** Countries already and/or planning to implement in Asia

		Action to achieve reproductive, maternal and newborn health results		
		Family planning and wider reproductive health	Maternal and newborn Health	Multi-sector and wider health support
Country (in order of number of maternal deaths a year from higher to lower)	India (poorest states focus)	✓	✓	✓
	Pakistan	✓	✓	✓
	Bangladesh	✓	✓	✓
	Nepal	✓	✓	✓
	Burma	✓	✓	✓
	Cambodia	✓	✓	✓
	Central Asia	✓	✓	✓
	Asia regional	✓	✓	x

92. The following are examples of action underway and planned:

- **Pakistan:** the UK will continue to support reproductive, maternal and newborn health interventions, focusing support in Punjab and Khyber Pakhtunkhwa (KP) provinces, home to 70% of Pakistan's population. Since 2007, DFID has supported provision of improved obstetric care services in 408 district hospitals and rural health centres, and the training of a new cadre of community midwives, contributing to an additional 670,000 deliveries conducted by skilled birth attendants over the period.
- **Nepal:** the UK will support the Government of Nepal's five year health sector plan for 2010-2015 that has bold ambitions for reaching the poorest and most excluded with services. It will also tackle barriers to access including through programmes to improve health-seeking behaviour by excluded groups. The plan's targets are disaggregated by gender, caste and poverty and will be monitored by population-level surveys and data from health management information systems, annual facility surveys and social audits.
- **In concentrated HIV epidemics in Asia,** the UK will continue to respond (bilaterally or multilaterally) to the needs of women and girls and those from marginalised groups who need access to integrated HIV and reproductive health services.

### Box 12: Tackling maternal and newborn undernutrition in Asia

Undernutrition is an important underlying cause of maternal death and disability in Asia, with high levels of anaemia. Improving adolescent, pregnant women and newborn nutrition will be a priority, including in India, Nepal and Bangladesh, through health-specific and multi-sectoral approaches. Community nutrition services, breastfeeding support and micronutrient supplementation for women and children will be scaled up and the quality of services will be improved. In Nepal, for example, the UK will support the Government to sustain high coverage of micronutrient supplementation and find innovative ways to improve low birth weight.

Evidence underlines the importance of both governance and gender equality for nutrition in South Asia. In the poorest states in India, for example, the UK will support the Government to develop multi-sectoral nutrition strategies. Investments will be made in education, action for gender equality, inclusive growth and water and sanitation, as well as reproductive, maternal, newborn and child health, to improve women's empowerment and nutritional outcomes for mothers and babies.

**Box 13: Delaying age of first pregnancy among adolescents**

Innovative work on adolescent reproductive health will be increased, including:

**Bangladesh:** Adolescent girls aged 15-19 have high fertility rates; it is common for girls to be married by the age of 18 years and 19% get married before the age of 14 years. Action to address this will be explored. This could involve support to adolescent clubs and peer development initiatives, including in rural areas, to enable adolescent girls and boys, including married girls, to learn a range of life skills, including about family planning.

**Kenya:** Pregnancy in adolescent girls in Kenya is very high with 47% of unintended births among women aged 15-19. DFID Kenya plans to increase information and access to health services by adolescents, including family planning. Operations research on a multi-sectoral approach will also be conducted to inform future programming for girls.

**Ethiopia:** The Amhara region has the highest level of early marriage in sub-Saharan Africa and the second highest level globally with 50% of girls married by the time they are 15. The UK is planning to support the scale up of innovative approaches to increase the age at which girls are married and have their first child.

Across both Asia and Africa: the UK will reduce the incidence and impact of unsafe abortion in selected countries in Asia and Africa through a regional programme working through public and private sectors.

## Delivering more for reproductive, maternal and newborn health in emergencies

93. The UK will work to address the relative neglect of women's health, particularly their access to reproductive health services and maternity care, in emergencies across the world. This will be at a range of levels:

- **Globally:** The UK will work with other agencies within the humanitarian health cluster such as WHO, Marie Stopes International and UNFPA, to ensure the need for the Minimum Initial Service Package (MISP) of reproductive health services is addressed in crisis and disaster situations and is expanded in complex emergencies.
- **Programmatically:** The UK will demonstrate that this is feasible, by encouraging those leading responses to incorporate reproductive health needs in their assessment and ongoing management of responses.
- **At country level:** Those delivering services in emergency situations and fragile states will be encouraged to collaborate with, and incorporate, quality reproductive, maternal and newborn health services.



### 3.2 Improving the effectiveness of the global response

94. **The UK provides some 10% of the aid financing to health globally but, working with others, far greater results are leveraged through our international partners and partnerships.** To accelerate progress to achieving the MDGs by 2015, international political momentum for reproductive, maternal and newborn health needs to be sustained, better performance from the international system ensured and accountability for delivery at the international level enhanced.

95. **The consultation told us that international experts think the UK is well placed to continue to play an important international role in reproductive, maternal and newborn health.** This includes helping to shape the global health architecture.

96. **The UK will work closely with partners to advocate for a more effective response to the health MDGs.** The following will be promoted with all partners:

- more equitable allocation of funds according to need and burden of disease
- more effective, and coordinated, support for countries' health systems
- a clearer division of labour among donors and institutions
- seizing opportunities for service integration
- better harmonisation and alignment of funds in support of national health plans
- more predictable, long-term support
- a greater focus on results
- innovative approaches to financing and delivery
- challenging market failures
- stronger mutual accountability and transparency.

97. **There are mechanisms to fulfil and promote harmonisation between donors and alignment to country plans.** These include the International Health Partnership (IHP+) and the Health Systems Funding Platform and strong international partnerships including the Partnership for Maternal, Newborn and Child Health (PMNCH). There is a real opportunity to strengthen collective support to country-led, evidence-based priorities and deliver substantial and long lasting change.

#### Increasing the effectiveness and accountability of the UK's multilateral partners

98. **The UK will seek more efficient and effective delivery of results by multilateral agencies.** Focus will be particularly on UNFPA, WHO, UNICEF, the World Bank, the EC and the Global Fund to fight AIDS, TB and Malaria (GFATM) who all have critical roles to play.

99. **Through board or council positions, performance frameworks and financial, technical and policy work, the UK will support wider reforms and more specific action.** We will work to maximise focus, cost-control, value for money, transparency and alignment with country priorities, in response to reform and policy priorities identified through DFID's Multilateral Aid Review which is due to report in early 2011. More specifically, the UK will support the following:

- **United Nations Population Fund (UNFPA) to:**  
Provide strong technical and policy leadership on women's and adolescent girls' sexual and reproductive health and rights, working closely with other UN partners in the 'H4+';<sup>xii</sup> continue to deliver and improve its Global Programme for Reproductive Health Commodity Security (see Box 14) and other initiatives to improve reproductive and maternal health; and support country-specific policies and programmes that use demographic data and assess population dynamics, and that respect and protect human rights, equity and social justice.

#### Box 14: Scaling up family planning impact through UNFPA

The UK government will continue to be a leading donor to UNFPA's Global Programme for Reproductive Health Commodity Security that works to improve the availability of contraceptives. Focus countries include those with high need where few donors are active, including Niger, Mali, and Burkina Faso. In these countries, the programme makes a substantial contribution to reproductive health outcomes. In Niger, contraceptive use has increased between 2007 and 2009 from 11.7% to 16.5%. Globally, the commodities funded through this programme each year will result in preventing more than 7.5 million unwanted pregnancies assuming staff and infrastructure are in place.

- **World Health Organisation (WHO) to:**  
Strengthen its essential technical and policy leadership role in health and health systems; specifically to increase its focus on reproductive, maternal and newborn health (including adolescents), working closely with other UN partners in the 'H4+'; promote effective evidence brokering and lesson learning; and coordinate efforts to strengthen accountability and align support behind strong national health strategies and systems.
- **United Nations Children's Fund (UNICEF) to:**  
Provide strong technical and policy leadership on: newborn health, especially at community level; girls' and maternal undernutrition and breastfeeding; and adolescent health more generally, working closely with other UN partners in the 'H4+'; develop and test new approaches for scaling-up integrated programmes; and champion a girl- and equity-focused agenda at global and country levels.
- **The World Bank to:**  
Work with the other UN agencies to advance progress; operationalise their Reproductive Health Action Plan 2010–2015 through policy dialogue and finance, with a clear focus on outcomes, results and transparency, gender and equity; use new and innovative approaches to health sector programming and delivery like results-based financing, through the rapid scale-up of the Results Based Lending Instrument and the Health Results Innovation Trust Fund; ensure, together with the Global Fund, GAVI and WHO, that agencies use the Health Systems Funding Platform to contribute to better reproductive, maternal and newborn health outcomes; and track the distribution of IDA commitments to reproductive, maternal and newborn health against need and burden.
- **European Union and Commission (EU/EC) to:**  
Play a stronger role in aid co-ordination and health policy coherence and ensure adequate attention is given to reproductive, maternal and newborn health; promote gender equality and the empowerment of women; continue to deliver more predictable funding to the poorest countries to deliver better MDG outcomes,

<sup>xii</sup> The H4+ is the group of UN agencies the H4+ is the group of UN agencies working on health: WHO, UNFPA, UNICEF and World Bank plus UNAIDS.

through innovative vehicles such as the MDG contracts. EU member states in total account for over half of all ODA. The EC was the channel for around one fifth of DFID's budget in 2008 with significant support for health. In 2010, the communication entitled the 'EU Role in Global Health' called for alignment behind strong national plans and support for health systems.

- **Global Fund to fight AIDS, TB and Malaria (GFATM) to:** Encourage countries to join up various efforts to reach the health MDGs by including reproductive, maternal and newborn health in their applications for Global Fund grants where appropriate; and ensure, together with the World Bank, GAVI and WHO, that agencies use the Health Systems Funding Platform to contribute to better reproductive, maternal and newborn health outcomes. Given that GFATM responds to country demand, the UK need to work at country level to support partners in programme design and application to these funds.

In addition, the UK will support:

- **UN Women** to: promote effective gender mainstreaming across the UN system, to support countries in implementing their international obligations on gender equality, and by helping and holding to account UN agencies over how their programmes are delivering on the ground. It is important that UN Women does not duplicate the work of other UN Agencies or implement projects that others are better placed to manage.
- **The GAVI Alliance** to: better support health systems through the Health Systems Funding Platform with GFATM, World Bank and WHO, and to continue to support immunisations which save the lives of mothers, babies and children.

## Global partnerships for reproductive, maternal and newborn health

**101. The UK's international policy work will strongly support the UN Secretary General's Global Strategy for Women's and Children's Health which aims to save the lives of 16 million women and children by 2015.** The UK will work with important partners including the Partnership for Maternal, Newborn and Child Health (PMNCH) to: strengthen the visibility of women's and children's health on the international stage; generate further commitments including from new partners; and improve delivery through the development of a global accountability framework.

**102. The UK will continue to support the Reproductive Health Supplies Coalition (RHSC).** Support to the Coalition will be to enhance coordination and cost effectiveness, in order to deliver the international commitment to enable 100 million new users of modern contraception by 2015. This will meet the needs of 80% of women in low income countries and will mean 96 million fewer unintended pregnancies; 54 million fewer abortions; 110,000 fewer mothers dying in pregnancy and childbirth; and 1.4 million fewer infant deaths.

**103. The UK's work to advance progress for adolescent girls' reproductive health includes an innovative partnership with the Nike Foundation.** See Box 15.

### Box 15: Girl Hub: reaching out to adolescent girls

Girl Hub, a public/private partnership between DFID and the Nike Foundation, is one channel through which adolescent girls will be enabled to delay their first pregnancy (recognising the heightened risk they face in pregnancy and childbirth) and support efforts to enhance their empowerment. Girl Hub brings together partners, technologies and creativity to listen to girls and empower them through programmes in Rwanda, Nigeria, Ethiopia and beyond.

**104. The UK will work closely with the US government, the Bill & Melinda Gates Foundation and the Australian government on the new Alliance for Reproductive, Maternal and Newborn Health.** This will accelerate progress and increase coordination at national and international levels to accelerate progress to meeting MDG 5 (Box 16).

#### **Box 16: Alliance with the US, Bill and Melinda Gates Foundation and Australia**

At the UN MDG Summit in September 2010, the UK Deputy Prime Minister joined other leaders to launch the Alliance for Reproductive, Maternal and Newborn Health. The Alliance is a five-year public/private global partnership to contribute to the goal of reducing the unmet need for family planning by 100 million women, expand the coverage of skilled birth attendance, and increase numbers of women and newborn receiving quality postnatal care by 2015.

The Alliance aims to work in high-need countries in sub-Saharan Africa and South Asia to accelerate progress in averting unintended pregnancies and reducing maternal and neonatal deaths, thereby addressing important elements of child and maternal health where progress has been especially slow. This will be achieved through close, results-oriented, coordination that support country strategies to scale-up proven, high-impact interventions and through exploring and adapting innovations that can advance health outcomes.

### Global civil society partnerships

**105. Civil society organisations (CSOs) at international, national and local levels are central to the UK government's response to reproductive, maternal and newborn health.** They play an important role delivering a wide range of development programmes, including providing information and services (as non-state providers), and taking community level action in countries across the world. They have particular strength in working with and supporting communities and local counterparts to make their voices heard and to take control of their own development. In many instances, they are best placed to reach poor and marginalised girls, women and babies.

**106. The UK government supports civil society in a number of ways.** Programme Partnership Arrangements (PPAs) will support large, multi-year and multi-country programmes, including those working on reproductive, maternal and newborn health, to 2013. The Civil Society Challenge Fund (CSCF) is open to UK-based organisations and specifically supports partnerships with CSOs and communities in developing countries. The new Global Poverty Action Fund provides an additional channel to support small and medium sized UK based non-profit organisations with a focus on action for service delivery to address the most off-track MDGs. It will support both higher risk innovative proposals and impact-focused projects implementing well established programme approaches. Country offices will design or support relevant civil society funding mechanisms. The UK government engages regularly with networks and coalitions of agencies, working at global and national levels to support improvements in reproductive, maternal and newborn health. At the global level, this includes members of the UK Sexual and Reproductive Health and Rights Network, the Manifesto for Motherhood Coalition, the White Ribbon Alliance for Safe Motherhood and the UK Gender and Development Network.

### 3.3 Investing in global public goods

#### Increasing efficiencies in global markets

**107. Action at the international level will improve value for money for reproductive health commodities.** The UK will seek improved market efficiencies for the supply of quality and affordable contraceptives, contributing to an estimated cost savings of £20 million a year. This will be achieved in several ways:

- Support for AccessRH (through UNFPA), a new procurement and information mechanism that aims to facilitate supply of quality, affordable reproductive health commodities and reduce delivery times for public and NGO clients in over 140 developing countries
- Working with the Reproductive Health Supplies Coalition (RHSC) to increase the number of quality suppliers in the market, and to develop and promote adherence to agreed quality assurance policies by public sector and other major procurers
- Complementing any investments in research and development, the UK will also seek to accelerate the introduction and take-up of new and adaptive technologies with our partners at global and country level.

**108. The UK's, and in particular DFID's, own commodity procurement is cost-effective, against global benchmarks.** Striving to increase the cost effectiveness of our own investments through value for money approaches is vital. For example, a global level service delivery framework for non-state providers will help the UK to reach the additional 10 million new family planning users more efficiently and cost effectively.

#### Building the global evidence base on reproductive, maternal and newborn health

**109. The UK will work to improve data, monitoring systems, robust evaluation and learning for accountability and improved results.** Pillar 4 and the Annex details how this will be achieved. At the global level, DFID will develop and support learning platforms that draw on evidence and experience of best practice for better results.

**110. A portfolio of relevant research programmes will be developed.** This will be based upon analysis of current research, DFID's evidence papers and consultation with researchers, policymakers, programme implementers and other stakeholders. It will build knowledge on how to scale up interventions to prevent unintended pregnancies and reduce maternal and newborn deaths, including context specific research on the effective delivery of services including strategies to increase demand and remove barriers to access. It will also examine how to improve the quality of care received by women and their newborns and how to improve the delivery of services to marginalised groups. It will include synthesis research to ensure that the right evidence is packaged in ways that are useful to decision makers.

**111. The UK is committed to supporting a new research programme on meeting the unmet need for family planning and improving access to safe abortion.** In addition, new operational research programmes will be funded which will help us address some of the wider determinants of poor reproductive, maternal and newborn health such as HIV and AIDS and undernutrition. An expansion of the UK's product development research portfolio will be explored, to include new and adaptive technologies and look at the use of new technologies to help deliver information and services (e.g. mobile phones). We will work with others, such as WHO, on new avenues for funding research on getting what works into practice is important.



### 3.4 Harnessing UK expertise

#### Health professionals and partnerships

**112. The UK signed the Global Code of Practice on the international recruitment of health personnel in 2010 which sets out an agreed set of guidelines governing the recruitment of foreign health workers.** The UK National Health Service (NHS) has its own Code of Practice (latest revision 2004) and has dramatically reduced the level of nurse and midwifery recruitment from developing countries. Through the Department of Health and international fora such as WHO, the UK encourages other countries to sign up and limit the active recruitment of scarce health workers from low resource settings.

**113. The UK has established the Health Partnership Scheme to promote and foster strengthened partnerships between broader UK health organisations and their counterparts in developing countries.** The scheme (see Box 17) will encourage skills transfer especially around UK development priorities including reproductive, maternal and newborn health. The Royal College of Obstetrics and Gynaecology and Liverpool School of Tropical Medicine are working in a number of countries to deliver a highly valued, context-specific training programme for health care providers on managing obstetric complications and emergencies and early newborn care, including supportive supervision in the workplace. The programme trains local health workers (doctors, nurses and midwives) and trainers who will then be able to carry on delivering the course to others.

#### Box 17: Health Partnership Scheme

The new Health Partnership Scheme, launched by the UK Prime Minister in June 2010, will strengthen the links between the UK health community and counterparts in the developing world. The Scheme will fund:

- ambitious multi-country partnerships for some of DFID's priorities, including maternal health, in countries most in need of support
- bespoke paired institutional partnerships whereby an NHS organisation links to a counterpart in developing countries, covering a broad range of health issues
- volunteering to help UK health professionals wanting to spend six months or more sharing their skills and experience overseas
- Healthbay, a new brokerage service, to help match demands from the developing world with expertise in the UK.

#### Other government departments

**114. Cross government working will be strengthened.** This includes through the cross-Whitehall group on health to ensure support to health in developing countries, including reproductive, maternal and newborn health, is coordinated to maximise impact. In developing countries, DFID and the Foreign and Commonwealth Office (FCO), in particular, work closely together.

**115. The Department of Health leads on the delivery of the UK's 'Health is Global' strategy and the UK's representation at the World Health Assembly.** Efforts recognise the interdependency of the UK and other countries and sets out our common interest in addressing these including managing existing and new diseases that spread rapidly around the world (such as drug resistant TB). They also focuses on health worker migration and the global scarcity of skills, and managing issues associated with trade, commercial interests and the global public goods elements of new, more efficacious drugs and technologies.

# Annex: Monitoring and Evaluation Framework

## A1: What will be tracked

Progress against results will be tracked against a core set of results/indicators across all programmes and other appropriate indicators as relevant. The majority of indicators are those internationally agreed through MDG, Countdown to 2015 and other processes, recommended for routine reporting by normative agencies such as WHO and UNFPA, or available from programme output data.

## A2. Determining our results

- Saving the lives of 50,000 women during pregnancy and childbirth and 250,000 newborns and enabling at least 10 million couples (measured as women) to use family planning**

These results were determined and agreed by G8 Health Experts, based on the estimated financing gap for women and children's health and the UK's expenditure on women and children's health (see table A1 and section A6 below). The results were subsequently verified through DFID's Bilateral Aid Review and other planning processes.
- The number of young women aged 15–19 to access family planning (1 million) is a sub-set of the 10 million women above and was determined through the Bilateral Aid Review process and other planning processes.
- Prevention of 5 million unintended pregnancies**

This was determined using the methodology agreed by the Reproductive Health Supplies Coalition (RHSC), and triangulated against Bilateral Aid Review results and other planning processes.
- At least 2 million safe deliveries**

This was determined through the Bilateral Aid Review process and other planning processes.

## A3. Tracking progress

Core results will be tracked in each programme. Each DFID country office and partner or contracting organisation will track a relevant set of indicators, ideally drawing on data which countries are already reporting to the UN and other organisations. Larger 'focus' programmes are likely to track most of the indicators. Not all countries or agencies will report on each indicator – only where relevant activities are supported. Where data are not easily available, countries and programmes will not be able to provide information on all indicators. This includes fragile contexts, countries with smaller programmes or where DFID is working in selected states/regions. Some indicators – including lives saved – involve modelling.

Core results/indicators attributed to UK support (tracked centrally using national and international data, annual (\*) or for mid and/or final review)

	Preventing unintended pregnancies	Safe pregnancy and childbirth
Indicators for <u>all</u> RMNH programmes (minimal set)	<b>Lives saved: women during pregnancy and childbirth and newborns<sup>13</sup></b> (modelled from: <i>maternal mortality ratio</i> ; <i>neonatal mortality rate</i> )	
	<p><b>Numbers of women using modern methods of family planning</b> calculated from <i>Contraceptive Prevalence Rate (CPR)</i> – for all women, the poorest 40% of women and for young women aged 15-19</p> <p><b>Number of unintended pregnancies prevented*</b> – modelled from <i>couple years of protection (CYP)</i> of family planning</p>	<p><b>Number and percentage of births attended by a skilled birth attendant*</b> – for all women, for the poorest 40% of women</p>

Recommended additional indicators to track wider progress (contributed to by UK's support)

Strongly recommended wherever possible	<p>Percentage of women receiving at least 4 antenatal care contacts during pregnancy.</p> <p>Number of health workers per 10,000 population by cadre (by rural/urban) – includes midwives and others with midwifery skills, community health workers.</p> <p>Number of functioning health facilities with emergency obstetric and newborn care (EmONC) per 500,000 population (WHO target is 5 facilities per 500,000 with at least 1 offering comprehensive EmONC)</p> <p>Where possible: Average availability of 14 selected essential medicines in public and private health facilities (plus some from WHO additional list for family planning methods &amp; maternal health supplies).</p>	
	<p>Unit cost of marker contraceptives to major procurers</p> <p>Percentage of women who have an unmet need for modern contraception</p> <p>Percentage and number of live births to girls and adolescent women (aged 19 and under)</p> <p>In high undernutrition settings: percentage of non-pregnant women aged 15-49 with a Body Mass Index outside normal range</p>	<p>Percentage live births delivered by Caesarean section (WHO target is 5-15%)</p> <p>Percentage of infants exclusively breastfed for up to 6 months</p> <p>In high HIV and AIDS settings: percentage of HIV positive pregnant women who received anti-retrovirals to reduce the risk of mother to child transmission</p> <p>In high malaria prevalence settings: % of women who received at least two doses of IPTp during ANC visits during their last pregnancy</p>
Indicators for development (and then use in projects and studies where possible)	<p>Percentage of first births to mothers under age 18 (measured among women aged 18-24 at the time of the survey)</p> <p>Indicator for empowerment</p>	<p>Percentage of mothers or newborns receiving at least one post natal contact [within two days] of birth</p> <p>Indicator for quality: Percentage of women reporting at least a satisfactory experience of services</p> <p>Indicator for clean birth including functioning water and sanitation infrastructure plus soap and hygiene in facilities</p>

<sup>13</sup> This does not include stillbirths although in some programmes this might also be tracked.

## A4. Improving data for planning and monitoring (see Pillar 4)

The UK will aim to not create additional reporting burdens for countries or parallel monitoring systems. Investment will be made in stronger monitoring systems and robust evaluation and support efforts to build countries' own routine health information management systems and vital events registration. This includes Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other national surveys, and health sector 'Management Information Systems'. For example, the DFID funded Africa Maternal Mortality Monitoring and Accountability Project will improve national and sub-national data collection and use in six countries.

Where appropriate, the UK will work with international partners to improve data reliability and regularity. Increased investment may be required in: additional surveys, (such as to fully assess unintended pregnancies and abortions prevented); maternal and newborn death enquiries; and, in qualitative studies. These will be developed with partners as part of the wider effort to report results as 2015 approaches. The UK will work with RMNH Alliance partners, including the US government, to ensure a number of countries can collect data in between DHS surveys where necessary (i.e. to generate data in 2012/2013 as well as 2014/15). We will work with existing interagency groups working to improve data for reproductive, maternal, newborn and child health.

The development of indicators where there are currently gaps will be supported. This includes indicators for tracking the quality of care (such as whether childbirth took place in clean and hygienic surroundings).

Participatory data collection will be supported. Participatory research, planning, monitoring and evaluation processes can empower women, and wider communities, as well as gather robust qualitative information, e.g. on women's experiences of the maternal health and family planning services they use.

## A5. Evaluation

A detailed evaluation framework will be developed by mid 2011, with the emphasis on accountability and lesson-learning. This will be based on a combination of data aggregated from country and multilateral programmes, supplemented by in-depth evaluations of the biggest and most innovative programmes. Key milestones will include:

1. A mid-term review of progress against this Framework for Results will be published by the end of 2013.
2. A full evaluation of the Framework for Results will be published by the end of 2015, commissioned internally by DFID or externally by the Independent Commission on Aid Impact (ICAI).

## A6. Tracking spending commitments on Women and Children's Health made at G8 and UN Summit in 2010

At the G8 Summit in Muskoka in June 2010, the G8, together with several other donor countries and foundations made commitments that will save the lives of over a million extra mothers and children by 2015. The initiative was underpinned by new commitments of an additional \$7.3 billion – including \$5 billion from the G8 – over the next five years. These commitments informed the announcement made by the UK at the event to launch the UNSG's Global Strategy for Women and Children's Health in September 2010, to provide an annual average of £740 million (US\$1.1 billion) for Maternal, Newborn and Child Health from 2010 to 2015.

These resources will support a broad range of interventions – from pre-pregnancy, like family planning, to essential health services for children, like immunisation and nutrition. The G8 agreed on a transparent methodology (Table A1 below) for measuring the baseline and tracking the commitments of G8 members' spend on women and children's health. It is important to recognise that spending on reproductive, maternal and newborn health, which will achieve the results in this Framework for Results, are a sub-set of the spending on women and children's health.

G8 members will track progress in implementing their commitments – starting with the 2011 G8 Accountability Report. The G8 will also work together with other organizations, such as the OECD-DAC, the World Bank, the WHO and the Countdown to 2015 to strengthen global tracking and accountability mechanisms around Reproductive, Maternal, Newborn and Child Health. The Commission on Information and Accountability for Women and Children's Health will track the commitments made to deliver the UNSG-led Global Strategy for Women and Children's Health.

**Table A1** G8 methodology for tracking commitments for women and children's health

DAC purpose codes	Description	Imputed %
<b>Bilateral</b>	--of which--	
12110	Health policy and administrative management	40%
12181	Medical education/training ( <i>Note: not commonly used as DFID code</i> )	40%
12191	Medical services ( <i>Note: not commonly used as DFID code</i> )	40%
12220	Basic health care	40%
12230	Basic Health Infrastructure ( <i>Note: not commonly used as DFID code</i> )	40%
12240	Basic nutrition	100%
12250	Infectious disease control	40%
12261	Health education	40%
12262	Malaria control ( <i>Note: this is not all spend on malaria</i> )	89%
12263	Tuberculosis control	19%
12281	Health personnel development	40%
13010	Population policy and administrative management	40%
13020	Reproductive health care	100%
13030	Family planning	100%
13040	STD control including HIV/AIDS	46%
13081	Personnel development for population and reproductive health	100%
14031	Basic drinking water supply	15%
14032	Basic Sanitation	15%
12010	General Budget Support	4%
<b>Multilateral</b>	--of which--	
	African Development Bank (AfDB)	3%
	Asian Development Bank (AsDB)	2%
	GAVI Alliance	100%
	Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM)	46%
	Global Polio Eradication Initiative (GPEI)	100%
	Inter-American Development Bank, Special Operation Fund (IDB Sp.Fund)	1%
	United Nations Population Fund (UNFPA)	67%
	United Nations Children's Fund (UNICEF)	55%
	United Nations World Food Programme (WFP)	15%
	World Health Organisation (WHO)	22%
	World Bank - International Development Association (IDA)	5%



**Table A2** Core results and recommended indicators. This is part of the wider set

Priority	Global results (attributable to UKaid)	Indicator	Use of indicator	Baseline	Target 2010-2015 (additional)	Frequency	Source*	Level of data
<b>Recommended for use across all DFID funded countries and programmes (minimum)</b>  (attributed to UK funding)	# lives saved: of women during pregnancy and childbirth; and of newborns	Maternal mortality ratio (modelled from)  Neonatal death rate (modelled from)	UN/ Countdown/ govt	0 [2004-08 24,000 and 117,000]	>50,000 women; 250,000 newborn	Modelled for 2015, based on UN 2013 data <sup>xiv</sup>	UN modelling, DHS, Maternal death enquiries Newborn death enquiries	National or State
	# additional women using family planning # women aged 15-19 using family planning. <i>All, poorest 40%</i>	Number and % women using contraception (modern methods) <i>Disaggregated by income quintile and by age (15-19)</i>	UN/Global Strategy/ Countdown/ govt	0 [2004-08: less than 5 million]	> 10 million	Every 3-5 years: mid point <sup>xv</sup> / 2015	DHS, MICS, NSOs	National or State
	# unintended pregnancies prevented	Couple Years of Protection supported (a proxy measure for unintended pregnancies prevented)	USAID & the Gates Foundation Some govt	0 [not currently used]	> 5 million	Annual; validated in selected countries every 3-5 yrs	HMIS, Programme data; studies in selected countries	National or State
	# safe deliveries; <i>All and for poorest 40%</i>	Number and % of births attended by a skilled health personnel <i>Disaggregated by income quintile (essential whenever possible)</i>	UN/Global Strategy/ Countdown Govt	0 [baseline in progress]	> 2 million	Annual – <i>poorest tracked every 3-5 yrs</i>	DHS, MICS, NSOs, HMIS	National or State
<b>Recommended for use (expanded)</b>		% and number of women with at least 4 antenatal care contacts during pregnancy	UN/ Countdown/ govt	Country specific	Country specific	Annual	DHS, MICS, NSOs, HMIS	National or State
		Number of health workers per 10,000 population (by cadre, including midwives/others with midwifery skills, community health extension workers); <i>Disaggregated by at least rural/urban</i>	UN/Global Strategy/ Govt	Country specific	Country specific	Annual	HMIS UN/govt	National/ State or Programme area
		Number of functioning facilities with emergency obstetric and newborn care per 500,000 population (WHO recommend at least 5, with at least 1 Comprehensive EmONC)	UN/govt	Country specific	Country specific	Annual	HMIS/Service Provision surveys	National or State
		Availability of 14 essential medicines in public and private health facilities plus selected family planning methods and maternal health medicines from WHO additional list	WHO/govt	Country specific	Country specific	Annual where possible; every 3-5 yrs	HMIS, facility surveys, WHO	National/ State or Programme

<sup>xiv</sup> Modelling methodology to be developed in line with UN process and DFID evaluation needs

<sup>xv</sup> For selected countries, mid term surveys (in line with national cycles)

Priority	Global results (attributable to UKaid)	Indicator	Use of indicator	Baselines	Target 2010-2015 (additional)	Frequency	Source*	Level of data	
Recommended		Unit cost of marker contraceptives to major procurers eg injectables, pills.	UNFPA/govt	2010 individual unit costs	2015 individual unit costs	Annual data for 4 year trend	UNFPA/ HMIS/ Project data	Global / National	
		% women who have an unmet need for modern contraception	UN/ govt/ Countdown	Country specific	Country specific	Every 3-5 years	DHS, MICS	National or State	
		% and number of live births to girls and adolescent women (aged 19 and under)	UN/ govt/ Countdown	Country specific	Country specific	Every 3-5 years	DHS, MICS	National or State	
		% live births delivered by Caesarean section (5-15%)	UN/ govt/ Countdown	Country specific	Country specific	Every 3-5 years	DHS, HMIS	National or State	
		% and number of infants exclusively breastfed for the first 6 (0-5) months	UN/Global Strategy/ Countdown/govt	Country specific	Country specific	Annual where possible; every 3-5 years	DHS, MICS, NSOs	National or State	
	Including indicators specific to context		% HIV positive pregnant women who received anti-retrovirals to reduce the risk of mother to child transmission	UN, Countdown	Country specific	Country specific	Annual	HMIS, UNAIDS	National
			% women who received at least 2 doses of intermittent preventive treatment for malaria during ANC visits during their last pregnancy	UN, Countdown	Country specific	Country specific	3-5 years	DHS, MICS	National or State
			% of non-pregnant women aged 15-49 with a Body Mass Index outside normal range	UN	Country specific	Country specific	Every 3-5 years	DHS	National or State
		% mothers or newborns receiving at least one post natal contact [within two days] of birth	UN/ govt/ Countdown	Country specific	Country specific	Annual/3-5 years	HMIS, DHS	National or State	
Indicators requiring further research and use at wider scale		% of women's reporting at least a satisfactory experience of reproductive and maternal health services	Project	Country specific	Country specific	Every 3-5 years	Project data DHS	Local	
		Indicator for clean birth including functioning water and sanitation plus soap and hygiene in facilities– under development	Agreed need	Country specific	Country specific	tbc	tbc	tbc	
		% of first births to mothers under age 18 (measured among women aged 18-24 at the time of the survey)	USAID	Country specific	Country specific	Every 3-5 years	DHS	National or State	
		Empowerment indicator – under development	Agreed need	Country specific	Country specific	tbc	Tbc, likely DHS	National or State	

# Glossary

## Adolescent girl

As defined and measured by the DHS and other surveys, a young woman aged 15-19. Globally, there is growing consensus that the term should include the 10-14 year old age group, many of who are 'of reproductive age' and sexually active, especially in countries where early marriage is common.

## Antenatal (care)

The period during pregnancy before birth, and the care required/provided during this stage including: recording medical history; assessment of individual needs; advice and guidance on pregnancy and delivery; screening tests; education on self-care during pregnancy; identification of conditions detrimental to health during pregnancy; first-line management and referral if necessary.

## Birth asphyxia

Failure to establish breathing – or lack of oxygen – of the baby at birth. A major cause of newborn death.

## Commodity security

For reproductive health, exists 'when every person is able to choose, obtain, and use quality contraceptives and other essential reproductive health products whenever s/he needs them'.

## Contraceptive prevalence rate (CPR)

Percentage of women of reproductive age (15-49) who are or whose partner is using a contraceptive method (modern or modern and traditional); often reported for married women or women in union only.

## Couple years of protection (CYPs)

A commonly-used measure of family planning performance at output level, CYPs provide an estimate of protection against unintended pregnancy provided by contraceptive methods, based on volume and types of contraceptive method provided to clients during a one year period.

## Emergency obstetric care (EmOC)

The treatment of complications that arise during pregnancy and childbirth. Services can be 'basic' (includes treatment of pre-eclampsia and haemorrhage, assisted delivery and basic neonatal resuscitation) or 'comprehensive' (includes surgery/caesarean section, blood transfusion).

## ICPD

The United Nation's International Conference on Population and Development held in Cairo in 1994 that agreed the respect for reproductive rights and provision of universal access to sexual and reproductive health services.

## Intervention

Drug treatments, clinical procedures or non-medical inputs such as information about the danger signs in pregnancy for the prevention of treatment of a problem. A package is a combination of single interventions.

## Lifetime risk of maternal death

The probability that a 15-year-old female will die eventually from a maternal cause.

## Maternal mortality/death

The death of a woman while pregnant or in childbirth, or within 42 days of the end of pregnancy, regardless of the site or duration of pregnancy, from any cause related to or aggravated by the pregnancy or its management.

**Maternal mortality ratio**

Annual number of deaths of women from pregnancy related causes per 100,000 live births.

**Modern contraceptive methods**

Includes all hormonal methods (the pill, injectables, implants), Intra-Uterine Devices, condoms and modern vaginal methods (e.g. diaphragm/spermicides) and permanent methods of male and female sterilisation.

**Neonatal (newborn) mortality/death**

Death of a baby during the first 28 completed days of life.

**Obstetric Fistula**

An abnormal opening between the vagina and bladder and/or rectum, resulting in uncontrollable leakage of urine and/or faeces, that is both preventable and treatable.<sup>xvi</sup>

**Postnatal (care)**

6 week period following the birth, and the care required/provided during this stage (including a visit from a health worker with the right knowledge and skills)

**Post partum period**

Usually 10 days following birth.

**Reproductive Health**

ICPD defines reproductive health as: 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes'.

**Reproductive Rights**

The 'basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so'; 'right to attain the highest standard of sexual and reproductive health', 'to make decisions concerning reproduction free of discrimination, coercion and violence'.

**Skilled attendant at delivery**

Accredited health professional, such as a midwife, doctor or a nurse, who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.<sup>xvii</sup>

**Stillbirth**

Death of a foetus occurring after 28 weeks of pregnancy.

**Task shifting**

Process whereby specific tasks are moved, where appropriate, to health workers with often shorter training and different qualifications.

**Unintended pregnancy**

A pregnancy that occurs when a woman wanted to postpone conception for at least two years or did not want to become pregnant. The total number of unintended pregnancies includes unwanted and mis-timed births, abortions and unintended pregnancies that end as miscarriages.

**Unmet need for contraception**

When a woman wants to avoid a pregnancy but is not using any method (modern or modern and traditional); often reported for married women/women in union only.

**Unsafe abortion**

Procedure meant to terminate an unintended pregnancy that is performed by individuals without the necessary skills, or in an environment that does not conform to minimum medical standards or both.

<sup>xvi</sup> The Royal College of Midwives. *Obstetric Fistula, a silent tragedy*. 2010

<sup>xvii</sup> World Health Organization. *Making pregnancy safer: the critical role of the skilled attendant: A joint statement by WHO, ICM and FIGO*, 2004. [www.who.int/making\\_pregnancy\\_safer/documents/9241591692/en/index.html](http://www.who.int/making_pregnancy_safer/documents/9241591692/en/index.html) (accessed 17 Dec 2010).

Front cover: Image of mother, child and health worker ©  
Zimbabwe Elizabeth Glaser Pediatric AIDS Foundation  
Chapter 1: Image of mother and baby, Nepal © Storyline/DFID  
Chapter 2: Image of couple, Ethiopia © Chloe Hall/IPPF  
Chapter 3: Image of pregnant woman, Sierra Leone © Aubrey  
Wade/Panos Pictures



# What is international development?

International development is about helping people fight poverty. Thanks to the efforts of governments and people around the world, there are 500 million fewer people living in poverty today than there were 25 years ago. But there is still much more to do.

1.4 billion people still live on less than \$1.25 a day. More needs to happen to increase incomes, settle conflicts, increase opportunities for trade, tackle climate change, improve people's health and their chances to get an education.

## Why is the UK government involved?

Each year the UK government helps three million people to lift themselves out of poverty. Ridding the world of poverty is not just morally right, it will make the world a better place for everyone. Problems faced by poor countries affect all of us, including the UK. Britain's fastest growing export markets are in poor countries. Weak government and social exclusion can cause conflict, threatening peace and security around the world. All countries of the world face dangerous climate change together.

## What is the Department for International Development?

The Department for International Development (DFID) leads the UK government's fight against world poverty. DFID has helped more than 250 million people lift themselves from poverty and helped 40 million more children to go to primary school. But there is still much to do to help make a fair, safe and sustainable world for all. Through its network of offices throughout the world, DFID works with governments of developing countries, charities, nongovernment organisations, businesses and international organisations, like the United Nations, European Commission and the World Bank, to eliminate global poverty and its causes. DFID also responds to overseas emergencies. DFID's work forms part of a global promise, the eight UN Millennium Development Goals, for tackling elements of global poverty by 2015.

## What is UKaid?

UKaid is the logo DFID uses to demonstrate how the UK government's development work is improving the lives of the world's poorest people.

## Department for International Development

1 Palace Street  
London SW1E 5HE  
UK

and at:

Abercrombie House  
Eaglesham Road  
East Kilbride  
Glasgow G75 8EA  
UK

Tel: +44 (0)20 7023 0000  
Fax: +44 (0)20 7023 0016  
Website: [www.dfid.gov.uk](http://www.dfid.gov.uk)  
Email: [enquiry@dfid.gov.uk](mailto:enquiry@dfid.gov.uk)  
Public enquiry point: 0845 3004100  
or +44 1355 84 3132 (if you are calling from abroad)