



House of Commons  
International Development  
Committee

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**Maternal Health:  
Government Response  
to the Committee's  
Fifth Report of Session  
2007–08**

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**Fifth Special Report of Session  
2007–08**

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## International Development Committee

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## Fifth Special Report

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On 2 March 2008 the International Development Committee published its Fifth Report of Session 2007–08, *Maternal Health*, HC 66-I. On 9 May 2008 we received the Government's response to the Report. It is reproduced as an Appendix to this Special Report.

In the Government Response, the Committee's conclusions and recommendations are in bold text. The Government's response is in plain text.

## Appendix: Government response

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### Introduction

DFID warmly welcomes the IDC Report and is grateful to the Committee for the interest they have generated in this key issue and for the helpful way in which the various hearings were conducted. The report provides valuable guidance and has undoubtedly helped to increase the profile of this subject, not just inside DFID, but also internationally.

### The global maternal mortality burden

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

We share the IDC's concern and agree with this conclusion. This is why DFID is continuing to invest in, and apply, research (for example by the Initiative for Maternal Mortality Programme Assessment—IMMPACT) that helps to better measure maternal mortality through a range of low-cost and appropriate measurement tools. It is very important that these new tools and approaches are shared with governments and implemented at country level and this is why we are encouraging IMMPACT to disseminate this research internationally and at country level.

DFID has provided £500,000 to the Health Metrics Network (HMN) between 2006/07 and 2008/09 to enable improved measurement of maternal mortality and better tracking of MDG 5—particularly through supporting the development of technical guidance and for advocacy for measuring pregnancy-related mortality in the census. DFID is also working at country and global levels to ensure the additional MDG 5 target (universal access to reproductive health by 2015) can be well monitored—and has funded consultancy work to support the development of appropriate monitoring indicators.

In reality, as was pointed out in the Lancet report, vital registration of all births and deaths is what is needed to ensure the rights of children (to citizenship and entitlements) as well as to cost effectively monitor maternal deaths. The UK government will be lobbying for scaled-up global efforts to register every birth and death and certify every cause of death

during key fora in 2008 and beyond. In the UK, compulsory registration of births and deaths, which highlighted the scale of the problem, led to public concern and pressure to reduce infant and maternal mortality.

### **The key bottleneck: a failure of advocacy and political will**

**[Paragraph 14] Over the course of the inquiry, we have been saddened by the stagnancy of MDG 5 and the fact that so many women continue to die during pregnancy and childbirth. A clear message from the evidence we took was that a key bottleneck in securing progress on maternal health is a failure of advocacy and a lack of political will.**

The lack of political will to address women's sexual and reproductive health and rights over the past two decades has directly contributed to the global collective failure to prevent maternal deaths. DFID recognises that the need for greater political will and action on maternal health has never been greater. It is the top priority in DFID's maternal health strategy. The UK Government is also working to ensure that we are not a lone voice. This is an international priority that demands an international response.

The Government believes advocacy needs to take place on several levels; to promote greater national and local awareness and ownership of the actions needed by governments and community groups; to boost the international response with other donors and multilateral agencies; and to engage high level political actors. DFID's annual Progress Reports on maternal health have demonstrated increased advocacy at all levels, though much remains to be done by all agencies.

But there has been progress during 2007. In launching the International Health Partnership in September 2007, the Prime Minister signalled the UK's clear intention to help lead an international drive for stronger national health plans and systems to deliver better health services. The Women Deliver Conference, in London in October and the Norwegian Prime Minister's Health MDG Campaign marked a turning point for advocacy. The UN Secretary General's meeting in September 2008, bringing together heads of state to galvanise action to achieve the Millennium Development Goals, is a crucial milestone.

The UK Government is determined to seize the opportunities presented to us to build on the current momentum to ensure effective action on tackling maternal deaths. The Government also continues to support the Partnership for Maternal, Newborn and Child Health (PMNCH) and the White Ribbon Alliance (WRA).

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

We entirely agree and welcome the call for a multi-sectoral response, particularly involving Ministries of Finance. We are pleased that the IDC has acknowledged DFID's own advocacy through its dedicated maternal health strategy, the launch of the IHP, high quality research on maternal health and its rights-based approach. DFID cannot achieve

progress alone and we welcome the emphasis on other agencies and governments. We are working with governments, NGOs, the UN and the private sector to address MDG 5 and will do more to raise the profile across national governments.

### Girls' and women's education

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

We entirely agree and welcome the emphasis on girls' education. The work of sectors outside of health, particularly education, social welfare, justice and transport, all play a key role in reducing maternal deaths.

Our Girls' Education Strategy paper states *"Educating girls helps to make communities and societies healthier, wealthier and safer, and can also help to reduce child deaths, **improve maternal health** and tackle the spread of HIV and AIDS. It underpins the achievement of all the other MDGs"*.

### Gender-based violence

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

We agree with this recommendation. DFID's funding through the International Planned Parenthood Federation (IPPF) has resulted in important findings from these programmes in Bangladesh and Nepal, which will have key lessons for other country programmes. DFID is also funding two Research Programme Consortia to research around violence against women, sexual and reproductive health and women's empowerment. These will also provide important recommendations for policy and programmes.

Access to family planning and counselling is crucial. These can be provided by trained health workers, in clinic settings, and by trained community distributors where there is no local clinic.

### Socio-economic empowerment

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

We agree with this recommendation. A number of programmes, funded by DFID and other agencies, have demonstrated this is a promising area for future development. Cash transfer schemes, now under way in India and Bangladesh, are demonstrating increased uptake of services for deliveries in health facilities, and in time will improve access to emergency obstetric care. The cost of emergency obstetric care can be catastrophic for poor families.

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

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

We agree that a strong civil society response is important to hold governments to account and note that the evidence submitted jointly by NGOs to the IDC states that DFID does “support the voices of the poor, civil society and the marginalised”.

DFID strongly supports the view that civil society should engage in national policy making processes and our Civil Society Challenge Fund provides resources for a wide range of agencies to engage in these activities. There is scope to do more, particularly on maternal health issues. Some examples of what is being planned include DFID’s support at the local level to the White Ribbon Alliance (WRA) in Malawi and Zambia and Orissa. DFID provides ongoing support to UNICEF for advocacy on maternal health in three States in India: Bihar, Rajasthan and West Bengal. Local NGOs are also enabling citizens to advocate for improved services, holding government to account. In Malawi, the WRA has been raising its concerns about the high levels of maternal mortality in parliament.

### **Ensuring pro-poor health financing**

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

User fees are not a good way to finance health systems and the UK Government White Paper, “Making Governance Work for the Poor” (July 2006) gave a commitment to support those governments who wish to remove user fees. In some countries, where a high proportion of health services are provided by the private sector, this is more complex to achieve. However, when requested by partner governments, DFID will continue to provide support to abolish user fees for basic health services and help governments tackle other

barriers to access, including discrimination against women. In Burundi for example, additional funds have been provided to assist the government to support the expanded demand for care. We agree that more work with Ministries of Finance and Health is needed to ensure that national resources and donor funds are directed at removing financial barriers to accessing maternal health.

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

We agree with this recommendation and have been encouraged by early results, for example in Nepal, demonstrating some progress in reducing financial barriers through cash transfers or voucher schemes. DFID is funding schemes to ensure that the most marginalised women can access services. In Bangladesh, DFID is funding WHO to assess the impact of a Ministry of Health and Family Welfare scheme to give vouchers to 100,000 pregnant women, to determine whether objectives have been achieved, prior to scaling up. In India, preliminary reports from the government's new Maternity Security Scheme (the Janani Suraksha Yojana) suggest that it is helping more women to give birth in health facilities. Under this scheme a payment (to help cover the costs of transport) is made to pregnant women in the poorer states for each institutional delivery. A payment is also made to the village health worker to accompany the woman in labour. The findings from these new schemes will influence the policy of DFID and other agencies in the future.

## A rights-based approach

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

We are pleased that the IDC has given credit to DFID for its rights-based approach to maternal health. DFID has a system of Country Governance Analysis, as a key component of its country strategy approval processes, which includes a human rights assessment. The National Audit Office report on Budget Support (February 2008) has recommended that DFID develop better systems to assess and monitor human rights in development partnership agreements and country programming. In response to this, we are strengthening the human rights guidance to cover assessment, implementation and monitoring. We believe this will enable country programmes to better implement DFID's rights-based approach in all its work, including on maternal health.

This is underpinned by corporate procedures to ensure staff carefully consider human rights issues in their decision-making. DFID Directors are all required to give assurances that policies, practices and procedures pursued in their Divisions comply with the Human Rights Act and that managers at all levels implement them in operating practices and procedures.

In an effort to ensure rights-based approaches are given profile at international level, DFID has provided £200,000 start-up funds to the International Initiative on Maternal Mortality and Human Rights that was launched at the Women Deliver Conference in October 2007.

## Unsafe abortion

**[Paragraph 52] Unsafe abortion is responsible for tens of thousands of women dying each year and is a highly neglected public health challenge. We agree with DFID's approach of not trying to impose abortion decisions on countries but seeking to support civil society where interest in changing the law and improving services already exists. In countries where abortion is illegal, we believe that DFID should continue to look for opportunities to help ensure women are aware both of the circumstances in which abortion is permitted and of the safe services that are available to them.**

The UK Government has been leading in actively promoting efforts to prevent unsafe abortion, and in focussing attention—and challenging policies—on this issue. We will continue to seek opportunities (in countries where it is appropriate) to inform women that abortion is legal and that safe services are available, as we are doing in countries such as India and Cambodia, and increasingly in Africa. Yet still an estimated 5.5 million women in Africa undergo an unsafe abortion each year (WHO). DFID continues to encourage other agencies, particularly EC members, to actively support the provision of safe abortion services.

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

DFID and other agencies reaffirmed their commitment to provide additional support for the prevention of unsafe abortion at the Global Safe Abortion conference, held in London in October 2007.

In response to a very high level of demand for funding, particularly from African countries, DFID Africa Division has approved an additional £1 million to the Safe Abortion Action Fund (on top of the original £3 million) plus a £6.5 million contribution to IPAS. These investments aim to: strengthen regional organisations and networks that advocate for safe abortion; support advocacy and production of policy relevant research; have an impact at country level and regional level on policy change and service delivery; and increase utilisation of high quality, safe abortion and post abortion services.

DFID's core funding for the International Planned Parenthood Federation continues to support all five of IPPF's strategic areas of work: adolescents, HIV/AIDS, (safe) abortion, access to sexual and reproductive health (SRH) services and advocacy.

## The UN: challenges and opportunities in its current approach

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

This issue has been recognised as a problem for several years and DFID has raised the need for more effective coordination and clear delineation of responsibilities with the agencies concerned. There has been some progress in the past year. With encouragement from DFID and others, the three agencies (UNICEF, WHO and UNFPA) have been negotiating at a central level to agree coordination of labour for MDG 5. We understand that agreement has been reached but the outcome has not yet been formally publicised by the UN. We also believe that roles need to be effectively delineated at country and regional level, as well as at the centre.

Too often the central-level policy decisions do not filter down effectively to the country level. We find that an agency's capacity to lead on a specific area of maternal health in-country is dependent on the level of priority given to it by the Head of Office and the level of staff competency, rather than the policy direction. This results in an unsatisfactory situation where an agency leading on maternal health in one country is unable to do so in another. We are pressing for agencies to better track the implementation of their strategic priorities and for greater accountability from the country offices to the centre and national stakeholders.

We agree that capacity to address MDG 5 needs to be strengthened across all three agencies.

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

We agree, and this is fully in line with DFID policy. Future support to UN agencies will be managed through performance frameworks to track specific activities to progress towards the MDGs. The performance frameworks will enable us (and other donors) to hold UN agencies to account and directly link our funding to results in thematic areas and their strategic priorities.

Under the proposed delineation of responsibilities, UNFPA will be accountable for the global advocacy role on unsafe abortion and commodity supply for maternal health (including family planning) and WHO will be monitored against progress towards its medium term strategic plan (MTSP) which includes objectives on health systems.

The performance frameworks will also monitor the agencies' effectiveness at delivering their strategic priorities including staff performance and results based management.

In Bangladesh DFID, in partnership with the EC, is contributing £11 million over 5 years to a joint UNFPA-WHO-UNICEF programme to accelerate progress on maternal and neonatal health which has already brought clarity on UN roles.

Margaret Chan, WHO, Thoraya Obaid, UNFPA, and Joy Phumaphi, World Bank, have acted as champions on maternal health for their respective agencies. UNICEF is in a point of transition, going through an organisational review, but we will encourage such a champion in future.

## The Partnership for Maternal, Newborn and Child Health

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

DFID has not resigned from the Board of the PMNCH, but has rotated off and is now represented by Norway. This rotation is similar for a number of international boards, working in partnership with others, and is fully consistent with the Paris Declaration principles regarding donor harmonisation. The Norwegians are leading on a major initiative on maternal and child health, which has strong support from the UK, and we feel it is appropriate for them to represent us on the PMNCH Board. We keep in regular contact with the Norwegians and with the PMNCH secretariat, particularly on technical matters, and have recently funded capacity strengthening work to enable PMNCH to better articulate and implement its global advocacy strategy.

## The Global Campaign for the Health MDGs

**[Paragraph 74] DFID deserves credit for spearheading the International Health Partnership. We were pleased to see this practical application of the Paris Declaration on Aid Effectiveness and hope it will help both recipient countries and donors to maximise development assistance for health. DFID must maintain its leadership role and help drive the IHP's implementation phase, ensuring that parallel donor efforts to strengthen health systems are delivered.**

DFID has been fully supportive of the group of eight leading global health agencies (the H8) taking forward the leadership of the IHP. The H8 consists of the World Bank, WHO, UNFPA, UNICEF, UNAIDS, the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), the Global Vaccine Alliance (GAVI) and the Bill and Melinda Gates Foundation. This has further ensured coordination and alignment of these critical agencies around strengthening health systems. Although the UK launched the IHP, it is keen for the IHP to be a global initiative supporting broader global (rather than DFID) health objectives.

The UK attended the second meeting of the H8 in January 2008, and continues to maintain a role in political leadership. With encouragement from DFID, Margaret Chan of WHO

has agreed to arrange a briefing on the IHP at the next World Health Assembly in May 2008. This will present an opportunity for participating governments to describe progress to date, as well as non-IHP country governments to make informed decisions over possible future engagement. DFID will continue to take a role in encouraging IHP member countries to bring new partners into the IHP.

**[Paragraph 75] Greater national ownership of health policies, as envisaged by the IHP, is dependent on effective advocacy for improved health by governments. We recommend that DFID use its leadership role to ensure that governments and both national and international civil society groups are fully involved in the implementation of the IHP so that successful advocacy for improved health takes place in tandem with improved aid effectiveness.**

DFID fully supports both government and civil society having a strong role in the IHP at country and global levels. Both global and national level civil society groups contributed to the first meeting of IHP Country Teams, in Lusaka from February 28<sup>th</sup>-March 1<sup>st</sup>. WHO and the World Bank are currently consulting with civil society groups to determine how best to deepen the civil society role in the IHP. DFID will continue to support strong engagement, not only in implementing the IHP, but also in holding IHP signatories to account, so that they demonstrate the behaviours needed for improved aid effectiveness.

**[Paragraph 76] We recommend that DFID and the other organisations involved in the IHP take steps to ensure that the process of reviewing pilot countries is managed promptly and efficiently. Assuming successful reviews emerge, the IHP should then be extended to other interested countries as soon as possible.**

A key part of the IHP is to minimise additional reporting requirements from countries. We agree that a review is required and are delighted that WHO and the World Bank have agreed to commission an external review. They will report back in September 2008.

## **The Global Fund to Fight AIDS, TB and Malaria**

**[Paragraph 83] We believe that DFID and other donors should build on a series of opportunities at the Global Fund to Fight AIDS, TB and Malaria—its new Director, gender strategy and membership of the International Health Partnership—and should encourage the Fund to support more maternal health care interventions which have direct relevance to these three diseases as well as to health systems strengthening.**

DFID has learned much about the effectiveness of Global Health Partnerships (GHPs) over the past few years and how they can best help to add value. We know that countries must be in the driving seat for health planning, but that technical assistance is important to ensure integration of issues such as maternal health, HIV and sexual and reproductive health and rights (SRHR). Since the Fund can only give support on the basis of the proposals presented to it, this integration is essential.

The recent move by the GFATM to increase its support for health systems (and for health workers) is significant, as functioning health systems are core to improvements in maternal health. GFATM's membership of the Health 8 group within the IHP demonstrates further progress and improvements in harmonisation amongst donors.

**[Paragraph 85] We believe that the Global Fund needs to communicate more clearly its willingness to accept funding proposals for maternal, sexual and reproductive health programmes—particularly those integrated with HIV/AIDS, TB and malaria interventions—to countries seeking funds. DFID should use its Board membership to help encourage a closer dialogue between the Fund and its recipients so that there is a clearer understanding of how the Fund’s resources can be spent.**

We agree that there needs to be a clearer understanding of how the Fund’s resources can be spent to reflect countries’ own needs. At the GFATM Executive Board meeting in November 2007, the Board approved a significant increase in the size of the Secretariat, a large proportion of which will be directed to operations, so that this closer dialogue can take place. As Board members, we will want to see that this increase in secretariat size is translated into improvements in GFATM performance on the ground, including on maternal health. The new window of support for health systems will result in some improvements in maternal health services.

### **The Japanese Presidency of the G8**

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

For the G8 summit this year, Japan is looking to balance efforts on HIV and AIDS with those on maternal and child health. During the preliminary G8 negotiations with the Japanese, DFID continues to push for greater clarity on accelerated action on maternal mortality reduction.

We are continuing to advocate at a high level on maternal health amongst other G8 members. In the March 2008 State Visit, the joint UK-France summit communiqué states *“As signatories to the International Health Partnership, the UK and France are today committing to ensure that our work to strengthen health systems will focus on achieving demonstrable reductions in maternal mortality.”*

### **The UK's role in stepping up advocacy**

**[Paragraph 88] We are pleased that DFID recognises the need to step up its efforts on international advocacy. We will keep a watching brief on how these efforts are translated into action during 2008, especially at the UN General Assembly meeting on the MDGs in the autumn.**

Point noted, we welcome IDC interest on this matter.

**[Paragraph 89] We agree that supporting specific maternal health champions and change agents in developing countries is a good idea. We recommend that DFID pursue its discussions about empowering such champions with the Elders Group.**

DFID will continue to seek and support champions at all levels for maternal health. We are delighted that Sarah Brown has agreed to be the Patron of the White Ribbon Alliance and that Gordon Brown is a member of the Global Leaders Network for MDGs 4 and 5, which

is led by Prime Minister Stoltenberg of Norway. The UK has not followed the example of some other countries by appointing an “Ambassador” for high profile programmes (such as for HIV and AIDS).

**[Paragraph 90] The scientific research community is an advocacy mechanism in its own right and should be supported by donors so that it mobilises itself more effectively. This is particularly important within developing countries where research can be applied practically as a way to inform and monitor government policies for maternal health.**

We agree. DFID has a strong track record of funding for research, both internationally and within less developed countries. A new Research Strategy for DFID is close to being finalised.

**[Paragraph 91] We agree that focusing intensified global advocacy efforts around existing processes, such as the 2008 Japanese G8 Presidency and the UN General Assembly’s meeting on the MDGs in the autumn of 2008, is likely to be more effective than creating a separate global fund for women’s health.**

Point noted.

## **What works in preventing maternal deaths: the example of Nepal**

**[Paragraph 95] We applaud DFID for its contribution to the Nepal Safe Motherhood Project and Support to Safe Motherhood Programme, which have included a range of interventions relevant to maternal health in Nepal over a decade that has witnessed progress in reducing maternal mortality. We urge DFID to support independent comprehensive evaluations of this experience, with a view to sharing lessons in the region and globally.**

We agree that independent evaluations of approaches to reducing maternal deaths are an essential part of lesson learning and informing policy, whether the work is funded by DFID or other donors.

In Nepal, as in other countries, DFID implements an on-going system of internal annual and mid-term reviews. Findings from these reviews are shared with advisers and key partners at retreats, continuing professional development days and at regional events.

Independent reviews of components of the Nepal SSMP have been held. For example, the Maternity Incentive Scheme (MIS) is being assessed by the London School of Hygiene and Tropical Medicine (LSHTM).

Key lessons learned from the Equity and Access Programme, the part of the SSMP that is ensuring the poorest are able to reach services, was presented to the OECD in London recently. Similar calls were made for such comprehensive reviews to be shared within the region, something we would encourage.

DFID’s research partners are encouraged to share published results in a way that is easily accessible to all, not just by publishing in learned academic journals. DFID’s Central Research Department has particularly encouraged the Research Programme Consortia (RPC), “Towards MDG 4 and 5”, to help it develop an effective communication strategy.

DFID advisers regularly share experiences through documentation, as well as through being part of teams that evaluate maternal health programmes in countries. The annual Maternal Health Progress Report to Parliament documents lessons learned and is shared with our development partners and the international agencies.

**[Paragraph 98] We urge DFID to look closely at options for replicating successful approaches from Nepal where appropriate, and to identify factors relevant to scaling-up and transference. We appreciate that success is often context-dependent, but believe the DFID-funded approach to supporting women’s groups, as in Nepal, is worthy of particular consideration wherever relevant.**

DFID agrees that replication of successful approaches is important, taking into account the particular context in the countries concerned. A number of maternity financial incentive schemes are being implemented in South Asia including Nepal, Bangladesh and India. DFID is supporting evaluation of these programmes, to determine what works in particular contexts. (See also response to the Paragraph 44 recommendation above.) DFID is looking forward to receiving and disseminating the conclusions of the research on women’s groups in Malawi and Nepal, which will also be relevant.

### **What works in strengthening health systems: boosting human resources**

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

We agree with this recommendation and are supporting the International Federation of Gynaecologists and Obstetricians (FIGO) and the International Confederation of Midwives (ICM) to research and identify key issues to address the shortage of midwives, along with our broader support to the Global Health Worker Alliance (GHWA). Our UN partners, specifically UNFPA and WHO, have been holding global consultations on this issue and we are supportive of their approach. Although a global problem, the midwifery crisis must be addressed country by country, in each context. In Nepal, for example, negotiations with the professional associations and government have led to the development of a new cadre of midwives. In Pakistan, priority is being given to developing a new cadre of 10,000 community midwives over the next five years along with strengthening of midwifery schools and increasing the number of midwifery tutors.

Sub-Saharan Africa has 25% of the global burden of disease, yet it has only 3% of the world’s health workers. Thirty-six countries in Africa are confronting critical shortages, with fewer than 2.3 health workers (doctors, nurses and midwives) per 1,000 people. DFID is pressing for increased numbers of health workers—especially in Africa.

We will advocate for the G8 to commit to support the scale-up of health workers, in-line with the WHO recommendation of at least 2.3 health workers per 1,000 people. WHO

estimates that this level of coverage by health workers will enable an 80% coverage rate of deliveries by skilled birth attendants, as well as providing more people able to administer medical tests, diagnose and provide treatment. Figures will vary country to country and we will continue to encourage governments to focus on national requirements for skilled birth attendants appropriate to reach MDG 5.

**[Paragraph 105] We believe that DFID and other donors should find new ways to help governments encourage health professionals to provide quality services in remote and rural areas. This should include supporting civil society to lobby for better salaries and conditions for doctors and midwives working outside urban areas and to ensure the necessary infrastructure, supplies, transport and equipment are in place to enable these professionals to provide prompt and effective care.**

We agree that more needs to be done to enable health workers to work safely and effectively in rural areas. The issues are complex. To retain health workers in remote rural areas, they need terms of service which will enable them to earn a living, along with arrangements for housing, education for children, and job opportunities for partners. Staff retention in urban areas has traditionally been easier because these support services are more readily available. DFID engages in provision of budget support, which is designed to meet the wider needs for all basic health services, including salaries, transport, equipment, drugs and consumable supplies.

DFID support to the White Ribbon Alliance is enabling midwives to raise concerns about their conditions of service. The WRA has supported midwives in Tanzania to lobby government and demonstrate to raise awareness of maternal health and the difficulties that midwives face—as women and as midwives—in providing care in remote areas.

**[Paragraph 107] DFID deserves credit for its support to the Emergency Human Resources Programme in Malawi, for which initial results show expanded staff numbers and better uptake of training. We recommend that DFID move swiftly to support the replication, where appropriate, of efforts to address human resources problems as soon as conclusive results are available.**

The Malawi programme is showing early signs of success. DFID will certainly be adapting, as appropriate, the lessons learned from the Malawi EHRP, once conclusive results are available and disseminating best practices to other country programmes.

## **Increasing the availability of equipment and supplies**

**[Paragraph 109] We were concerned to hear about the lack of even very basic supplies and medicines in many developing countries. We recommend that donors, including DFID, work with the World Health Organization to advocate with national governments for national Essential Drugs Lists to contain drugs such as magnesium sulphate, which are crucial to maternal survival.**

The lack of basic supplies is a result of the budget constraints experienced by countries (or lack of prioritisation on health), and also arises from health systems that are too weak to effectively deliver the drugs and supplies to the health facilities where they are needed. As discussed above, DFID provides budget support to help governments address these shortages and ensure long-term predictable financing that enables Ministries of Finance to

enter into long-term supply contracts and drive down the costs of procuring drugs and supplies.

The WHO essential drugs list is an important instrument and is designed to encourage countries to procure generic drugs, rather than proprietary drugs that are very much more expensive. The WHO list includes magnesium sulphate, a low-cost drug which is highly effective in preventing maternal deaths from eclampsia.

Where a country has limited resources, priority tends to be given to the drugs most used by health staff. In some countries, although magnesium sulphate had been purchased, it was not actually being widely used by midwives or doctors, and supplies went out of date. Although the drug is cheap and effective, there can be dangerous side effects. Without access to emergency resuscitation, health workers may be reluctant to take the risk of managing serious side effects in isolated areas. Strong health systems, including well trained staff with access to a functioning referral systems (transport and communication) are needed to ensure that patients, particularly in remote rural areas, have access to the essential drugs they need.

**[Paragraph 112] In addition to insufficient quantities of essential drugs, many countries have widespread shortages of other pre-requisites for maternal health and services, including adequate blood and family planning supplies. We believe that DFID should seek to build political commitment within countries to ensure that these crucial supplies are appropriately funded within national health plans and budgets. The Department should also campaign internationally for a reversal in declining budgets for family planning supplies and services.**

DFID will continue to support the development of strong national health plans that include improved access to blood transfusion and family planning commodities. Budget support and Sector Wide Approach (SWAp) are processes of negotiation and prioritisation with government and other donors to reach a consensus on what is needed across the health sector, with regular review and revision.

DFID is fully supportive of increasing budgets for family planning, both at country level and globally. DFID allocated an additional £100 million, over five years, to improve commodity supplies and family planning services. DFID will again lobby for increased funds for family planning at the G8 (as it did effectively in 2007), but also funds partners, such as IPPF, to provide services and campaign for greater access.

### **Balancing the demand and supply-side of care**

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

DFID-supported maternal health programmes in Asia and Africa have placed considerable weight on balancing demand and supply side interventions. For example, in Malawi new

knowledge on the cultural barriers to good sexual and reproductive health, including HIV and AIDS, arose from the Safe Motherhood Project research. This led to innovative communications tools, including the use of radio and drama, significantly increasing demand for maternity services.

In Pakistan DFID will launch a Research and Advocacy Fund (£11.5 million) to foster rights-based approaches and test innovative proposals for demand-side financing.

Where DFID does not have separate programmes, but provides support through budget support, we work closely with other partners (i.e. UN or another donor such as the Netherlands), to highlight any imbalances, as well as conducting regular reviews

In line with Paris Declaration principles on donor harmonisation, DFID takes the lead role in some sectors in each Public Service Agreement (PSA) country but other funding agencies lead where they may have a comparative advantage. DFID liaises closely but it is not possible or desirable for us to lead in all countries on the health sector. We are also working towards more effective partnerships with the UN.

### Working in conflict-affected and fragile states

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

We agree with this recommendation. There has been increasing concern about the sexual and reproductive health and rights (SRHR), particularly of young women, especially in conflict and humanitarian situations. We are raising the profile of these issues within the global health cluster working along with other partners. For example, we have recently ensured that questions around SRHR have been included in updated DFID guidelines to NGOs seeking funding for work in humanitarian situations.

WHO leads the health cluster in humanitarian situations and sets the strategic direction and priorities for the health response in close collaboration with the government (where possible). We are planning to work with WHO to ensure that SRHR should be a core component of the cluster's strategic response. The health cluster needs to work closely with the Ministry of Health to ensure alignment of sensitive issues within the overall national strategy.

**[Paragraph 122] We believe that DFID should go beyond immediate emergency relief and build on its ability to work on sensitive issues such as abortion, for which there is greater demand in conflict-affected and fragile settings and which urgently needs support. Efforts should be made to ensure that maternal care is a core part of both DFID's and national health programmes from the outset. A long-term dual approach that seeks to strengthen or re-build systems whilst continuing some aspects of emergency care is likely to work best.**

We agree that sensitive issues such as abortion should be addressed in conflict situations, where feasible, and that the post-disaster relief and rehabilitation period can provide a significant opportunity to open up negotiation on sensitive SRHR issues.

DFID believes that working on SRHR in conflict-affected and fragile states is about ensuring a full range of comprehensive information, supplies and services to women and men, including to adolescents, who are particularly vulnerable.

DFID has learned that much will depend upon the context of the emergency. In Nepal, for example, support from DFID enabled the passing of legislation on access to safe abortion, as well as the rapid scale-up of services, throughout the period of conflict. In the DRC, the current emphasis is on establishing basic services, given the extreme weakness of the health system and the lack of trained health personnel. In Sierra Leone, DFID acted swiftly to support the government to develop a sexual and reproductive health policy, as a first step in planning wider post-conflict maternal and child health inputs.

**[Paragraph 124] We believe that DFID should learn from what has worked in terms of supporting maternal health programmes in fragile, conflict and post-conflict settings and share this knowledge appropriately elsewhere. This should include successful examples from DFID’s own programmes, such as recent experiences in Nepal, Sudan and Afghanistan.**

A key lesson from this IDC report has been the need for DFID to be more effective in disseminating our experience in maternal health in several ways. Within DFID and among our key international partners and civil society, there are opportunities for this experience to be more widely shared. However, a proportion of this high quality work, although supported by DFID, is implemented by other agencies (UN, NGO, etc) or by government and we will do more to actively encourage them also to share in appropriate ways.

### **The need for improved health information systems to monitor progress**

**[Paragraph 129] Supporting improved health information systems in developing countries is of crucial importance to identifying and sustaining successful policies for maternal health. We believe that DFID should continue to support initiatives addressing weak information systems, such as the Health Metrics Network and Impact. DFID should ensure that its programmes include a focus on strengthening national capacity to collect, analyse and use maternal health data.**

All DFID maternal health programmes, or health sector-wide approaches (SWAps), support national efforts to monitor progress on the health MDGs. The capacity to collect, manage and use maternal health data is variable and support has been provided either specifically for maternal health (Malawi, Nepal) or across the health system, particularly where budget support is provided.

DFID is a Board Member of and provides financial support to the Health Metrics Network (HMN), which works to improve the collection, analysis and use of appropriate data. The HMN is currently being evaluated and we will consider future support in light of the evaluation findings.

The Initiative for Maternal Mortality Programme Assessment (IMMPACT) has successfully achieved its objectives and has made a significant contribution. DFID and other funders have encouraged the development of Ipact, which is an independent consultancy arm of IMMPACT, to implement research findings in various countries, as requested by governments.

**[Paragraph 130] The opportunities to highlight and address the urgent need for improved data that arise through various international initiatives, such as the International Health Partnership, should be seized and championed by DFID. The use of maternal indicators as a basis for financing decisions, for example, is likely to be a powerful stimulus to countries to improve maternal health itself.**

We agree with this recommendation and note that some countries are at an early stage of developing health information systems and few countries have yet reached the more sophisticated stage of effectively using data to educate financial decisions—arguably it is only recently that the UK has started to achieve this standard. Undoubtedly, this is the direction of travel.

DFID is championing the use of indicators of maternal health as core to assessing overall improvements in health systems and services—for example in the International Health Partnership (IHP). The proposed framework for monitoring and evaluation of the IHP includes, among the output indicators, the coverage of maternal and child health services including skilled birth attendance. Impact indicators include both maternal and child mortality rates.

In Burundi the IHP has already helped influence health reforms on MDG 5. The Memorandum of Understanding/country compact has agreed that two of five indicators directly relate to maternal health, the percentage of births “in a health care environment”, and increases in couple years of protection.

**[Paragraph 131] Helping countries to monitor maternal deaths and the quality of care through routine audit systems will help to focus policies. We believe that DFID should help share lessons from developing countries that have successfully implemented audit systems of maternal deaths.**

We agree that auditing maternal deaths is important, helps to focus policy and enable steps to improve service delivery. Innovative work on maternal death audit, that we have supported and helped disseminate, includes that done in the Malawi Safe Motherhood Project (SMP).

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

**[Paragraph 135] We were pleased to hear that DFID’s funding to maternal health will increase to over £50 million in 2008. DFID’s additional financing for family planning through UNFPA and its funding for research are particularly welcome.**

Point noted.

**[Paragraph 136] We reiterate our recommendation from Paragraph 122 that, in order to strengthen health systems, aid to maternal health should be predictable and long-term, especially in fragile and conflict-affected states.**

We agree, point noted.

### **Budget support and maternal health**

**[Paragraph 140] We believe that delivering support to maternal health through budget support is appropriate and will assist the predictability of aid. However, better tracking is needed of the extent to which the funds contribute to improved maternal health outcomes. DFID should explore specific mechanisms to ensure this, including giving support to public expenditure reviews of government budgets—especially those involving civil society—and making maternal health a specific headline indicator for budget support. The choice of measures of maternal health will be crucial, in terms of their availability, accuracy and ability to reveal inequities, and we recommend that DFID takes a lead role internationally in ensuring the most appropriate and effective selection.**

DFID has been encouraging the use of maternal mortality ratios (MMR) (or a proxy indicator, such as number of institutional deliveries, or proportion of deliveries with skilled birth attendant) as a key tracking indicator for budget support programmes and has particularly stressed this approach in work on the IHP. Our experience is that this will help raise the profile of maternal health and place the onus on countries (and funding agencies) to take MMR far more seriously, thus increasing political attention to the issue. However, the choice of the actual indicator needs to reflect the country context, especially if a maternal health indicator is already being monitored by the government.

### **DFID's human resource capacity**

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

At the IDC hearing, Parliamentary Under-Secretary of State Vadera gave assurances that country and regional programmes in the poorest countries were receiving priority for staff resources. Since March 2004, in line with other UK Government Departments, DFID staff numbers have fallen by 12%, with many of these reductions in administrative staff. The Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) peer review of DFID last year praised us for “a golden age of

growth and achievement". DFID has also scored very well in the recent Whitehall Capability Review.

DFID has to work within the reality of UK policy. However, addressing the MDGs, including maternal mortality reduction, is a stated priority. DFID's operations to address maternal health are expanding in Asia and there is also planned expansion in Africa. The IHP process will rationalise how and where donors engage, and will bring opportunities for more effective division of labour at country level. DFID is also exploring options for wider division of labour, for example with Norway rotating on to the Board of the PMNCH, and the Netherlands now representing DFID on the Board of Roll Back Malaria and STOP TB.

Looking forward, the Comprehensive Spending Review settlement means that for the next three years the budget for staffing in country offices, where most of our health advisers are based, will increase modestly in real terms. DFID country programmes will be exempt from headcount cuts resulting from the requested efficiency savings. In UK-based departments, administration cost budgets will fall. However, we will be aiming to protect professional capacity in front line services as far as possible.

### DFID's comparative advantage

**[Paragraph 147] We agree that DFID has a comparative advantage in working on sensitive issues such as unsafe abortion. Whilst we reiterate our view that abortion is a national issue, we believe that DFID should challenge governments which seek to restrict access to contraception services and safe abortion. This should include working with international and national advocacy and rights-based groups to communicate the facts about preventable deaths and disabilities from unsafe abortion.**

DFID policy is to actively encourage governments to review legislation where abortion is illegal, pointing out the consequence of such legislation is almost always a significant increase in unsafe abortion, resulting in subsequent increases in severe complications and maternal deaths. Advocacy work and services to provide safer abortion have been a comparative advantage for DFID, as the IDC has noted, and will continue to be a major focus of our work in SRHR and we will continue to work closely with leading NGOs and civil society organisations (such as IPPF and MSI) on this subject.

**[Paragraph 150] Identifying DFID's role within the international drive to meet MDG 5 also relies on establishing the limits of the Department's contribution. DFID cannot do everything. Part of its approach should focus on supporting other actors, especially the UN, to play their part. DFID's next maternal health strategy—which we believe should be produced sooner rather than later—should set out a clear and focused approach that seeks to engender more realistic expectations of its work from other aid organisations and set out what it cannot, as well as what it can, achieve.**

We agree and there are plans to update the Maternal Health Strategy. Preliminary work will start later in 2008 and the revised strategy will be completed during 2009. Policy and Research Division, in liaison with regional and other divisions, will develop a Position Paper on meeting the unmet need for family planning, which could form part of the updated Maternal Health Strategy.

## Re-appraising priorities

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

DFID Ministers have already called for advice on how DFID can increase efforts on maternal health. As discussed above, DFID is also engaging at high level to give greater prominence to maternal health issues in the G8 summit and the UN MDG summit in September 2008. There has also been strong leadership on this subject from the Prime Minister’s office, particularly in the recent discussions with French authorities, during the State Visit.

**[Paragraph 153] We believe that the three pre-requisites of family planning, emergency obstetric care and skilled birth attendance must remain at the centre of DFID’s work.**

DFID agrees that these three priorities are essential effective interventions and would also add the prevention of unsafe abortion.

**[Paragraph 154] Countries such as Honduras show that when maternal health is made a national priority, and a strong focus is given to emergency obstetric care, skilled birth attendance and family planning, maternal mortality can be reduced substantially in less than a decade. We believe that DFID and other donors should prioritise supporting other countries to emulate this success, which will help ensure MDG 5 is within closer reach by 2015.**

Point noted. We agree that Honduras provides a very useful example and should be included in efforts to disseminate best practice, described above.