



Maternal Health:

Investing in the Lifeline of Healthy Societies & Economies

Africa Progress Panel
Policy Brief
September 2010

EXECUTIVE SUMMARY

One woman dies per minute in childbirth around the globe. Almost half of these deaths occur in Sub-Saharan Africa. Despite the progress made in many countries in increasing the availability of maternal healthcare, the majority of women across Africa remain without full access to this care. Countries face a variety of obstacles to improved maternal health: insufficient data prevents ministries from implementing programmes most effectively, while cost and other access issues prevent women from using the available resources. There are known, cost-effective interventions that can dramatically reduce maternal mortality. Investing in maternal health is a political and social imperative, as well as a cost-effective investment in strong health systems overall. Three key approaches can considerably improve the health of women in Africa: maximizing services of health workers; efficient financing mechanisms; and building political partnerships.

Community health worker (CHW) programmes can improve maternal health, and have successfully reduced maternal mortality in both Ethiopia and Nepal. CHWs are instrumental in providing healthcare to underserved populations, particularly in rural areas, with few healthcare facilities. CHWs can improve maternal health more cost-effectively and reach more of the population if given the proper tools, such as mobile phones, bicycles and delivery kits.

African governments continue to explore and implement different cost-effective strategies

to finance maternal health in their countries. Countries have provided subsidies, abolished user fees, implemented national and community health insurance schemes, utilized performance-based financing and built partnerships to improve maternal health. While donors can provide much-needed funding, it is important for countries and donors to work together to ensure that programmes are cost-effective and in line with national priorities. Governments must also harness the power of the private sector to improve maternal health.

Political will and strong leadership make innovative, cost-efficient interventions possible. Because women are often marginalized economically, politically and socially, sustained leadership on gender equality is required to advance maternal health. Strong leadership at the highest levels promotes accountability within ministries and enables them to find reliable partners to drive and champion progress in maternal health.

Investing in maternal health is a wise health and economic policy decision. Women are the sole income-earners in nearly one third of all households globally. There are spill-over macro-economic benefits from the women whose lives are improved by maternal health interventions. Many maternal-care interventions are proven to be both effective in reducing maternal death and cost-effective, especially for high-risk groups. Some of these interventions are cost-saving, yielding returns of investment of over 100 per cent.

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FOREWORD

Maternal health is not a “women’s issue”. It is about the integrity of communities, societies and nations, and the well-being of all the men, women, boys and girls whose own prospects in life depend upon healthy women and mothers.

Maternal health is not only needed as a basis for social harmony and economic productivity; it also reduces costs and burdens to families, communities, service providers and the Treasury. Smart investments in maternal health strengthen health systems overall, and increase cost-effectiveness of resources allocated to the health sector.

We believe that investing in maternal health makes compelling political and economic sense. Failure to invest in maternal health is not only irresponsible and immoral; it is also deeply counterproductive, undermining national growth and development.

This report recommends what can and must be done if Africa is to end the unnecessary death of millions of African women. It is simply unacceptable that so many women are dying. Nearly 50 per cent of all maternal deaths in the world happen in Africa, which has only 15 per cent of the world’s population.

Pregnancy and childbirth are all too often a cruel and harsh lived experience for Africa’s women, particularly the poor and women in rural areas. Almost 75 per cent of women who die in childbirth would be alive if they had access to the interventions for preventing pregnancy and birth complications.¹

This policy brief is intended to complement the efforts of maternal health advocates in government, civil society

and the development community by making the case for why urgent action to reduce maternal mortality must be a top priority for African leaders, including Ministers of Finance and the private sector. It recommends policy interventions and considers mechanisms to help with the financing of maternal health initiatives.

Success in reducing maternal mortality is dependent on and can accelerate progress on wider issues such as nutrition, education, and sexual and reproductive rights, including access to comprehensive voluntary family planning. This brief recognizes, but does not focus on, these issues. It acknowledges that maternal health requires taking a holistic view by addressing women’s sexual and reproductive health needs throughout their lives, including adolescence, and articulating the responsibility of men and boys in reducing gender inequalities. Rather, it focuses on actions that can be taken now to halt and reverse the daily tragedy facing simply too many women on the continent.

Partnerships are essential for progress – whether between the public and private sectors, communities and local government, or African governments and donors. All have a role and can share responsibility, as the many inspiring examples of success underscore, for contributing to dramatic improvements in mortality rates, health systems and women’s lives.

Achievement of MDG 5 is not a distant dream. We know what needs to be done. We just need to do it.

Graça Machel,
Member of the Africa Progress Panel

INTRODUCTION

Investing in maternal health is not only a political and social imperative for Finance and Health Ministers, Heads of State and other policymakers, but it is also cost-effective. Healthy mothers lead to healthy families and societies, strong health systems, and healthy economies. As one step towards achieving these results, there are proven cost-effective interventions that can dramatically improve maternal care in Sub-Saharan Africa's health systems. Money alone will not solve the problem, but three key approaches can have a dramatic positive impact on the health of women in Africa:

- health systems interventions: health workers
- efficient financing mechanisms
- political partnerships.

Investing in maternal health is urgent: not only because giving life should not result in death, but also because women are important economic drivers and their health is critical to long-term, sustainable economic development in Africa. Furthermore, investing in maternal health is a way to improve health systems overall, which benefits the entire population of a country.

Every year globally approximately 536,000 girls and women die from pregnancy-related causes – one girl or woman dies every minute.² Over 99 per cent of maternal deaths occur in developing countries, with nearly half of these taking place in Sub-Saharan Africa.³ In fact, a woman living in Sub-Saharan Africa is at a higher risk of dying while giving birth than women in any other region of the world. This is especially evident among women aged 15 to 19 in Africa, for whom giving birth is the leading cause of death. Moreover, it is estimated that globally up to 20 million girls and women a year suffer from maternal morbidities – surviving childbirth, but enduring chronic ill health.⁴


International organizations and individual governments have recognized the severity of the problem and have made commitments to reduce the number of maternal deaths globally. Millennium Development

Goal 5 (MDG 5) calls for national maternal mortality ratios to be reduced by three-quarters between 1990 and 2015. While this may be an unrealistic target at present – the maternal mortality ratio declined only by an average of 5 per cent between 1990 and 2005 – African organizations have committed to work towards achieving it.

The African Union (AU) launched a Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) in 2009 to bring attention to this challenge and foster champions to advocate for policies to improve maternal health. CARMMA was born out of the Maputo Plan of Action (Maputo PoA), adopted by the AU in 2006, which aims to achieve universal access to comprehensive sexual and reproductive health and rights in Africa by 2015.

In July 2010, the African Union Summit's main central theme was 'Maternal, Child and Infant Health and Development in Africa'. All African Union members were present, with over 35 African heads of state, international partners (including several heads of UN agencies), civil society and media. The many health challenges in Africa were extensively debated raising the profile of MDG 4 and 5 to an unprecedented level. It was unanimously agreed that women and children's health deserves greater investment – both politically and financially.

In April 2010, the UN Secretary-General launched a global effort to focus leaders' attention on women's and children's health.⁵ More recently, leaders at the Canadian G8 Summit (June 2010) pledged to mobilize \$10 billion to accelerate progress on MDGs 4 and 5 between 2010 and 2015 as part of the Muskoka Initiative, an integrated approach to reducing maternal and newborn deaths in developing countries.⁶ These proposals highlight the importance for urgent action on maternal health. National programmes must be implemented without delay to stop women from dying needlessly. Furthermore, the poor maternal health statistics in Africa underscore the need for countries to prioritize women in overall health and development strategies.

	Goal 5 Targets	Official Indicators used to track progress
 <p>MDG Goal 5: Improve maternal health</p>	Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1 Maternal mortality ratio 5.2 Proportion of births attended by skilled health personnel
	Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate 5.4 Adolescent birth rate 5.5 Antenatal care coverage (at least one visit and at least four visits) 5.6 Unmet need for family planning

Source: UN Statistics Division (2010)

FACTS ON MATERNAL MORTALITY IN AFRICA

- Every year globally approximately 536,000 girls and women die from pregnancy-related causes – one girl or woman dies every minute.⁷ A recent Lancet study, using a revised maternal mortality methodology, estimates this number to be significantly lower – 343,000 in 2008.⁸
- Over 99 per cent of maternal deaths occur in developing countries, with nearly half of these taking place in Sub-Saharan Africa.⁹ Women living in Sub-Saharan Africa have a higher risk of dying while giving birth than women in any other region of the world.
- For women aged 15 to 19 in Africa, giving birth is the leading cause of death.
- Globally, up to 20 million girls and women a year suffer from maternal morbidities – surviving childbirth, but enduring chronic ill-health.¹⁰
- Progress is slower in some regions than others: while every North African country has reduced maternal mortality by at least 5.5 per cent per year since 1990, only one Sub-Saharan African country (Rwanda) has achieved an average yearly reduction of more than 4 per cent.
- The rate of maternal mortality varies significantly across the world, and globally is the most inequitably distributed health indicator. One thousand women die per 100,000 live births in Sub-Saharan Africa, compared to 24 deaths per 100,000 live births in European countries.¹¹
- For every maternal death, there are approximately 20 other women who suffer pregnancy-related disability. That is equivalent to an estimated 10 million women each year who survive pregnancy, yet experience some type of severe negative health consequence.¹²
- A woman's lifetime risk of maternal death is 1 in 7,300 in developed countries versus 1 in 75 in developing countries.¹³ In Sub-Saharan Africa, a woman's lifetime risk of maternal death is a staggering 1 in 22.¹⁴

MATERNAL DEATHS ARE PREVENTABLE

- Maternal deaths are caused by a wide range of complications in pregnancy, childbirth or the postpartum period. Most of these complications develop because of the pregnancy itself, and some occur where pregnancy has aggravated an existing disease.
- The four major killers are: severe bleeding (mostly bleeding postpartum), infections (also mostly soon after delivery), hypertensive disorders in pregnancy (eclampsia) and obstructed labour.¹⁵ Complications after unsafe abortion cause 13 per cent of maternal deaths. Globally, about 80 per cent of maternal deaths are due to these direct causes.
- Among the indirect causes of maternal death (20 per cent) are diseases that complicate or are aggravated by pregnancy, such as malaria, anaemia and HIV. Women also die because of poor health at conception and a lack of adequate care needed for the healthy outcome of the pregnancy for themselves and their babies.¹⁶

Increased donor funding from sources such as the Muskoka Initiative can be used as a tool to improve maternal health; however, projects and financing are often based on donor prerogatives, rather than national priorities. In light of these campaigns and the increased amount of donor funding devoted to improving maternal health in Africa, it is particularly important for governments to determine and subsequently implement their own strategies.

While women face a plethora of problems when pregnant in Africa, three challenges or barriers to maternal health seem particularly problematic. Successful interventions should be aimed at addressing these challenges: 1)

access and availability; 2) cost; and 3) information and attitudes.

Despite grim maternal health indicators and these significant barriers to success, if African governments focus on tackling these barriers by improving health systems, utilizing efficient financing mechanisms and forming political partnerships, maternal health will improve in Africa. The key to successful programmes is political will, accompanied by a steady source of funding, to support gender equality and maternal health. Steady sources of funding ensure the sustainability of programmes and political will ensures the sustainability of steady funding.

MATERNAL HEALTH: BARRIERS TO SUCCESS

Despite the progress made in many countries on increasing the availability of maternal healthcare, the majority of women across Africa remain without full access to this care. Countries face a variety of obstacles

to improved maternal health: insufficient data prevents ministries from implementing programmes most effectively, while cost and other access issues prevent women from using the available resources.

COST

Although some countries have made efforts to reduce or eliminate user fees for health services in recent years, professional healthcare remains too expensive for many women. Surveys of West African women found that well over half listed cost as a reason they did not seek healthcare. In Burkina Faso, Cameroon, Guinea and Niger that proportion was 60 per cent.¹⁷

These costs are both direct and indirect: fees for the use of facilities, services and drugs are high enough on their own. When combined with the cost of transportation to clinics and the possibility of lost wages from work, they are often prohibitive. Furthermore, treatment

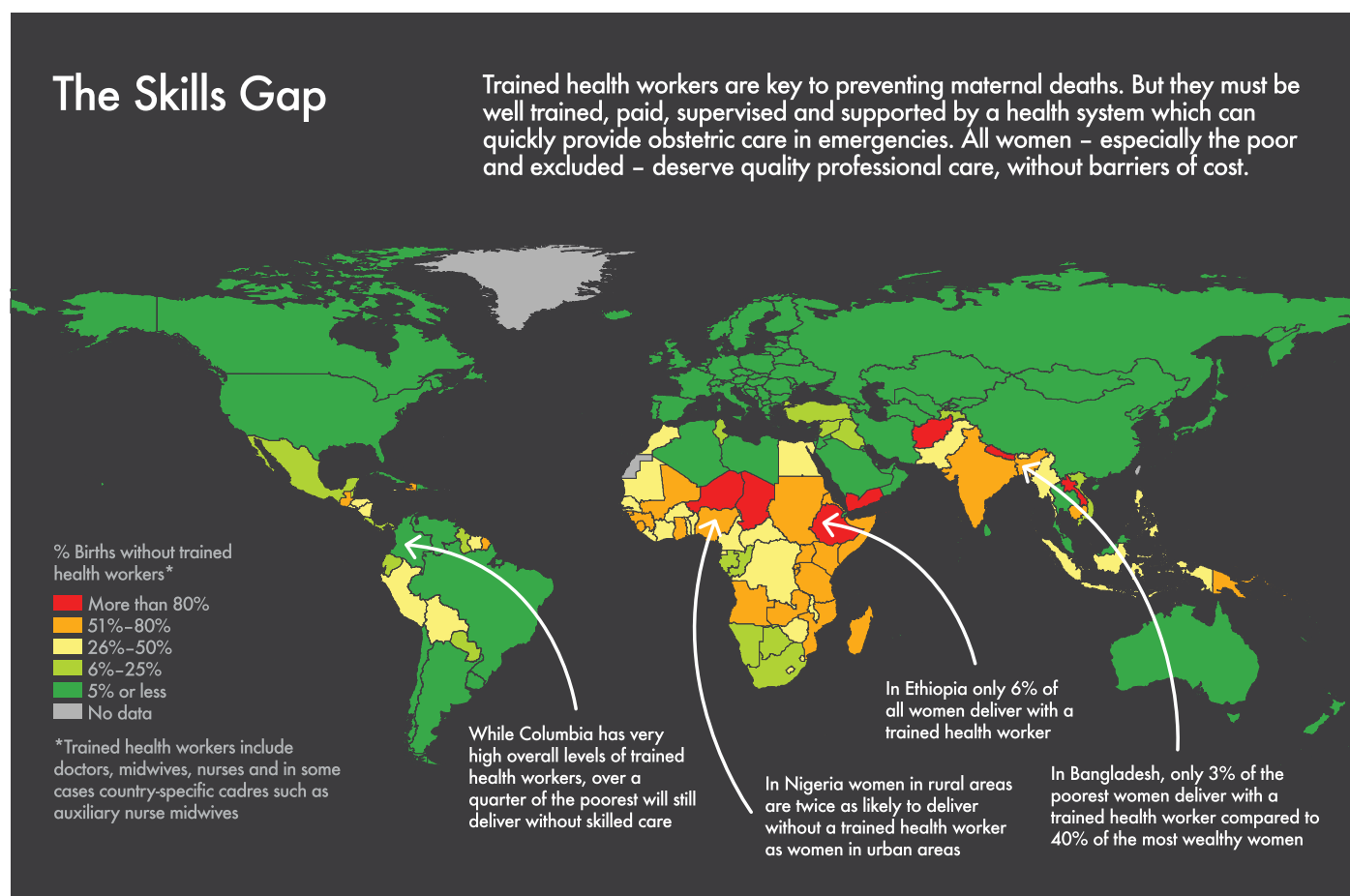
for obstetric complications is often more expensive, making pregnant women with complications doubly vulnerable.¹⁸

In addition to regular user fees, many nation- or community-wide healthcare plans require some registration cost. For instance, Ghana's National Health Insurance Scheme (NHIS) was successful in covering more than half of Ghanaians in its first four years alone, but coverage is much lower among the country's poorer people partly because of the registration fee.¹⁹ In Egypt, only half as many women in rural areas give birth in health facilities as do those in urban areas.²⁰

ACCESS

Even when cost is not a primary obstacle, women are often unable to access quality maternal healthcare when they need it. Africa faces a health-worker crisis: on average, there are only 13.8 nursing and midwifery personnel for every 10,000 people.²¹ In the poorest countries, this ratio is less than 1 per 100,000 people. Also, this care may not be available when it is most needed. A study in Malawi found that only 13 per cent of clinics had 24-hour midwife care, a major hazard

for women who face complications from childbirth or neonatal emergencies at night.²² The geographic distribution of health workers further complicates the issue of access. The health-worker average does not give a full picture of the shortage in rural areas, where there are far fewer health workers than in urban areas. For example, South Africa's rural areas account for about 46 per cent of the population but only 12 per cent of doctors and 19 per cent of nurses.²³



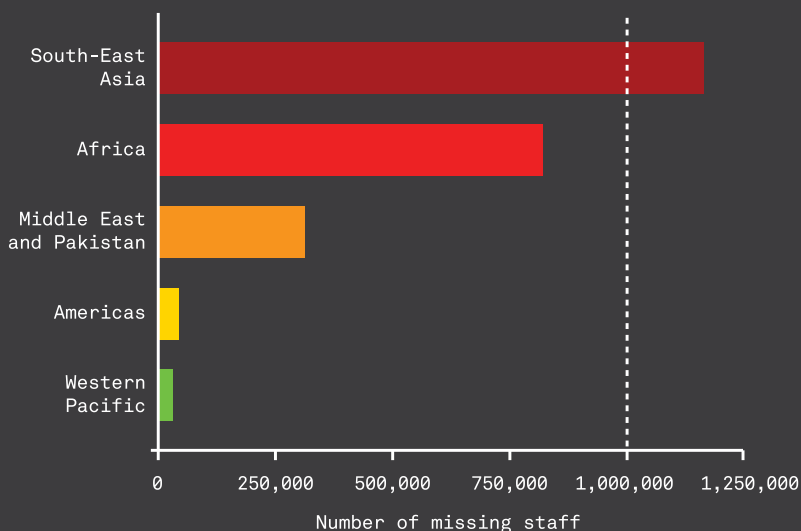
White Ribbon Alliance, Atlas of Birth (2010), in conjunction with GHP3 (University of Southampton) and Impact (University of Aberdeen). Data source: WHO Proportion of births attended by a skilled worker (estimates by country 2008).

INFRASTRUCTURE

Poor road infrastructure and transportation present another hurdle to effective care. Especially in rural areas, clinics are often too far away or otherwise inaccessible. Frequently there are no roads to the nearest health facility, or existing roads are impassable due to road quality, terrain, natural disasters or the rainy season. The Overseas Development Institute (ODI) reports that in rural Zimbabwe, transportation problems were cited in 28 per cent of maternal deaths, compared with 3 per cent in Harare.²⁴ Tunisia has made impressive strides in scaling up maternal care and reducing maternal mortality, but there has been less progress in rural areas. This can be particularly dangerous for women suffering from obstetric complications, where delays in reaching medical care can have permanent consequences. Obstetric fistula, a painful and unhygienic consequence of obstructed labour over a long time is compounded by the inability to reach medical attention and disproportionately affects poor and rural women, often resulting in their social isolation. Increasing road access to clinics has a demonstrable impact on care; one study showed that use of Ghana's public health facilities nearly doubled when distance to clinics or hospitals was halved.²⁵

HEALTH STAFF SHORTAGE

57 countries across the developing world have critical shortages of midwives, nurses and doctors. A total of 2.4 million health workers are needed in these countries.



Progress in reducing maternal deaths will accelerate dramatically with the right health workforce in place. These key workers must be well trained, paid, supervised and supported by a working health system including the right drugs, supplies, equipment and functioning facilities.

White Ribbon Alliance, Atlas of Birth (2009), in conjunction with GHP3 (University of Southampton) and Impact (University of Aberdeen).
Data source: The World Health Report 2006.

QUALITY AND SUSTAINABILITY OF CARE

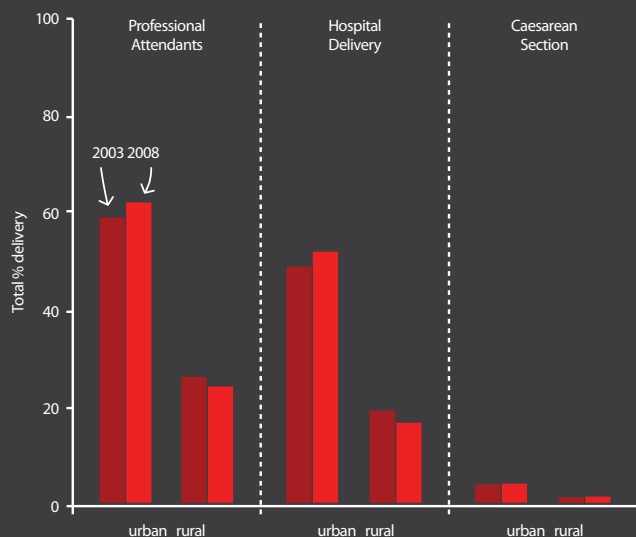
There is insufficient data on the quality and sustainability of care provided. The report *Countdown to 2015* concludes that not only is more health coverage imperative, but also there must be greater attention paid to “what care is actually provided during antenatal, childbirth and postnatal contacts.”²⁶ One important aspect of the quality of care is its sustainability. While some improvements in access and coverage have been made through projects financed by international donors and NGOs, only projects that develop health system capacity to ensure sustainability will be able to

continue achieving positive health outcomes once the implementing agency has left.

Many of these access issues disproportionately affect the poor, causing a problem with equity across health systems. In Sub-Saharan Africa's lowest income quintiles, skilled medical attendants are present at only 25 per cent of births.²⁷ Healthcare is even sparser in rural areas. For instance, in Nigeria, rural women are twice as likely as urban women to give birth without a trained health worker present.²⁸

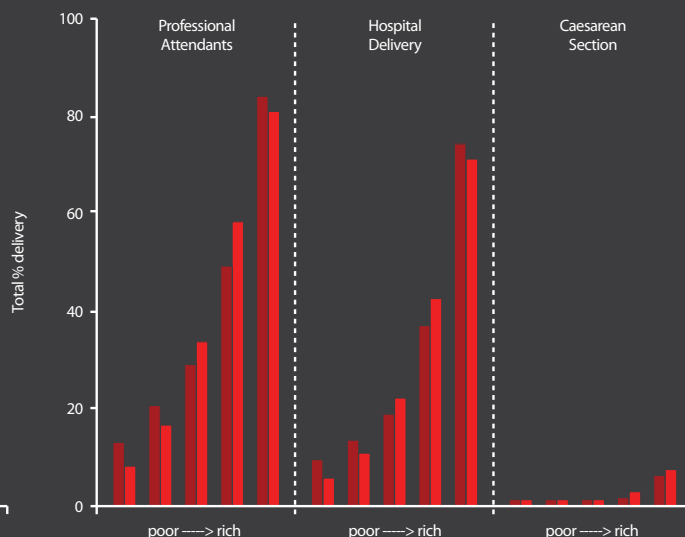
The Case of Nigeria

Delivery by Urban-rural residence



There is an increase in the inequity of the distribution of each delivery care indicator by urban and rural areas.

Delivery by poverty quintile



This can also be seen in the distributions of care by poverty quintile: for each indicator uptake of care falls among the poorest 2 quintiles, increases in the middle quintiles and changes little in the richest quintile.

White Ribbon Alliance, Atlas of Birth (2010), in conjunction with GHP3 (University of Southampton) and Immpact (University of Aberdeen). Data source: Nigerian Demographic and Health Survey (DHS) 2008.

INFORMATION DEFICIT

Most governments in Africa face a lack of accurate data on maternal health and existing funding. This makes it difficult to determine accurately how much funding is needed and what programmes are most effective.

Presently, most health project funding from outside a country's ministry of health, such as money from foundation grants and NGO projects, is distributed independently of the host government. NGO health interventions are not often coordinated or monitored at national level, and many organizations do not publish their individual project finances. As a result, African governments do not have accurate

data on total spending on maternal health in their countries.

Where information does exist, the lack of a commonly held definition of funding for maternal health prevents effective data use. For example, the Bill and Melinda Gates Foundation makes grants in a category called "Maternal, Neonatal and Child Health", which includes technology and treatment development but also advocacy for government policies related to maternal health.²⁹ In other cases, an allocation for maternal health is captured under the heading of HIV/AIDS prevention and treatment. Some United States Agency for International Development (USAID)

and United Kingdom Department for International Development (DFID) maternal health programmes include money for family planning; many funders do not. In other words, funding names and destinations are disparate.

Most African health ministries, with limited human resources, cannot fully monitor and coordinate all these varied streams of funding towards maternal health. The multitude of players in each country makes it very difficult for ministries to coordinate efforts and create economies of scale to benefit more people. As a result, projects and financing are determined by the preferences of the donor or implementing organization, not the priorities and strategy of the government.

The lack of accurate, up-to-date statistics on maternal deaths also prevents governments from allocating resources most efficiently. The World Health Organization (WHO) reports that 40 million people

worldwide die unregistered and 40 million babies are born without record each year.³⁰ Of the 30 countries in the world with the highest maternal death rates, only Botswana and South Africa have country-wide civil registration systems. In most other countries in this group, data collectors rely on crude measures from imprecise surveys such as polling women about their sisters' experiences with childbirth.³¹ Because governments recognize that they cannot improve maternal health without accurate information on the levels and causes of maternal death, countries are working with partners to develop new, cost-effective tools to collect and analyze data efficiently.³²

WHO Director-General Margaret Chan has discussed the consequences of this lack of information: "Without these fundamental health data, we are working in the dark. We may also be shooting in the dark. Without these data, we have no reliable way of knowing whether interventions are working, and whether development aid is producing the desired health outcomes."³³

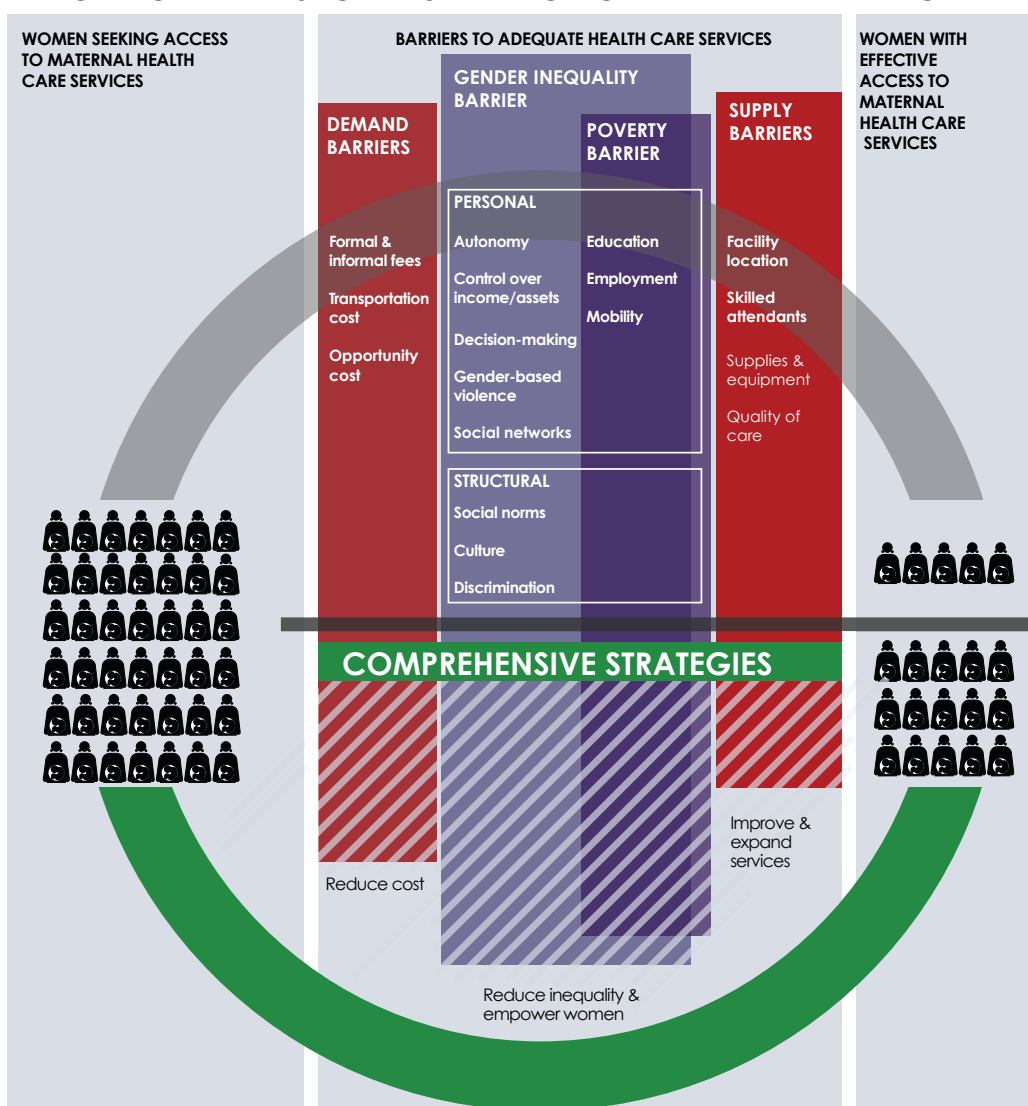
ATTITUDES

Pervasive attitudes about women in many areas frequently stop women from accessing existing healthcare resources – maternal or other. In many parts of Africa, women must seek permission from their husband or family to visit a clinic for care. Even when permission is nominally given, women's lack of autonomy in their families can still prevent them from seeking care. According to Women Deliver, "other family members may consider childbirth as a woman's concern and not that of the household. As a result, women may find it difficult to get the money to pay for services or to obtain transport to get to medical care."³⁴ This may lead to incomplete treatment if husbands or family members do not appreciate the need for long-term care. For example, in Sub-Saharan Africa, 73 per cent of women receive

at least one antenatal care visit, but only 44 per cent receive four or more.³⁵ Lack of education for women also prevents them from making informed decisions about their health and, sometimes, from knowing when to seek care.

Barriers to access exist throughout Africa's healthcare systems; cost, social dynamics and other obstacles prevent women from fully accessing care, and insufficient information prevents governments from creating the optimal systems. These impediments combine and reinforce each other to prevent successful utilization of health services by many women. To achieve real progress in maternal health, effective financing methods must consider these barriers.

REMOVING BARRIERS TO THE UTILIZATION OF MATERNAL HEALTH CARE



Source: Africa Progress Panel, based on Women Deliver (2010).

KEY APPROACH 1: ADDRESSING COST, ACCESS AND INFORMATION BARRIERS

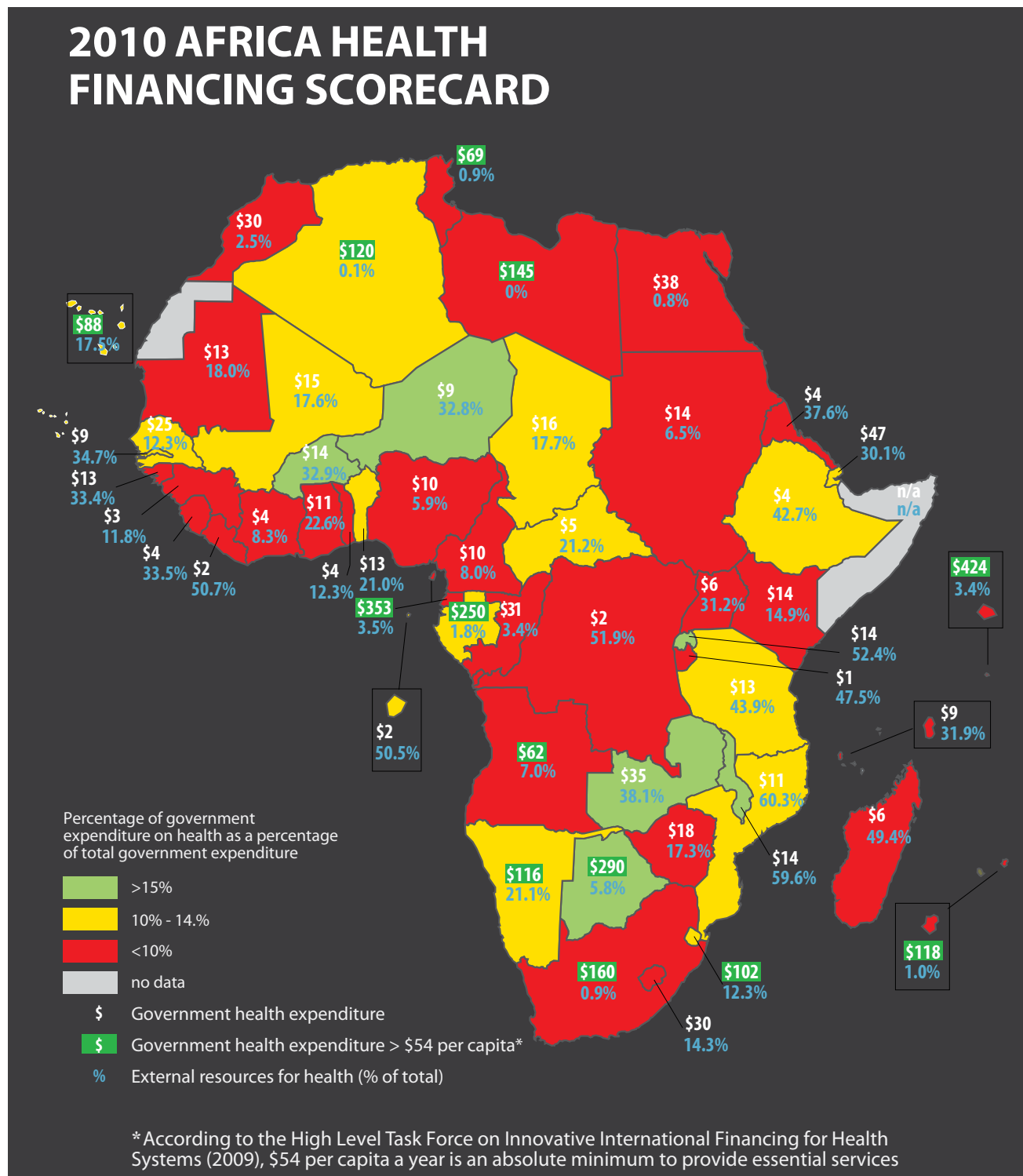
African governments are the chief financiers of health programmes, yet the health sector remains largely underfunded – an inevitable result of competition for government funds among ministries with urgent needs. Within health ministries, maternal health is generally given low financial priority. As a result, the sector lacks skilled workers and facilities that could help to avert thousands of preventable deaths. Moreover, approximately half of all African countries have yet to cost implementation plans fully for maternal, newborn and child health.

The WHO has identified 68 “Countdown countries” which account for 90 per cent of all global maternal deaths – 45 of these countries are African.³⁶ Among those Countdown countries in Africa, government expenditure on health as a proportion of total government expenditure ranges from as low as 2 per cent in Burundi to almost 19 per cent in Rwanda.³⁷ The average government expenditure on health in Africa is almost 9 per cent, compared to the European average of approximately 15 per cent.³⁸

In tackling MDG 5, on lowering maternal mortality, several African governments have taken steps to improve funding for health programmes, by:

- increasing national budget allocations for (maternal) health
- increasing government funding and support for community health services
- enacting health insurance schemes
- reducing user costs through free care, subsidies and vouchers.

2010 AFRICA HEALTH FINANCING SCORECARD



Data source: Africa Public Health Information Service - in Partnership with Africa Public Health Alliance & 15%+ Campaign, 2009-2010. <http://www.africapublichealth.info>

INCREASED BUDGETS FOR MATERNAL HEALTH

In 2009, Kenya, Ghana and Rwanda made significant allocations in their budgets towards improving maternal health. The Kenyan Government allocated KSh4 billion (\$49.6 million) to improve health infrastructure and hire 4,200 additional nurses.³⁹ Ghana's National Health Insurance currently covers 54 per cent of the Ghanaian population and provides a comprehensive healthcare package, including free care for all pregnant women. This includes childbirth in public, mission and private health facilities. Furthermore, in recent years Ghana has been consistently increasing its health workers and

facilities. In 2009, Ghana increased the number of health-assistant training centres to 67 countrywide. In 2008, 530 midwives and 105 medical assistants were trained and integrated into the health system, with extended funding for existing free maternal services and midwife training.⁴⁰

Rwanda's 2009 budget statement provided for 45 new maternal centres to be constructed, plus enhanced transportation systems, particularly to service pregnant women in rural areas. It provided for purchase of 64 ambulances for 45 districts.⁴¹

HEALTH SYSTEMS INTERVENTIONS – COMMUNITY HEALTH WORKERS

Lack of access to health facilities is a major cause of maternal mortality, but infrastructural constraints result in very few health facilities in rural areas. In Eastern Africa, only 34 per cent of women giving birth have a skilled attendant present, which is a major cause of maternal mortality.⁴² In response, most African governments are working to mobilize health personnel to rural areas to provide healthcare. According to the UN, Tunisia's 80 per cent reduction in maternal deaths was due largely to the country's emphasis on skilled attendance at delivery.⁴³ Community Health Workers (CHWs) are instrumental in providing healthcare to underserved populations and can be vital in reducing maternal mortality. A study in the Upper East Region of Ghana found that increased training and mobilization of community health nurses reduced mortality rates among women and children.⁴⁴

There are several examples of effective strategies for utilizing CHWs to extend healthcare to underserved populations – appropriate selection, including by gender, continuing education and education-level, involvement and reorientation of health-service staff, appropriate curricula, supervision and support.⁴⁵ Most studies say that CHW programmes cannot be sustained on a voluntary basis, since CHWs are generally poor and need an income.⁴⁶ Financing methods may

affect the effectiveness of a CHW programme: CHWs who receive often-unreliable community financing have twice the attrition rates of those receiving regular government salaries. Because considerable investment is made in each CHW, programme costs for identifying, screening, selecting and training each worker rise with high attrition rates. CHW programmes are not cheap or easy, but are a good investment. The alternative is no care for the poor living in peripheral areas. The key to effective programmes is political will and a steady source of funding.⁴⁷

Ethiopia

The Government of Ethiopia, with the support of several donors, is investing heavily in Health Extension Workers (HEWs). The Federal Ministry of Health launched a programme in 2004 to train and deploy female HEWs to villages, with each worker receiving a government salary. There are currently 31,000 extension workers in place, each with a year's training in basic maternal health services. These workers also provide diarrhoea treatment, training in hygiene and sanitation, malaria prevention and treatment, and they will be trained to administer antibiotics to treat pneumonia.⁴⁸ Several organizations are working with the Ministry of Health to provide funding and technical assistance to train

health workers, including the African Medical and Research Foundation (AMREF), USAID, UNICEF and the Gates Foundation. The HEW programme has been crucial in reducing Ethiopia's annual maternal mortality rate, from 22,000 in 2005 to 17,500 in 2008.⁴⁹

Nepal

Nepal halved its maternal mortality rate between 1990 and 2008, from 471 to 240 per 100,000 live

births, potentially saving approximately 5,000 lives per year.⁵⁰ A key component of this success has been the recruitment, training and deployment of 50,000 Female Community Health Volunteers (FCHVs). FCHVs play an important role in rural public-health programmes, including providing expertise on family planning and maternal care. FCHVs educate and inform women about birth preparedness, make post-partum visits and treat children with diarrhoea and pneumonia.⁵¹

COMMUNITY HEALTH WORKER TOOLS FOR SUCCESS

Community health workers can improve maternal health more cost-effectively and reach more of the population if given the proper tools. Providing means of communication to health personnel can improve access for those in need of care. Phones allow pregnant women to ask questions of health workers and alert them when they are going into labour. Additionally, phones allow health workers to communicate data to health facilities. In Rwanda, community health workers have received 10,593 government-funded mobile phones.⁵² Telecommunications companies, such as MTN and Voxiva, are working with the Rwandan Government to support this initiative. In a recent speech to health workers, Dr Richard Sezibera, Rwandan Minister of Health, described the phones as: "a tool that will enable you to perform your duties effectively so that you can significantly cut mortality rates especially among mothers and children under five, in line with the health goals".⁵³

Bicycles can help community health workers to reach more women in rural areas, increasing distances covered fourfold, compared to walking, and saving

time.⁵⁴ With this in mind, the Government of Kenya allocated KSh500,000 (\$6,200) in its 2010 National Budget to provide motorcycles and bicycles for community health workers in all forty-six districts.⁵⁵ Donor organizations such as World Vision and the Clinton Foundation have also provided community health workers with bicycles in Ethiopia, Kenya, Mozambique, Rwanda, Tanzania and Zambia to enhance the effectiveness of maternal health programmes.

In a study in Pakistan, traditional birth attendants were trained and issued with disposable clean-delivery kits. In accordance with WHO principles of cleanliness at birth, most clean-delivery kits include: soap, a plastic sheet, string for tying the umbilical cord, a razor blade for cutting the cord, and pictorial instructions explaining how to use each item in the kit. The result was a significant reduction in prenatal and maternal deaths. Risk rates dropped from 0.70 and 0.79 to 0.59 and 0.45, respectively.⁵⁶ In Tanzania, it has been found that, when a clean-delivery kit is used during birth, women are three times less likely to develop sepsis or genital-tract infection.⁵⁷

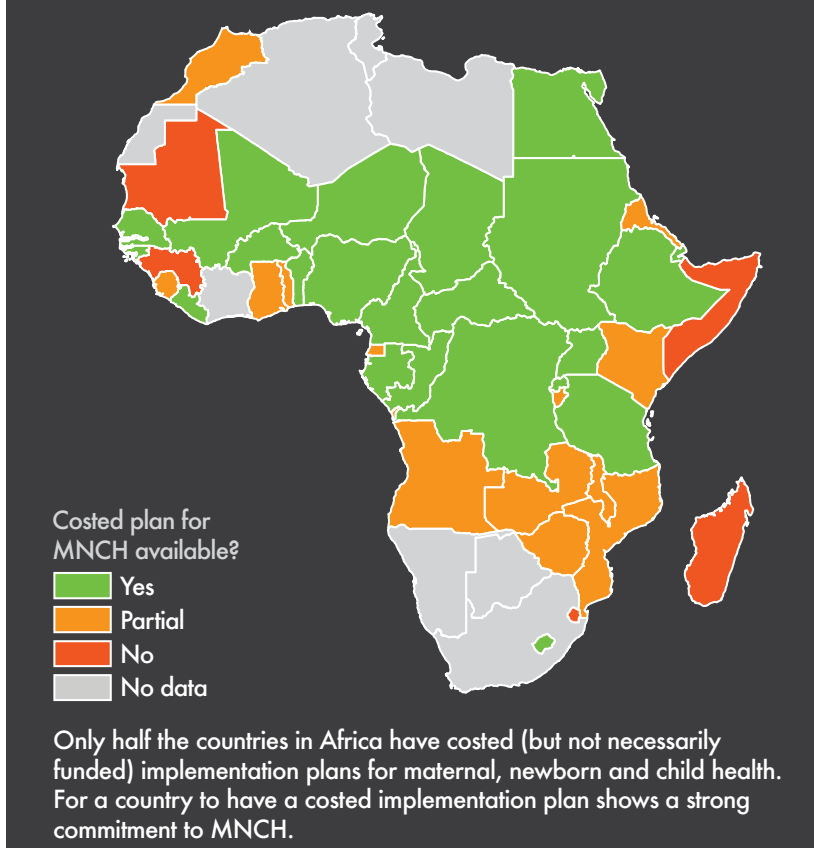
KEY APPROACH 2: EFFICIENT FINANCING MECHANISMS

African governments continue to explore and implement different strategies to improve maternal health in their countries. Health Ministries face the challenge of how to pay for the implementation of key interventions in the short, medium and long term. Countries have given subsidies, abolished user fees, implemented national health-insurance schemes and built partnerships to improve maternal health. It is vital that programmes to improve maternal health are cost-effective investments for governments, while improving access to care and reducing the cost for citizens.

SUBSIDIES AND PAYMENT EXEMPTIONS

Although user fees can improve the quality of healthcare and reduce demand for care, such costs have proven to be a major barrier for poor women in Africa. User fees are typically regressive.⁵⁸ For instance, the average cost of complications during delivery may comprise about 10 per cent of household annual income; in poorer Benin however, this cost is equivalent to between 11 and 51 per cent.⁵⁹ With such a high cost relative to income, user fees considerably decrease utilization and delay treatment in maternal health services. In Nigeria, the cost of obstetric care is prohibitive and has been shown to lead to maternal deaths. In Tanzania, user costs reduce the number of births with a skilled attendant present.⁶⁰

Availability of costed implementation plans for maternal, newborn and child health



White Ribbon Alliance, Atlas of Birth (2009), in conjunction with GHP3 (University of Southampton) and Immpact (University of Aberdeen).

Examples of subsidies and free care in Africa include:

- Burundi: pregnant women
- Zambia: user fees suspended for rural districts
- Burkina Faso (2006): 80 per cent government subsidy for all deliveries
- Kenya (2007): free deliveries
- Liberia (2007): free primary care
- Sudan (2008): free caesarean sections and free child care⁶¹
- Morocco: free transportation to obstetric facilities in rural areas.⁶²

Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA)

Despite a decade of economic boom and increased international assistance, Africa remains far from achieving the Millennium Development Goal of reducing maternal mortality by 75 per cent from 1995 figures by 2015. In recognition of this, and the fact that the food, climate, and economic crises further compound the challenge, the African Union Commission has initiated CARMMA to bundle the efforts of its member states in four key areas:

- (a) Building on-going efforts and particularly on best practices;
- (b) Generating and providing data on maternal and

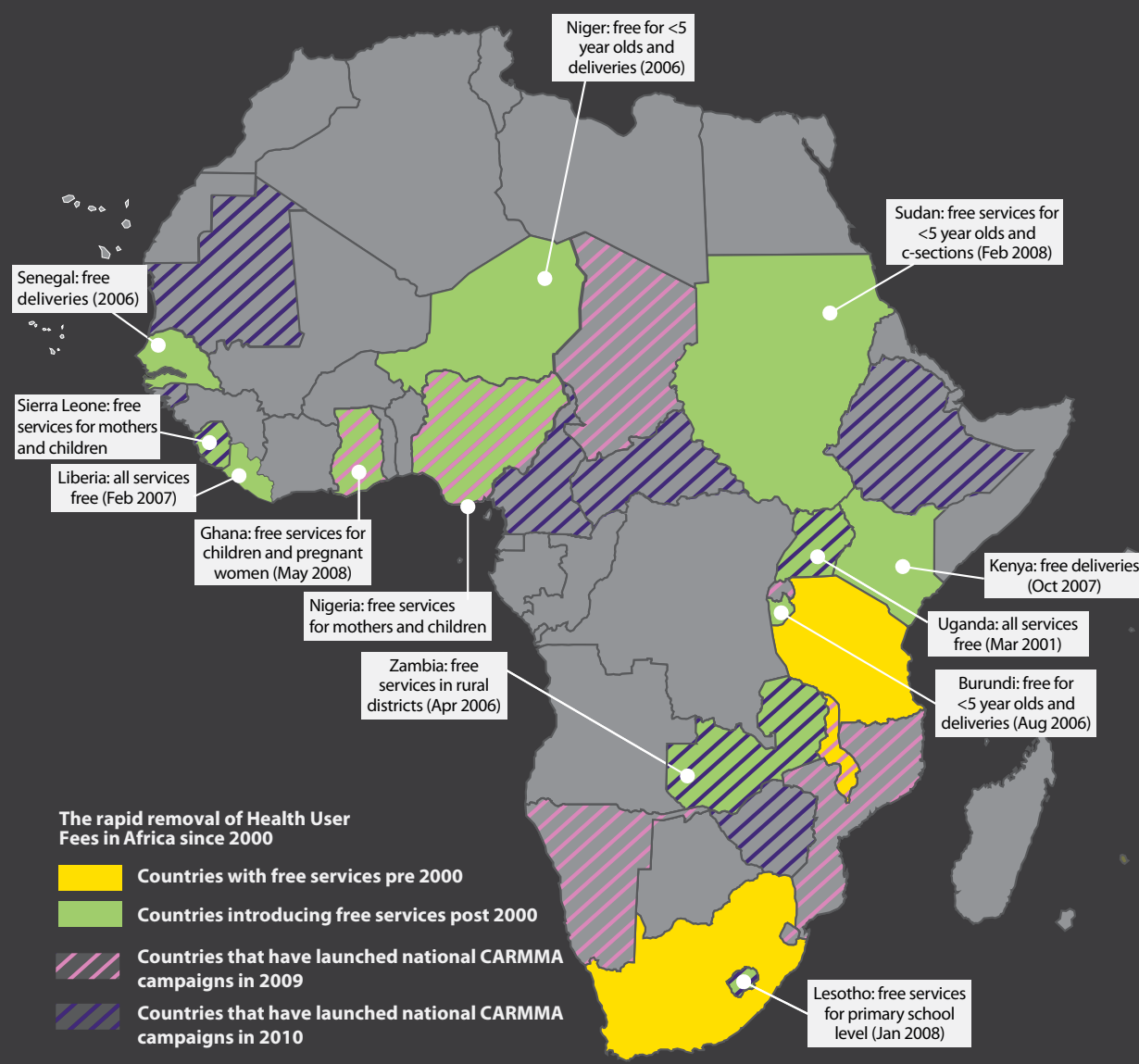
newborn deaths;

(c) Mobilization of political commitment and support of key stakeholders including national authorities and communities - mobilizing addition domestic resources in support of maternal and newborn health and mobilizes communities to let them know that everyone has role in maternal health and reduction of maternal deaths; and

(d) Accelerating actions aimed at the reduction of maternal and associated infant mortality in Africa.

Source: UNFPA CARMMA Publication (forthcoming 2010)

TACKLING BARRIERS TO ACCESS IN AFRICA & COUNTRIES THAT HAVE LAUNCHED CARMMA



Source: Africa Progress Panel, based on the presentation by Partnership for Maternal, Newborn & Child Health at the Africa Partnership Forum (April 2009) and updated information on CARMMA provided by Africa Regional Office, UNFPA.

HEALTH INSURANCE PROGRAMS

In recent years, a number of governments have implemented or sought to implement health insurance schemes to finance healthcare efficiently and reduce the cost burden for the population. Insurance schemes are typically funded by taxes paid to national governments, community assets, or premiums charged to beneficiaries. Coverage and target populations vary depending on the size and scope of the programme. Some insurance schemes are universal, like Ghana's, while others target a specific demographic or economic group, like Nepal's. Insurance typically boosts health-facility attendance – in the case of Vietnam the number of insured pregnant women who visited health facilities was double that of uninsured women. A major drawback of most large schemes, however, is that they are largely unknown among the very poor, and people cannot use programmes they are not aware of.

Below are examples of health insurance programmes in developing nations around the world that have yielded positive results.

Ghana: National Health Insurance Scheme and Free Maternal Care (NHIS)

The Government of Ghana introduced a free delivery-care programme for all women in 2004, financed by money released from lower debt repayments. This programme led to an increase in births at medical facilities, specifically covering all institutional costs.⁶³ Funding for the universal programme ended in 2007, when it was superseded by the National Health Insurance Scheme, also launched in 2004. From 2007, women who were not enrolled in NHIS had to pay delivery fees. In order to provide inexpensive access to care, the Government of Ghana announced in 2008 that all pregnant women were exempt from paying health insurance premiums, encouraging women to join the health insurance scheme and avoid paying user fees. Maternity services covered under the NHIS include antenatal care, delivery,

caesarean section, management of emergency obstetric conditions, and postnatal care.⁶⁴

The Government of Ghana conducted its first survey on maternal morbidity and mortality, the Ghana Maternal Health Survey, in 2007. The maternal mortality ratio calculated for the five years preceding the survey was 580 per 100,000 live births.⁶⁵ As the Government of Ghana has not conducted a survey since 2007, other sources estimate the 2008 maternal mortality ratio at 409 per 100,000 live births. This is a substantial reduction from the average maternal mortality ratio of 580 between 2001 and 2006, and from the 538 ratio for 2000 reported recently by the *Lancet*.⁶⁶

Nepal: Access for the Poor

In July 2005, Nepal provided cash transfers to women for transportation, depending on topographical constraints. The government also gives incentives to skilled birth attendants to undertake deliveries, and provides free delivery at health centres in Nepal's poorest regions. Increasing access to maternal care for poor women, in addition to a robust programme based on community health workers has helped to reduce Nepal's maternal mortality ratio from 343 in 2000 to 240 in 2008.⁶⁷

Bolivia: Maternal Insurance for 15 Years

Bolivia has historically had the second-worst health indicators in Latin America and the Caribbean. In the past decades, the government introduced measures to improve maternal health, including three schemes for maternal health insurance. The most recent, Universal Maternal and Child Insurance (SUMI), was introduced in 2003. SUMI provides free care for pregnant women until six months after childbirth. This

newer programme is a narrowed version of one that covered all women of reproductive age. Currently, the services provided include comprehensive maternal and child care, ambulatory care, hospitalization and surgical procedures. Public facilities and some NGO- and Church-run facilities are the main centres for implementation.

As a result of these insurance programmes, maternal mortality decreased sharply from 390 per 100,000 to 230 per 100,000 between 1994 and 2003, a 41 per cent decline. The sharpest decline took place when the insurance scheme covered all women of reproductive age. Some argue that restricting the beneficiary group led to a climb in maternal mortality rates because of a return to more limited access to contraception to prevent unplanned pregnancies. Maternal insurance has been beneficial, however – maternal mortality decreased to 180 by 2008 and, as of 2010, 70 per cent of all births occurred in health facilities.⁶⁸

Mauritania: Donor-Government Collaboration

Forfait Obstetrical is an example of a donor-government collaboration to implement a viable programme of maternal health insurance. With funding from the French Agency for Development and implementation assistance from NGOs, the Mauritanian Government provides an obstetrical package for women. This is an insurance system based on shared obstetrical risk for pregnant patients that decide to join. The women pay a subscription fee which covers all future costs relating to their pregnancy (prenatal consultations, ultrasound scans, examinations), childbirth (whether normal or with complications), and post-natal supervision.⁶⁹ *Forfait Obstetrical* began in 2002 and will be extended to cover 80 per cent of the population by 2010.⁷⁰ The maternal mortality ratio in Mauritania declined from 866 to 712 per 100,000 live births between 2000 and 2008.⁷¹ Mauritania is on track to attain MDG 5, and officials point to this programme as instrumental in Mauritania's success in reducing maternal mortality.⁷²

Rwanda: Community-Based Health Insurance and Performance Based Financing

A combination of community-based health insurance and performance-based funding has contributed to a dramatic reduction in maternal mortality rates in Rwanda. Rwanda is on target to meet MDG 5 and reduced its maternal mortality rate from 952 to 383 per 100,000 live births between 2000 and 2008.⁷³ The Government of Rwanda uses community-based health insurance (CBHI) coverage or "Mutuelles de Santé" to improve access to care for pregnant women. Each household pays a fee of \$2 per year, health services are almost free and almost 91 per cent of Rwandans are currently insured.⁷⁴ Resources are pooled at the community level and packages include both preventive and curative care. Through community health insurance, women have access to family planning and antenatal care and, if they have sought antenatal care, can give birth in healthcare facilities for free.

In addition to establishing community-based health insurance, Rwanda has developed a nationwide system of contracts issued based on results – performance-based financing (PBF) – which has supported dramatic improvements in maternal health. PBF involves contracts between central and local governments and healthcare facilities. The system typically measures the quantity of prevention interventions and the quality of both prevention and curative services.⁷⁵ Good results are rewarded with increased funding for the relevant healthcare facilities and workers. Results-based contracts in Rwanda have led to an increase in assisted birth deliveries and the quality of services. Additionally, the quality of antenatal care was 15 per cent higher in performance-based financing clinics than in other clinics.⁷⁶

DONOR FUNDING

Donor-led initiatives have contributed to funding health projects in Africa through official development assistance (ODA) from governments or grants from private donor organizations. In 2008, total ODA commitments from the governments and government development agencies for maternal and child health programmes in both Sub-Saharan and North Africa amounted to just under \$694.5 million; however, the actual amount disbursed in that year was only one-sixth of the money allotted – less than \$101 million.⁷⁷ Additionally, private donors such as the Gates Foundation have made substantial grants to support maternal health projects in Africa, but the majority of these contributions fund NGOs, as opposed to African governments. At the June 2010 Women Deliver Conference, the Gates Foundation announced that it would spend \$1.5 billion over the next five years to support maternal and child health in developing countries. The money will support projects addressing family planning, nutrition and healthcare for pregnant women, newborns and children.⁷⁸

While large amounts of funding are coming into countries, those funds are not necessarily spent

cost-effectively, and donor programmes may not be aligned with national health and development strategies. In fact, the multiplicity of donors can be a burden on health systems – some African countries host more than 1,000 donor-funded activities and are required to provide 2,400 quarterly progress reports.⁷⁹ Therefore, it is imperative that governments are able to articulate their national health priorities and work to form meaningful partnerships with donors so that money is invested efficiently and where it is most needed. Many governments feel that money can be spent more effectively if donor money comes directly to the ministries, rather than being funnelled to NGOs. Donors often reply that this would require increased accounting capacity on the part of the ministries; nevertheless, governments should continue to be explicit about what they need to strengthen their ability to improve maternal health and commit their own resources to accomplish their strategies. It is governments which are held accountable to their people, not donors or NGOs; however, all stakeholders should work together to ensure that their work is complementary and cost-effective.

THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

HIV/AIDS, TB and malaria place a heavy burden on the health of women, directly causing 1.1 million deaths a year among women aged 15 to 59. The three diseases worsen pregnancy and child health outcomes, and HIV and malaria are among the most common indirect causes of maternal deaths. The Global Fund to Fight AIDS, Tuberculosis and Malaria, through its investments in HIV/AIDS, TB, and malaria programs and by strengthening the health systems of developing countries, is contributing to improving the health of women and their families.

Since its inception in 2002, the Global Fund has effectively channelled large resources to people in need, approving US\$19.3 billion and already having disbursed over US\$10-billion globally – 60 per cent of which is in Africa – to combat the three diseases. This makes the Global Fund the largest international financing source for MDG 6 (fighting infectious diseases) as well as a prime contributor to MDGs 4 and 5 (child and maternal health).

As of July 2010, the Global Fund has supported almost a million HIV-positive women (930,000) to access services to prevent transmission of HIV to their newborn. In the same time period, Global Fund supported programs have ensured a 10-fold increase in the percentage of women in Africa sleeping under a bed net, protecting them from malaria. However, at 21 per cent coverage, work remains to reach the Roll Back Malaria 2010 target of 80 percent of all persons at risk to effectively remove malaria as public health threat. The systems and delivery mechanisms to achieve this by 2015 exist, but in order to reach more women and improve the health of African women and their families, the Global Fund requires a substantial increase in its funding. In October 2010, under the leadership of UN Secretary General Ban-Ki Moon, the Global Fund will hold its Third Voluntary Replenishment conference where donors will pledge resources for the coming three years. The Replenishment will determine whether the Global Fund can support countries to scale up their efforts to fight disease and improve the health of their people, and meet the health related MDG targets by 2015.

HARNESSING THE POWER OF THE PRIVATE SECTOR

Governments must analyze the best ways to utilize the private sector to improve maternal health in their countries. The private sector plays an increasingly important role in healthcare provision in Africa; some 60 per cent of health expenditure is financed by private entities.⁸⁰ WHO estimates that in Sub-Saharan Africa 32 per cent of pregnant women used public facilities, while the remaining 68 per cent used a variety of private facilities (including home deliveries).⁸¹ Among the poorest women, 18 per cent delivered babies in a public facility while 78 per cent delivered by themselves or in a private facility. Private services are generally more expensive for the consumer as they receive little or no support from government. Public-private collaboration is therefore imperative to ensuring an efficient and affordable healthcare delivery system, particularly for pregnant women.

In some countries, governments collaborate with the private sector to provide a range of services from private facilities participating in health insurance, voucher schemes, or working to provide free services on behalf of the state. In 2008, free care for all pregnant women was included in the benefits of the Ghanaian National Health Insurance Scheme. This included deliveries from public, mission and private facilities. Private facilities enjoy subsidies from participating in the insurance scheme.⁸²

Since 2005, the Government of Gujarat, India, has been working in partnership with private practitioners to improve access to affordable quality maternal health services. “Chiranjeevi Yojana” or “plan for a long life” seeks to ensure that skilled attendance at delivery and emergency obstetric care is available

free of cost to all women living below the poverty line.⁸³ The state government pays private gynaecologists Rs1,795 (\$40) per delivery, which includes Rs200 to the patient for transportation costs and Rs50 for the person accompanying the patient to compensate for a loss in wages.⁸⁴ The programme began in 5 pilot districts and was then expanded to all 25 districts of Gujarat. From January 2006 to March 2008, the government contracted 180 doctors who performed 100,000 deliveries, with each doctor performing an average of 540 deliveries.⁸⁵ The programme suggests that harnessing the private sector to provide maternal health services while the public sector builds capacity to cater to the needs of poor, rural women improves maternal health. Additionally, it’s good business – by ensuring private health providers a demand for services, the scheme has helped the health market grow in parts of rural Gujarat.

Financial institutions are developing new mechanisms to invest in private-sector healthcare facilities in Africa. The International Finance Corporation (IFC) recently announced the launch of the Health in Africa Fund, which will invest in socially responsible and financially sustainable private health small and medium-sized enterprises (SMEs), such as clinics and diagnostic centres, to help low-income Africans gain access to affordable, high-quality health services.⁸⁶ The fund is supported by the IFC itself, the African Development Bank, the Gates Foundation and the German development finance institution, and plans to make 30 long-term equity investments, ranging from \$250,000 to \$5 million.⁸⁷ While this fund does not directly target maternal health, the Fund’s investments in clinics can improve the availability of and access to healthcare for pregnant women.

KEY APPROACH 3: POLITICAL PARTNERSHIPS

Political will and strong leadership enable innovative, cost-efficient interventions. Investing in and improving maternal health builds political support for leaders among diverse national constituencies. Strong leadership at high levels promotes accountability within ministries and enables them to find reliable partners to drive and

champion progress in maternal health. In the case of Ethiopia, Minister of Health, Adhanom Tedros Ghebreyesus is a strong leader and outspoken advocate for maternal health, but those within the Ministry acknowledge that Prime Minister Meles Zanawi’s leadership plays a crucial role in prioritizing maternal health and the community

health- worker support that has been vital in improving maternal health status in Ethiopia.

Similarly, in Rwanda, expected to be the first African country to meet MDG 5, First Lady Jeannette Kagame is seen as a champion for improving maternal health. While champions of maternal health are important outside government, leaders within government are also crucial. The 2008 annual report of the Rwandan Ministry of Health lists maternal health as the second major priority for budget support – after family planning.⁸⁸

In Mozambique, President Armando Guebuza launched a Presidential Initiative for Mothers and Children in 2008 to speed up the reduction of maternal and infant deaths. He called maternal deaths “one of the worst tragedies in any society, since they can always be avoided”.⁸⁹ President Guebuza’s initiative is complemented by the May 2010 launch of the National Partnership for Maternal, Newborn and Child Health in Mozambique, by the Ministry of Health. The Ministry of Health is working to improve healthcare for women and children in Mozambique in partnership with: the Ministries of Labour, Science and Technology, Women and Social Action; the World Health Organization; the United Nations Children’s Fund; and the US Agency for International Development (USAID).⁹⁰

In Sierra Leone the abolition of user fees for women and children was a personal priority of President Koroma. In a country where cost is the biggest barrier to accessing healthcare, making services free was a critical step to increase health-service utilization and reduce infant and maternal mortality rates. In 2008, the lifetime risk of a woman dying from complications in pregnancy and childbirth was one in eight and only a quarter of all births took place in health facilities. Such an ambitious reform required a significant strengthening of the health system. In the run up to the launch of Free Healthcare, health workers’ salaries were increased, the infrastructure of health facilities reformed and the drugs supply chain improved.

These reforms were achieved through concerted Presidential focus and close partnership working between government and donors. Partners from government, civil society and the development community attended weekly steering-group meetings, often chaired by the Vice President, and monthly meetings chaired by the President. The President personally visited all district

hospitals and drugs-storage facilities in 13 districts before the launch, to assess the provision of services and state of facilities and staff. Through such visits and monthly progress updates, President Koroma brought his personal authority to bear and accelerated improvements. As well as assisting with planning and coordination, donors provided this initiative with significant additional funding. Early results are impressive; in the immediate aftermath of the launch, demand rose tenfold and has resulted in a fourfold increase of attendance.

Because women are often marginalized economically, politically and socially in Africa, sustained leadership on the value of women is required to improve maternal health. Attitudes about women in rural areas can be particularly negative. According to an official at the Ministry of Health in Nigeria, men sometimes “think it’s cheaper to take another wife than to save a life”. Investing in girls and women, particularly in education for girls, can be an effective measure to reduce maternal mortality in the longer term. Educated girls tend to marry later and have fewer and healthier and better-nourished children. Mothers with little or no education are less likely to receive skilled support during pregnancy and childbirth.⁹¹ Therefore, governments should prioritize women in overall development strategies.

Sustained political will has been instrumental in reducing maternal mortality and improving the lives of women in Sri Lanka. Sri Lanka’s investment has been long term, but yielded striking results: since 1935, Sri Lanka has brought its maternal mortality ratio from 550 maternal deaths per 100,000 live births to only 58. While the Government is making a significant investment, Sri Lanka spends only 3 per cent of its GNP on maternal health, compared to 5 per cent in India, where a woman is eight times more likely to die in childbirth.⁹² The Government of Sri Lanka invests in health and education and promotes gender equality. Almost 89 per cent of women are literate, compared to an average of 63 per cent in West and Central Africa.⁹³ The civil registration service in Sri Lanka records deaths, the Government set up a public-health system and trains midwives, all of which have helped to improve maternal health in Sri Lanka.

Committed leaders are often able to bring in partners who can provide technical assistance and funding to improve maternal health. For instance, Ethiopia has received a substantial grant from the Gates Foundation,

which will go towards improving maternal health. The \$1.5 billion that the Gates Foundation will invest through 2014 will support projects addressing family planning,

nutrition and healthcare for pregnant women, newborns and children. A significant portion of this new money will support maternal health programmes in Ethiopia.⁹⁴

WHY INVEST IN THE 3 KEY APPROACHES? WEIGHING THE COSTS AND BENEFITS OF INVESTING IN MATERNAL HEALTH

Investing in maternal health is a wise health and economic policy decision. Both overall resources and government health spending remain crucial gaps in addressing maternal health.⁹⁵ Many maternal care

interventions are proven to be both effective in reducing maternal death and cost-effective, especially for high-risk groups. Some of these interventions are cost-saving, yielding returns of investment of over 100 per cent.

COST-EFFECTIVENESS

The cost-effectiveness of an intervention is a measure of its impact in terms of life-years saved, or the effect on morbidity or mortality, versus the per-person delivery cost of that intervention. The most cost-effective interventions are those considered to have the most efficient return on investment in terms of lives saved and morbidity reduced. It is often difficult, however, to assess the wider economic, spill-over effects of reduced morbidity and mortality, such as increased worker productivity of the women whose lives are saved or improved by maternal health interventions. The UN Secretary-General, Ban ki-Moon, estimates the global financial impact of maternal and newborn deaths to be \$15 billion per year in lost productivity.⁹⁶ Cost-effectiveness analysis often then is an underestimate of the total economic benefits of promoting an intervention.

Interventions for maternal health encompass various approaches, including promotional, preventive and therapeutic.⁹⁷ Promotional interventions target populations with health promotion campaigns and counselling, such as advocating reproductive health, family planning, care-seeking and antenatal care

during pregnancy. Preventive interventions include, but are not limited to, provision and availability of contraceptives for birth spacing and safer sex and the provision of clean-delivery kits. Treatment interventions include the use of skilled birth attendants and post-partum haemorrhage care. Of the wide array of interventions, studies have shown that a majority of the most cost effective are preventive interventions.⁹⁸ While the adage holds that prevention is cheaper than cure, prevention is not necessarily only health-related, and should include girls' education more generally. The World Bank estimates that for every 1,000 girls who get one additional year of education, two fewer women will die in childbirth.⁹⁹ Investing in girls' education has many additional health benefits, ranging from HIV prevention to delaying marriage to helping women to make informed choices about sex.

The role of the primary healthcare system is central to integrating and delivering these services at country level. Hence, investment in a robust maternal health system can prompt early intervention and prevent more expensive treatments for complications that burden individuals, families and the healthcare system.

HEALTH WORKERS AND HEALTH SYSTEMS

Countries and district health services will have to consider the gains of developing a cadre of trained community health workers versus alternative approaches. In circumstances where the primary healthcare system is reasonably functional and care-seeking is normal, strengthening of facility-based health services, incentives and support (such as transport) to encourage facility use is likely to be more cost-effective than the development of a new cadre of health workers.¹⁰⁰ In populations with very low coverage, however, a cadre of community health workers working in tandem with facility-based health staff (public and private) may be the most effective way to reach those in greatest need.¹⁰¹

While the details of implementing a maternal health strategy will lie within the Ministry of Health, Ministries of Finance play a crucial role in recognizing the importance of these approaches and allocating funding accordingly. While the development of a cadre of community health workers might be an appropriate

short-term solution to maternal health problems, strengthening country health systems should be the ultimate goal of financing for maternal health. Working in collaboration with the Ministry of Health to define the most appropriate interventions facing each country's unique health system will be essential to expanding effective services to women and mothers. Information on cost-effectiveness must be balanced with other health goals such as equity, acceptability, and the feasibility of implementation.¹⁰² While these interventions will help to reduce maternal mortality and achieve MDG 5, they will be insufficient alone. Coordination between health and other sectors to reduce poverty and improve education for women and girls will also be necessary.¹⁰³ The potential of intervention strategies on maternal health will be limited by funding. It is here that the Ministries of Finance across Africa must maintain a central role in reducing unnecessary maternal deaths and disabilities. Ministers of Health must be able to articulate effectively to Ministers of Finance the urgency of funding maternal health.

HEALTHY MOTHERS, HEALTHY ECONOMIES AND SOCIETIES

Safe-motherhood interventions save a significant number of newborn lives: maternal mortality and morbidity have a direct negative impact on the welfare of infants and children.¹⁰⁴ Children whose mothers die are at an increased risk of dying themselves.¹⁰⁵ The death or illness of a mother also leads to a reduction in household welfare and income given the important economic role of women, such as in agricultural production and trade.

Women constitute over 70 per cent of agricultural workers across Sub-Saharan Africa. While the majority of women in agriculture are, or are the spouses of, smallholder subsistence farmers, they contribute substantially to national agricultural production and food security. It is estimated that rural women in Africa produce 80 per cent of the continent's food supply. Improvement in maternal health can thus translate

into improvements in food security and nutrition at the community level.¹⁰⁶

Beyond the agricultural sector, women represent 92 per cent of the informal sector, which contributes an estimated 45–60 per cent of non-agricultural GDP. Official employment figures drastically underestimate the contribution of women to economies in Africa, as they do not capture women's contribution to the informal sector. The informal economy is the predominant source of household income supplementing farming incomes. It also offers a buffer in times of economic crisis or cyclical downturns, especially in urban settings.¹⁰⁷

Women are the sole income earners in nearly one third of all households globally.¹⁰⁸ There are spill-over macro-economic benefits due to increased worker productivity

from those living in a healthier household and from the women whose lives are improved by maternal health intervention. This translates to growth in national income. Moreover, studies on household expenditures have shown that women tend to spend more than men on welfare-improving goods and services for their families such as food, education and medicine.¹⁰⁹ In addition, women contribute most of the unpaid work such as water collection and caring for children, the sick, and the elderly. Women's unpaid work equals about one-third of the world's Gross National Product (GNP).¹¹⁰ This type of work has national economic implications because it saves expenditure and replaces income in times of economic crisis.¹¹¹ The negative impact of

maternal mortality on social and economic cohesion, and on a country's growth and development, makes reducing maternal mortality a pivotal MDG.

Investment in maternal health has valuable equity benefits, since differences in maternal mortality mirror the huge discrepancies between rich and poor both within and between countries. Poor women are especially vulnerable during pregnancy and tend to live further away from health facilities. Improving maternal health contributes more broadly to poverty reduction.¹¹² Thus, directing resources to maternal health can be an effective way of achieving multiple country planning and development goals.¹¹³

HEALTHY MOTHERS, HEALTHY SYSTEMS

A further argument for investing in safe-motherhood interventions is the potential for wider improvements in delivery of health services. To respond to obstetric emergencies, for example, skilled personnel and equipped facilities are necessary. These aspects of a well-functioning health system are also important in response to other health problems, such as road traffic accidents and other emergencies, which comprise an ever-greater proportion of death and disability

across Africa.¹¹⁴ In sum, investing in maternal health provides an entry point for achieving both significant economies of scale *and* scope. A determined, high-level push to address maternal health can harness the cost-saving benefits of reduced marginal costs of maternal healthcare and at the same time increase the number of people in general who can be reached by the health system as a whole per dollar spent.

HEALTHY MOTHERS: A GLOBAL PRIORITY

In recognizing the important role of state legislators and executive bodies in reforming health-financing systems to achieve greater coverage, the WHO resolved in 2005 to promote expanded coverage and improved quality of healthcare to attain internationally agreed development goals such as reducing maternal mortality.¹¹⁵ Systems-oriented approaches are receiving a greater emphasis in the international community as an important entry point for investment, such as through: the Global Alliance for Vaccines and Immunisation (GAVI); the World Bank; the Global Fund to Fight AIDS, Tuberculosis

and Malaria; and the new United States Global Health Initiative. As has been shown, health systems weaknesses are an important obstacle to improving maternal survival.¹¹⁶

There is global support for governments to prioritize the allocation of resources to systems strengthening to reduce maternal mortality rates. Carefully composed maternal health strategies at country and local levels are likely to garner more attention from large donors, be it for pooling resources for health sectors or more vertical maternal health

interventions. If governments are to exert leadership to promote maternal, newborn and child health, policies need to be in place to create a facilitating

environment and direct the use of scarce resources.¹¹⁷ Such efforts will require leading voices from Ministries of Finance across Africa.¹¹⁸

EFFECTIVE INVESTMENT

The conditions that facilitate policy change and reduce the gap between policy and implementation are strong global and national commitment, efficient financing mechanisms and systemic technical support. While Ministries of Health are heavily involved in the technical

implementation of maternal health strategies, Ministries of Finance are largely responsible for the allocation of funds to direct national policies on maternal health and help foster national momentum in addressing the burden of maternal mortality across Africa.¹¹⁹

CONCLUSION & CALL TO ACTION

Maternal health is a vital component of healthy societies, economies and nations. The future of nations depends upon healthy women and mothers. Women are the sole income-earners in one-third of households globally, and comprise 70 per cent of agricultural workers in Sub-Saharan Africa. Women's unpaid work, including farming, managing homes and caring for family members equals approximately one-third of the world's Gross National Product (GNP).

Smart investments in maternal health strengthen health systems overall, and increase the cost-effectiveness of resources allocated to the health sector. Failure to invest in maternal health is not only irresponsible and immoral but also deeply counterproductive, undermining national growth and development. Pregnancy-related deaths of women and newborns cost about \$15 billion in lost productivity annually. These deaths and economic losses are nearly 100 per cent preventable.

While women face a plethora of problems when pregnant in Africa, three barriers to maternal health are particularly problematic. Successful maternal health interventions should be aimed at addressing these challenges: 1) access and availability; 2) cost; and 3) information and attitudes.

Despite grim maternal health indicators and these significant barriers to success, African governments can improve maternal health in Africa. They can do this by focusing on: 1) strengthening health systems through community-health-worker programmes; 2) utilizing efficient financing mechanisms; and 3) forming political partnerships. The key to successful programmes is political will, accompanied by a steady source of funding, to support gender equality and maternal health. Steady sources of funding ensure the sustainability of programmes and political will ensures the sustainability of steady funding.

Several developing countries have used these tools to make dramatic improvements in maternal health. For example, Ghana, Ethiopia, Rwanda, India, Mauritania, Nepal and Sri Lanka have reduced maternal mortality rates and improved maternal health by using innovative financing mechanisms, working with community health programmes and building political partnerships. Governments should look closely at the most effective approaches for their own countries and look to regional best practice as a source for practical ideas and inspiration.

We do not have one more minute to waste – every minute we waste, another woman dies in childbirth. Governments must act now!

RECOMMENDATIONS:

WHAT AFRICAN GOVERNMENTS AND POLICYMAKERS NEED TO DO...

African governments and policymakers have ultimate responsibility for their people and the economic growth and development of their country. All African governments have made commitments both regionally and internationally to improving maternal health. Realizing these commitments requires political leadership at the highest level. Moreover, national development plans and strategies for improving maternal health must be articulated and drive action on the ground, including the implementation of health programmes. Therefore, African governments and policymakers should take the following steps.

Increase Government Funding for Maternal Health

An investment in maternal health is an investment in health systems in general. These investments help to improve the health of pregnant women, as well as the health of the general population. Funding for maternal health can encompass a range of activities: national insurance schemes, deployment of health workers, tools for health workers, education, family-planning activities and investments in infrastructure. To determine what would be most effective in an individual country, it is important to assess accurately the most pressing country-specific barriers to maternal health including cost, access, and information and attitudes.

When governments provide funding to improve maternal health, this shows potential donors the strength of government commitment, which can then lead to increased funding from donors. It is important for governments to establish clear priorities with donors, to make sure donor programmes are in line with national maternal health priorities and to enhance the cost-effectiveness of national health programmes. Additionally, it is important to prioritize gender equity as a cross-cutting issue throughout governments.

Consider Gender Role in Community Health Worker Programs

In countries where health workers have played a significant role in reducing maternal mortality, the workers are part of largely female forces. While the gender of health workers may not affect other community health programmes, it does seem to be a significant factor contributing to successful maternal health work. This should be an important consideration when building community health worker programmes.

Develop Innovative Incentive Structures to sustain Community Health Worker Programs

Studies show that community health workers who are paid salaries by the government stay in their positions longer, which increases the return on investing in these workers. Regular government salaries also typically increase the sustainability of programmes, since poor health workers can expect consistent salary payments. Studies also show that community health workers can be motivated by prestige, as health workers are often seen as community leaders.

Provide Basic Tools to Increase Community Health Worker Performance

Health workers can use tools like mobile phones, bicycles and supplies to handle trauma and blood

transfusions to improve overall access to maternal healthcare for rural women. Mobile phones allow them to communicate with pregnant women, and to be alerted when a woman goes into labour; bicycles allow workers to travel longer distances relatively quickly in rural areas; and basic supplies can help women to deliver babies safely.

Ensure the Priority of Maternal Health in Health Insurance Schemes

It is important for governments to ensure that maternal health is a priority in health insurance schemes. Many countries are successful in using national health insurance schemes to reach pregnant women to improve maternal health. Nevertheless, these schemes can be expensive to implement at the national level and sometimes do not reach the poorest and most

rural women. In cases where national insurance schemes have yet to be developed, community-based insurance schemes can be an effective way to support maternal health.

Work toward Broad-based Support for Women

Many governments recognize the importance of addressing gender issues to improve the health of women. Policies to improve gender equality should be integrated across government lines, and many governments are working hard to do this. Greater investment in Africa's women will yield positive results. Many countries in Africa have Ministries for Women (or gender) and it is important that these Ministries coordinate closely with Ministries of Health to ensure a holistic and cost-effective approach to enhancing gender equality.

WHAT THE INTERNATIONAL COMMUNITY NEEDS TO DO...

The international community has accepted part of the responsibility for achieving the MDGs, including the improvement of maternal health. Donor countries have made commitments that must be honoured, whether through funding mechanisms, knowledge transfer or strong partnerships. International organizations also have an important role as they champion development. The international community should take the following steps regarding maternal health.

Identify High-Level Champions

Developing maternal health champions in high-profile leadership positions is important to establishing the legitimacy of the cause. Countries with outspoken champions at high levels are typically more successful in improving maternal health. These high-level

champions can help to bring in global partners to champion the cause publicly.

Educate the General Public

It is imperative that citizens understand the importance of investing in women, and in maternal health specifically. Education is the most efficient way to change attitudes – citizens should be educated about the inherent value of women, their tangible socio-economic contributions and the importance of maternal health in building healthy societies.

African leaders and first ladies have been essential in reducing the stigma around HIV – leaders sent a powerful signal to their populations by being publicly tested for HIV. A similar coordinated effort could be used to promote the importance of maternal health.

WHAT THE PRIVATE SECTOR NEEDS TO DO...

The private sector's prominence in Africa is rapidly increasing, including in healthcare. As a result, we have seen much innovation, new models of providing services to poor people, and strong public-private partnerships. It is in the best interests of private sector organizations to be a part of healthy communities, and to contribute to the sustainable development of their communities and those of their consumers. The private sector should take the following steps.

Harness the Power of the Private Sector

The private sector plays an increasingly important role in healthcare provision in Africa: roughly 60 per cent of expenditure is financed by private entities. While many pregnant women are too poor to pay for private services, governments can work with the private sector by forming partnerships, getting best-practice, logistical or technical advice, or securing funding for facilities through equity or debt channels.

Develop Cost-Effective Tools to Collect Data on Maternal Health

The lack of accurate, up-to-date statistics on maternal deaths prevents governments from allocating resources most efficiently. To improve maternal health, data on the levels and causes of maternal death need to be collected and analyzed. This cannot be done without developing tools to collect data efficiently and reduce the costs associated with data collection.

While governments and partners are working to develop such tools, the private sector plays an important role. The private sector can use its innovation in the development of tools, while its knowledge of supply chains can help to make tools widely available. To maximize impact, these tools should be tested and modified according to each specific environment.

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ABOUT THE AFRICA PROGRESS PANEL

The Africa Progress Panel (APP) was formed as a vehicle to maintain a focus on the commitments to Africa made by the international community in the wake of the Gleneagles G8 Summit and of the Commission for Africa Report in 2007.

Under the chairmanship of Kofi Annan, it pays equal attention to the implementation of Africa's commitments as set out in the Constitutive Act of the African Union and landmark international agreements.

The Africa Progress Panel's added value is in drawing upon first class research and using the Panel members' reach to:

- Track progress by highlighting good practices and positive change in Africa that have led to sustained development across the region.
- Monitor the role of Africa's trading, donor and investment partners in supporting the continent's progress.
- Support African initiatives driving social, economic and/or political progress on the continent whether it is brought about by African leaders, institutions or international partners.
- Identify key areas for the continent's development such as south-south partnerships, climate change, maternal health, infrastructure, technology or regional integration.

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