Choice for women: wanted pregnancies, safe births

Help us shape the UK Government’s policy on reproductive, maternal & newborn health in the developing world

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Context and background

Millennium Development Goal (MDG) 5 to improve maternal health is the most off-track MDG, and yet has a critical impact on the achievement of all the other MDGs. More than a third of a million women die every year from complications during pregnancy and childbirth. For every woman that dies another 20 women suffer from chronic ill-health or disability. MDG 4 to reduce child mortality is also off-track. Over 8 million children die every year before their fifth birthday – at least 3.5 million of these deaths are of babies who die within the first month of life.

Improving reproductive, maternal and newborn health in the developing world is a major priority for the UK Government. DFID is therefore developing a new business plan, which will determine DFID/UK’s contribution towards achieving MDG 5. We want to ensure that every pregnancy is wanted and that every birth is safe. In doing so, we know that we will also make an enormous contribution to reducing child mortality – particularly through improving the survival chances of newborn babies.

Choice for women – wanted pregnancies

Investing in family planning is one of the most effective development interventions and the most cost effective way to reduce maternal mortality. There are 215 million women in the developing world who would like to delay or avoid pregnancy, but do not have access to modern family planning methods – each year there are 75 million unintended pregnancies.
Failing to prevent unintended pregnancy leads some women and girls to seek an abortion. Every year 35 million of all pregnancies in the developing world end in induced abortion. An estimated 20 million of these abortions are unsafe and result in up to 70,000 maternal deaths each year.

Choice for women – safe births
More than a third of a million women die due to complications in pregnancy or childbirth each year. Young women are particularly vulnerable. Most of these deaths would have been prevented if women had access to quality reproductive, maternal and newborn health services before and during pregnancy, during labour and after the birth.

The few minutes and hours around childbirth is the time when the risk of death is greatest for both mothers and babies. More than 3.5 million newborn deaths (accounting for more than 40% of deaths to children under 5 years of age) occur in the first month of life – up to 45% of these in the first 24 hours.

Women’s rights, empowerment and choice
Women and girls’ ability to take action for their own and their children’s health, and to access contraception and services for a safe pregnancy and delivery, is essential for their empowerment. A girl or woman’s ability to make choices (with her partner whenever appropriate) about if and when she becomes pregnant, and what information and services she accesses, depends on her ability to negotiate and control these issues. Her status within a family and wider society determines the importance given to her health.

Integration of health services
Success in tackling HIV and AIDS, malaria, tuberculosis, and other diseases will contribute to the achievement of MDG 4 and 5, particularly in areas where these conditions are highly prevalent and underlie significant numbers of maternal, newborn and child deaths. By focusing on strengthening health systems and integrating services, effort towards MDG 5 will also support progress towards MDG 6 to tackle HIV and AIDS, malaria and other major diseases.

How you can get involved
We are developing our policies and plans of action in a number of ways. We are working with partner governments and other donors in country to determine what to support and how best to deliver; global experts give us advice; our research provides strong evidence, and we are looking at the budget and resources available to support programmes of activity.

We particularly want to hear what people around the world have to say on the subject of reproductive, maternal and newborn health. We want to
know more about your views, opinions and experiences. This will help us to understand different viewpoints, how these issues might vary in different countries, and how DFID could work better with partners.

The views and opinions expressed in this survey and discussion forum will be assessed by DFID and will give us a greater understanding of reproductive, maternal and newborn health issues around the world.

This template should be used if you do not or cannot use the open, online version. If you are considering these questions as a group, you might find the presentation useful to stimulate discussion. Enough information is provided here for each question to be answered independently should you wish to just respond to a few questions.
1. What should we aim to achieve?

Our ultimate aims are to improve women’s control of their reproductive lives and to save mothers’ and newborn lives. Within the context of strengthening health systems to deliver for all and recognising that different countries have different needs, what do you think that we should be aiming to achieve?

You might like to consider the following options:

- Reducing the number of unintended pregnancies
- Increasing availability of and access to contraception (the contraceptive prevalence rate)
- Reducing the unmet need for family planning
- Reducing the number of unsafe abortions
- Reducing the adolescent fertility rate
- Increasing the number of births attended by skilled birth attendants
- Increasing newborn survival
- Increasing the availability of prevention of mother-to-child transmission (PMTCT) services
- Improving maternal nutrition
- Reducing the prevalence of malaria in pregnancy
- Do you have any other ideas to share with us?

Your response:

Population and Sustainability Network (PSN) welcomes this consultation and DFID’s focus on extending women’s reproductive rights and choices as a key strategy for improving reproductive health and empowering women worldwide. We fully support the emphasis the policy places on increasing access to voluntary family planning and safe abortion. Particularly in countries with high fertility and a high unmet need for family planning, this policy offers DFID a key opportunity to alleviate poverty and promote the wellbeing of poor communities, by ensuring that every child is a wanted child. Taking forward this policy we believe that DFID is well placed to play a key role in encouraging increased action and effective responses by the international community to achieve Millennium Development Goal 5, and by doing so drive progress towards the other MDGs. We thank DFID for the opportunity to contribute to this important consultation.

PSN supports all of the draft policy’s aims and in addition strongly encourages DFID to link reproductive health policy and programmes, and the positive interaction they can have on population dynamics, including population growth, to other related development issues. Voluntary family planning and the realisation of reproductive health and rights have a key role to play in addressing other pressing development priorities including issues such as climate change, poverty alleviation and fragile states. There are many opportunities for DFID to promote the integration of reproductive health with other development agendas, including through policy, programmes and funding streams, and to promote the benefits of family planning. These would maximise the impact that DFIDs maternal health policy will bring for the other MDGs. Within our response to the other consultation questions we have set out these opportunities.
2. Which interventions should we prioritise?

Where should we focus our efforts along the continuum of care (pre-pregnancy, during pregnancy and birth and after delivery) and why, in order to have an impact on MDG 5 by 2015? What do you think is most important to tackle in order of time priority?

You might like to consider the following options:

- Comprehensive family planning to enable women and men to make choices about their reproductive lives and delay, space and limit their family size
- Safe abortion services and to make the consequences of unsafe abortion more widely known to ensure that abortion is safe, legal and rare
- Antenatal care services
- Skilled birth attendance (and/or institutional deliveries)
- Post natal care services
- Maternal nutrition interventions before and during pregnancy
- Emergency obstetric care
- Newborn care
- Exclusive breastfeeding
- Prevention and treatment of malaria for pregnant women
- Prevention of mother to child transmission of HIV before, at and after birth
- HIV prevention with sexual and reproductive health services
- Health system strengthening (including health workers, medication, contraceptives and other health commodities) to deliver quality services along the continuum of care
- Specific sexual and reproductive health services for women who are survivors of violence or rape
- Do you have any other ideas to share with us?

Where appropriate please also indicate to which world region you are referring.

Your response:
While recognising the importance of high quality, holistic service provision across the continuum of care, PSN supports the prioritisation of comprehensive family planning, including increasing access to voluntary family planning, through access to as wide as possible a range of contraceptive methods and to safe and legal abortion. This is an effective and cost-efficient rationale for a number of reasons.

Prioritisation of voluntary family planning is an effective strategy because there is a large unmet need for contraception, it is highly cost-effective, and it contributes to the realisation of other development priorities. There are an estimated 215 million women worldwide who want to avoid pregnancy but do not have access to contraception (Singh et al., 2009). An estimated 40% of all pregnancies worldwide are unplanned. In many West African countries, including Niger and Nigeria, less than 10% of all married women are using modern contraception (Stephenson et al., 2010). The longer birth intervals and lower fertility that would result from addressing this unmet need and preventing unplanned births would have significant cost saving effects for other development goals. For every dollar spent in family planning, between 2 and 6 dollars can be saved in interventions aimed at achieving other development goals (Moreland, Scott and Talbird, 2006). This contributes to poverty alleviation by reducing population growth, which for example reduces the costs of public service delivery and eases pressure upon natural resources. Prioritising family planning therefore reduces the costs of meeting the other MDGs.

Increasing access to contraception is an extremely effective way of improving overall sexual and reproductive health incomes. Reducing unplanned pregnancies by addressing the unmet demand for contraception reduces maternal and infant mortality and morbidity. This is particularly effective in countries with high levels of maternal mortality because the pregnancies are more risky. This is shown by how countries with the largest unmet need for contraception also have the highest rates of maternal mortality (APPG on Population, Development and Reproductive Health, 2009). Increasing access to contraception also reduces deaths and illness due to unsafe abortions. It is estimated that meeting the need for family planning and maternal and newborn health services would (Singh et al., 2009):

- avert 72% of all maternal deaths
- avert 44% of all newborn deaths
- reduce unsafe abortions by 73%

The cost effective-nature of investments in family planning is shown by the case-study of Kenya. Kenyan women have on average 5 children each. 25% of married women of reproductive age want to space or limit births but don’t have access to family planning. It is estimated that addressing this unmet need would prevent 14,040 maternal deaths and 434,306 child deaths by 2015. Reducing the number of unplanned births through meeting family planning needs would considerably reduce the costs of meeting the other MDGs, outweighing the additional costs of family planning by a factor of almost 4 to 1 (USAID, 2009).

Increasing access to voluntary planning will have particularly high impact on improving health outcomes in countries with:

- high fertility rates and low contraceptive use
- high rates of maternal mortality and morbidity
While there is a need to ensure universal access to contraceptive choices worldwide, these countries should be a particular focus for initiatives to increase access to voluntary family planning. Further information is provided in Question 3 and below we provide further recommendations about the prioritisation of family planning.

**Prioritisation of family planning, must include a focus on ensuring women have access to a range of contraceptive choices**, as well as increasing overall contraceptive use. Ensuring universal access to condoms must play an important role in reducing HIV infection as well as unplanned pregnancy. But due to the limited capacity many women have to engage in sexual-decision making, women need to be able to choose contraceptive methods that are culturally appropriate and meet their individual needs. For example, due to the stigma sometimes associated with family planning services, some women need to be able to access contraception discreetly and due to gender inequalities, use methods that don’t require male cooperation in order to be effective. Given that contraceptive supplies are prone to shortages in many developing countries, as well as the difficulties that women can experience in accessing health services on a regular basis, access to long-acting and permanent contraceptive options should be increased. A focus on long-acting and permanent options must particularly ensure that service users have the necessary information and understanding so that they can make a fully informed and autonomous choice.

**A focus on voluntary family planning is necessary across the care continuum.** While family planning is considered one of the three pillars of maternal health, family planning should be integrated with other aspects of service delivery. For example, services that come into contact with women during pregnancy and birth offer ideal opportunities to discuss and provide information about contraceptive use. This would help women to avoid subsequent unplanned pregnancies and space their children. A particularly valuable opportunity for providing family planning services is after women have had abortion, yet often, because the provision of safe abortion services has, in some settings, jeopardized funding for family planning services, these services are not offered to women who have demonstrated that they are at risk of unplanned pregnancies.

**Family planning programmes should be integrated with sexual health information and education programmes, and initiatives to increase women’s empowerment.** This is necessary in order to increase take-up of family planning, for example by increasing awareness and understanding of family planning, by tackling cultural issues such as ‘silence’ on sexual topics, including gender-based violence, and by increasing women’s capacity to engage in sexual-decision making with partners.

**Prioritisation of voluntary family planning should come hand in hand with increasing access to safe and legal abortion.** Where abortion is illegal or restricted, based on the ICPD-endorsed recognition of the public health impact of unsafe abortion, we would particularly urge DFID to play a leadership role in ensuring legal reform. Interventions are also necessary to ensure that health services are well equipped to effectively and sensitively respond to the needs of women suffering from complications caused by unsafe abortion. Further information is provided about these points in Question 5.

3. Where should we work?
Where should we focus our efforts to advance progress on reproductive, maternal and newborn health?

You might like to consider the following options when thinking about the basis of how we should prioritise where we work:

- The lowest contraceptive prevalence rate
- The highest unmet need for family planning
- The highest absolute numbers of maternal deaths
- The greatest lifetime risk of maternal death
- The greatest inequities in access to services e.g between rich and poor
- Fragile states
- A combination of all of the above

Your response:

We recommend that the following countries should be a particular focus to advance reproductive, maternal and newborn health, with a particular focus on increasing access to voluntary family planning. Countries with:

1. High unmet demand for contraception / low rates of contraceptive use
2. High fertility rates
3. High rates of maternal mortality and morbidity
4. Fragile states
5. High vulnerability to the effects of climate change

Countries with high unmet demand for contraception
Prioritisation of countries with high unmet demand for contraception will have great impacts on reproductive health outcomes, as low rates of contraceptive prevalence are strongly correlated with high rates of maternal mortality (APPG on Population, Development and Reproductive Health, 2007). Addressing the unmet need for contraception will reduce unplanned pregnancies, thereby reducing the number of high risk pregnancies and maternal and child mortality and morbidities, and bring savings to the health system. This includes reductions in deaths due to unsafe abortion.

Sub-Saharan African countries have on average the highest unmet need for contraception, with 23% of married women of childbearing age who do not want to conceive a child without access to any form of contraception. This is followed by Latin America and the Caribbean (19%), South and SE Asian (15%) and North and West African and Europe (10%) (APPG on Population, Development and Reproductive Health, 2009). In total there are an estimated 215 million women worldwide who would like to be able to control their fertility but do not have access to contraception. Many of these women live in extreme poverty. As well as the health implications, these women are denied a basic right of empowerment in their lives.

Countries with high fertility rates
Prioritisation of countries with high fertility rates also has the scope to bring great advances in reproductive health because high fertility is known to be strongly associated with high maternal and child mortality rates. Countries with high rates of population growth are likely to have a large unmet demand for family planning. This
is the case for sub-Saharan Africa. No country (with the exception of a few oil-rich states) has succeeded in rising from poverty at the same time as maintaining high fertility rates. Slowing the rate of population growth by addressing the unmet need for family planning would therefore permit greater investment in education, health and skills for employment, helping to lift these nations out of poverty.

**Countries with high rates of maternal mortality and morbidity**
Prioritisation of these countries for investments in family planning is a sensible rationale because high rates of maternal mortality are correlated with low rates of contraceptive prevalence. Reducing unplanned and high risk pregnancies in this way also reduces infant mortality and morbidity. As outlined above, high rates of maternal morbidity commonly coincide with high unmet demand for contraception and high fertility rates.

**Fragile states**
Given the links between high fertility, poor reproductive health outcomes and civil conflict, fragile states, and particularly those with mounting demographic pressures, should be considered a priority for reproductive health interventions, particularly family planning. High rates of population growth can contribute to the potential for civil conflict, where they involve pressure on limited land or water resources, mass migration and high rates of youth employment. Of the top 20 failing states 17 have populations increasing at close to 3% a year (20-fold per century). In five of these 17 countries, women have an average of nearly seven children each (APPG on Population, Development and Reproductive Health, 2009). Of the top failing states, those that are identified as facing the most significant demographic pressures (scoring 9 or more out of 10 in a ‘mounting demographic pressures’ index are (Fund for Peace 2007):
- Sudan (ranking 1 in the top 20 failed states, demographic pressure index: 9.2).
- Iraq (2, 9)
- Somalia (3, 9.2)
- Zimbabwe (4, 9.7)
- Chad (5, 9.1)
- Democratic Republic of Congo (7, 9.4)
- Ethiopia (18, 9)
- Burundi (19, 9.1)

Further information is available at: http://www.fundforpeace.org/web/index.php?option=com_content&task=view&id=229&Itemid=366

There is also a need to promote access to health services as part of rapid onset humanitarian response in fragile states. Women’s specific reproductive health needs, including the needs of pregnant women, lactating women, and women of reproductive age, are often overlooked in emergency settings. This has detrimental maternal and child health outcomes, and exacerbates women’s vulnerabilities to the impacts of conflict.

A case study of Somalia, which has not had a functioning government for almost 20 years, exemplifies the links between conflict, high fertility rates, poverty and poor reproductive health outcomes. The average number of children a woman has in her lifetime is very high at 6.4 and has barely changed since the early 1980s. Population growth is high at 2.27% and rates of maternal and infant mortality are amongst the highest in the world. In the list of failing states compiled by the *Fund for Peace* (2007), Somalia is listed as having one of the highest degrees of population
pressure. Trends reflecting strong population pressures such as droughts, chronic food shortages and famine, high risk of disease, and environmental degradation, are all severe in Somalia. Population issues, and particularly population growth, need to be integrated into strategies for assisting fragile states. A focus on family planning would improve health and contribute to reducing pressures on the state and potential for violent conflict.

**Countries most affected by and vulnerable to the impacts of climate change**

There is good rationale for prioritising countries that are most affected by climate change for interventions to increase access to voluntary family planning. High fertility in countries affected by climate exacerbates the impacts on the local population by increasing demand for natural resources such as land and water. At the same time, adaptation is more difficult as the demands of an increasing population limit governments’ capacity to respond to climate changes.

As part of the UN Framework for Climate Change Convention, developing countries have produced National Adaptation Programmes of Action (NAPAs), in which they outline their top priorities for adaptation and specific local vulnerabilities to climate change. An analysis of 40 of these reports demonstrates how closely issues associated with population growth and vulnerability to climate change are linked. 93% (37 out of the 40) of the country reports refer to rapid population growth as a factor that makes coping with at least one impact of climate change harder (Bryant, Carver, Butler and Anage, 2009).

To identify specific countries for prioritisation, countries identifying population pressures exacerbating vulnerability to climate change in their NAPAs should be a particular priority for interventions to increase access to voluntary family planning. Many of these countries are listed in the article:


An additional effective strategy would be to prioritise small developing country island states, which are highly vulnerable to climate change due to rising sea levels. Sub-Saharan Africa countries are also highly vulnerable to climate change, at the same time as having high fertility rates, high unmet need for contraception and poor maternal and child health indicators. Many sub-Saharan African countries are also conflict-prone.

The island state of Madagascar provides an illustration of the need to link reproductive health and climate change adaptation strategies. Madagascar’s NAPA identifies population growth as heightening vulnerability to climate change, and exacerbating depletion of the marine environment which the population greatly depends upon for livelihoods and food security. Madagascar has one of the fastest growing populations in the world, high rates of maternal mortality, and only one in five women in a sexual relationship have access to contraception. Please refer to Question 6 for an example project in Madagascar integrating reproductive health and population issues, which through replication would also offer opportunities to improve reproductive health and contribute to poverty alleviation elsewhere.

Reducing unplanned pregnancies in countries affected by climate change would reduce pressure on and lessen the deterioration of limited natural resources and help local communities to adapt to climate change. In turn this would contribute to the achievement of MDG 7 to ensure environmental sustainability, and to wider poverty alleviation. Developing countries which are characterised by rapid population growth...
and high vulnerability to climate change should therefore be supported to integrate family planning into climate change adaptation programmes.

For further information about the links between population dynamics, family planning and climate change, and further recommendations about integrated strategies, in addition to the article listed above we recommend:


4. How should we address inequality?

What are the most important approaches that DFID/UK should consider to tackle inequalities in reproductive, maternal and newborn health outcomes?

You might want to consider the following options:

- Cash transfers and other mechanisms (such as vouchers and services that are free at the point of use to pregnant women and children) that remove financial barriers faced by the poorest and offer choice where relevant
- Innovative and community based solutions for transporting women in need of referral
- Making services women and girl friendly, tackling discrimination and exclusion within the health system
- Better and more transparent data to track if results benefit the poorest and to improve accountability of impact and quality of provision

Your response:

**Addressing the barriers that create unequal access to family planning should be prioritised, given the cost-effective nature of family planning and savings it brings for other development priorities. A focus on health inequalities must ensure that services are free at the point of delivery.** Cost-related issues present the greatest barriers, with individuals being unable to afford services coupled with a lack of suitable service provision and shortages of commodities such as contraceptives, due to lack of investment in reproductive health services. Ensuring that services are free at the point of delivery is therefore critical to reducing health inequalities, in order to allow the most marginalised communities and individuals with the poorest health outcomes to be able to access the health services they need. Emphasis on service sustainability has masked the fact that serving the poorest of the poor effectively will always mean investing in services with little hope of cost recovery.
Addressing cost-related barriers requires a significant increase in investment in family planning. It is estimated that only 10% of funding needed from developed nations for the necessary investments in family in the global South is actually being provided, at a time when unmet need is increasing (APPG on Population, Development and Reproductive Health, 2007). Since the mid-1990s, donor assistance dedicated specifically to family planning has dropped dramatically in absolute terms. We fully commend DFID’s reproductive health strategy for seeking to address this gap. As well as directly providing increased funding for reproductive health initiatives we would encourage DFID to play a leadership role in increasing international support and funding for investment in reproductive health by other bilateral and multilateral donors.

Cultural, social and religious factors that present barriers to access must be a focus of interventions to address health inequalities. These factors can inhibit discussion, education and information provision about sexual matters, and stigmatise services. Gender inequalities, including limited educational opportunities for women, also undermine women’s ability to access to information and services, and to participate equally in sexual-decision making. A human rights-based approach, which emphasises the goal of universal access to services with the potential to save lives can increase the acceptability of family planning in some settings. The concept of saving preventable deaths through health services has traction in many social settings.

The complexity of factors which prevent access to reproductive health require holistic, rights-based approaches to sexual and reproductive health. Through focusing on respecting and protecting rights with a central focus on choice, a rights-based approach should seek to address the inequalities that undermine women’s ability to make and exercise informed sexual decisions, and access to appropriate services. This includes addressing issues such as sexual violence and coercion, and undertaking interventions that seek to promote behaviour change and challenge the social norms underlying gendered power inequalities. This approach should also include education strategies to address information needs, increase peoples understanding of rights, as well as providing means of redress for rights violations. Such an approach will also protect services from manifesting any element of coercion which has damaged the reputation of family planning services in some parts of the world, and had the effect of preventing women and men from identifying such services as attractive or having the potential to improve their lives.

Rights-based approaches to sexual and reproductive health should include increasing understanding of preventable maternal mortality and morbidity and ‘forced pregnancy’ as a violation of women’s rights. Women’s lack of access to contraception and safe abortion and the resultant ‘forced pregnancies’, as well as preventable maternal mortality and morbidity should be viewed as a violation of women’s human rights. A recent (2009) UN Human Rights Council resolution has now recognised preventable maternal mortality and morbidity as a human rights violation. We would also advocate the view that pregnancies that result from women being unable to access contraception or a safe abortion (which are sometimes coupled with coercive relations) be seen as ‘forced pregnancies’, and as such a violation of women’s rights (Cook et al., 1999). We recommend that DFID considers adopting this terminology, which could help to address the lack of international support and funding for sexual and reproductive health and rights. Such an approach is certainly within the spirit of “children by choice and not by chance”.

Local rights-focused NGOs and women’s groups should receive support to undertake rights-based information and awareness raising work at the local
Case studies from Bangladesh and Nepal provide examples of work of this kind by groups supported by Women and Children First (2007). Through undertaking awareness-raising on health issues and working with communities to increase their understanding of their entitlement to health services, women’s groups have been able to support communities to find local and low-cost solutions to health service delivery. Further information about this work is available at: http://www.wcf-uk.org/northsouth/extra3.nsf/Resources/CC95FCBF81BFF4E802572AA00556993/$FILE/WCF%20Women's%20Groups%20Paper%20Sep%2008.pdf?openElement

Microfinance schemes, particularly those integrated with health programmes, offer opportunities to address inequalities in reproductive health. There is a wealth of evidence of the role that microfinance schemes, particularly those that provide credit to women, can play in reducing poverty and promoting women’s empowerment. While this alone can bring improvements in health, schemes that have incorporated health education, advice and referrals to health services as part of microfinance group meetings have delivered the greatest improvements in health outcomes, by improving knowledge, promoting behaviour change and facilitating access to public and private service providers (Leatherman & Dunford, 2010). Both as a result of the empowering nature of microcredit schemes, and schemes that have specifically included education and facilitation of access to family planning, contraceptive use has been found to be considerably higher amongst Bangladeshi women who are members of microcredit schemes. In Bolivia, a CRECER scheme incorporates a community-based contraceptive distribution system – facilitated by a credit scheme member who was trained in this role. A different integrated scheme in Bolivia had by 2005 supported 45,000 members to access sexual and reproductive health consultations and 5,700 to receive prenatal consultations. In Ghana, integrated health and microcredit schemes have achieved increased access to skilled attendance at birth and delivered health improvements relating to breastfeeding, nutrition and HIV/AIDS prevention practice (Watson & Dunford, 2006).

Investigating and supporting community-based models of service delivery has to play a key role in addressing health inequalities, particularly amongst marginalised and rural communities. Mobile Health Clinics serving nomadic and isolated rural communities in Kenya provide an example of innovative, local solutions that are able to significantly reduce health inequalities. Providing reproductive health and HIV/AIDS services, immunisation, basic curative health care and FGM awareness and education, health teams travel by four-wheel drive, bicycle, camel and foot. Each year they are able to make over 60,000 visits and provide family planning to over 2,000 women annually (Mobile Clinics Africa, nd). The health teams are run with two African organisations, the Nomadic Community Trust & Community Health Africa Trust, working in partnership with community-based representatives, the Ministry of Health and other NGOs. Further information about these Mobile Health Clinics is available at: http://www.mobileclinicsafrica.org/

Long-acting and permanent contraceptive options offer opportunities to address sexual and reproductive health inequalities. These options may be particularly effective in areas where contraceptive supplies are prone to shortages, and where women have difficulties accessing health services on a regular basis. Rights-based approaches are particularly important for these forms of contraception, to ensure service users have the necessary information and understanding so that they can make fully informed, autonomous choices. The capacity for these forms of contraception to address health inequalities is demonstrated in Nepal, where between 2001 and 2006 the national total fertility rate dropped from 4.1 births per woman to 3.1, and contraceptive prevalence use increased from 39% to 48% (MSI,
There was a focus on long-acting and permanent contraceptive methods, at the same time as legalising abortion in 2002. Maternal and child mortality has been reduced. Most progress has been achieved in rural areas, where clinical outreach teams have formed partnerships with the government, national and international organisations such as MSI. Further information about this case study is available at: http://www.mariestopes.org/documents/publications/MSIs_impact_on_fertility_decline_in_Nepal_FINAL_0109.pdf

Effective use of training to support task shifting to increase access to services such as family planning offers opportunities to reduce health inequalities. Evidence is provided of this in the following case studies:

- Nurse auxiliaries in Guatemala and Honduras inserting IUDs and providing contraceptive injections – increasing access to contraceptive choices and reducing costs. Further information is available at: http://download.journals.elsevierhealth.com/pdfs/journals/0968-8080/PIIS0968808009334308.pdf

- Health extension workers in Ethiopia increasing access to contraceptive implants and undertaking other cost-saving tasks: http://www.unfpa.org/public/cache/offonce/news/pid/4675

- Volunteer community health workers in Uganda increasing access to contraceptive injectables: http://www.fhi.org/en/RH/Pubs/fhr/v1_2/article5.htm

In Sierra Leone for example, there are only 200 trained doctors, yet doctors are required to insert IUDs. Providing training to lower-level health workers to undertake this role could increase access to contraception at the same time as allowing doctors to work more efficiently and productively.

Other examples of reproductive health service improvements resulting from task-shifting are provided in this special edition of Reproductive Health Matters on task-shifting:
http://www.rhmjournal.org/issues/contents?issue_key=S0968-8080%2809%29X1733-7

Better performance tracking mechanisms to track where and how money is spend, how effectively and with which outcomes must play a role in increasing accountability and reducing health inequalities. Data collection should track not only service users but those who are excluded from accessing services. Consultation with service users as part of performance management and programme evaluation should be promoted as a donor requirement.

5. How can we improve the realisation of women’s rights and women and girls’ empowerment?
Which aspects of promoting women’s rights, empowerment, and choice should we prioritise to help increase access to reproductive, maternal and newborn health?

You might like to consider the following options:

- Political commitment to girls’ and women’s health at all levels
- Girls’ education, including post-primary
- Women’s economic empowerment (income and employment opportunities)
- Legal frameworks for girls’ and women’s rights
- Reducing violence against girls and women
- Girls’ and women’s participation and organisation for their own and their babies’ health
- Social change (social norms, attitudes and practices that drive girls’ and women’s control over resources and own body)

Your response:

PSN fully agrees with the importance of integrating work to promote women’s empowerment with sexual and reproductive health initiatives and believes that all of the options listed have a role to play. A rights-based approach to sexual and reproductive health would support this integration, including a focus on gender inequalities and other social inequalities that undermine the right to health, including lack of education, information and political commitment. Further suggestions regarding rights-based approaches are included in our response to Question 4, including participatory work with local women’s groups which can increase the capacity of local communities to secure access to services and address rights violations. Commissioning local women’s and community groups is also a valuable way of effecting social change to address the social norms and beliefs that reduce women’s autonomy and ability to negotiate safe and consensual sex, including issues relating to gender based violence. It is of course critical that any programmes to address gender inequalities and promote social change work and effectively engage with men.

A gendered approach necessitates the consideration of the gendered implications of any intervention, at all stages of programme design and delivery. For example, the current focus on promoting male circumcision to reduce HIV transmission may also reduce women’s ability to negotiate use of condoms (which circumcised men may feel are less necessary). Yet this consideration has been neglected. This example demonstrates the importance of holistic interventions, and in this instance the need for circumcision programmes to incorporate information, education and women’s empowerment programmes that emphasise the continued need to practice safe and consensual sex. The full participation of women in service design and delivery can be supported through local women’s groups and we would encourage the promotion of service-user consultation through funding streams.

We agree that increasing economic opportunities for women is an important aspect of promoting empowerment, and point to the highly effective role that microcredit schemes can play in reducing poverty (Leatherman and Dunford, 2010). Microcredit
schemes are also known to bring health improvements, especially when integrated with health education programmes such as those discussed in Question 5.

6. Which neglected and sensitive issues should we focus on?

We believe DFID has comparative advantage in tackling neglected and sensitive issues. Which neglected and sensitive issues should we prioritise in our work?

You might like to consider the following options:

- Improving adolescents’ sexual and reproductive health and rights
- Delaying age at first pregnancy
- Improving access to safe abortion services
- Reducing violence against girls and women
- Addressing female genital mutilation/cutting
- Addressing obstetric fistula

Your response:

PSN agrees that DFID is extremely well placed to tackle sensitive issues such as those listed, that contribute significantly to inequalities in sexual and reproductive health yet which are neglected by governments and other donors. Very often these issues relate to cultural and religious beliefs and practices that drive violations of women and girls’ rights, such as many of those listed. In addition to these issues to which we will turn, there is a pressing need for the issue of rapid population growth in the global South to be recognised as a sensitive issue, for which reason key sectors have been reluctant to give it urgently needed attention. DFID could help here by using its credibility and supporting communication approaches that make the issue easier to discuss openly. This issue is one that relates strongly to reproductive and sexual health and rights yet is neglected to an even greater extent both within the reproductive health field and the wider development field.

The link between population dynamics, poverty and reproductive health and rights is a sensitive and neglected issue that should command urgent attention. Population dynamics are linked to key determinants of poverty including health, nutrition, education, gender, and significantly, economic development. Over the past few decades, rapid population growth has been associated with high levels of poverty (De Souza, 2006). Countries with rapid population growth tend to have the highest incidence of poverty and lowest levels of human development. As high birth rates are maintained and populations grow, there is increasing pressure on national resources and social services. In poor countries, fewer resources are available, which can diminish access to and quality of basic health care, education and sanitation as well as hinder progress in human development. Within large households, incomes must be spread amongst several members, limiting funds for
basic services, human capital development (especially for girls and women) as well as monetary savings. Increasing pressures on natural resources are also heightening vulnerability to climate change and inhibiting adaptation initiatives. For these reasons, and others, population growth in the global South is undermining poverty alleviation, at the same time as increasing the costs and difficulties of achieving the Millennium Development Goals. Education is a case in point; some countries are faced with the challenge of finding 30,000 teachers every year if class sizes are to remain constant.

While discussing population issues is imperative for reducing poverty and promoting sustainable development, and voluntary family planning programmes must play a key role in reducing fertility rates by preventing unplanned pregnancies, the complexity and sensitivity of these issues mean that they are often ignored. This is partly due to the historical legacy of the mistakes of the coercive ‘population control’ programmes in the 1960s. It is also due to the fact that 95% of global population growth is taking place in the global South, and yet the pressures population growth places on the natural environment in developing countries are being exacerbated by climate change, which is driven predominantly by industrialised countries in the North. With world population, currently at 6.9 billion, projected to surpass 9 billion people by 2050 (UNDESA, 2009), there is an urgent need to address the silence over population issues, and DFID has a key opportunity to do so through an integrated reproductive health strategy. DFID is particularly well placed to demonstrate to the world that concern about global population growth is not incompatible with respecting and protecting human rights; indeed intensifying efforts to secure universal access to sexual and reproductive health and rights is an effective way to advance and uphold these rights, provided that they are respected in the way that services are designed and offered.

Addressing the unmet need for contraception that exists in developing countries by promoting universal access to family planning is necessary to prevent unplanned pregnancies and reduce population growth. A rights-based reproductive health strategy from DFID is ideally placed do this, by overcoming what is a neglected and sensitive issue through the promotion of rights and choice, while giving the citizens of developing countries what they want and need. We therefore strongly encourage DFID to integrate into the policy consideration of population issues, drawing the links between population and reproductive health and rights, as well as other development priorities for which consideration of population dynamics, while complex and at times controversial, is critical. Opportunities to promote the integration of reproductive health and population programmes with other development agendas exist within policy, programmes and funding streams. We include specific suggestions in our responses to questions below.

There are case studies that provide successful examples of the benefits that integrated population and reproductive health programmes can bring - including poverty alleviation, increased environmental sustainability and the realisation of reproductive health and rights. The island state of Madagascar has one of the fastest growing populations in the world, high rates of maternal mortality, and only one in five women in a sexual relationship have access to contraception. Population growth is exacerbating depletion of the natural marine environment upon which the population depends for livelihoods and food security. It is also heightening vulnerability to climate change. A programme in Madagascar is addressing the unmet need for family planning at the same time as promoting management of the natural marine environment, thereby reducing poverty and vulnerability to climate change. The Mobile Health Clinics in Kenya discussed also provide examples of the benefits that family planning can bring for environmental management and poverty alleviation. In Kenya, where fertility and maternal and child mortality levels are high, these clinics
are promoting reproductive health and reducing unplanned pregnancies in remote and fragile environments where population growth is putting great pressure on natural resources. Further information about these projects is available on our website at: http://www.populationandsustainability.org/46/model-projects/model-projects.html

DFID should take a leadership role in promoting a comprehensive and rights-based approach to sexual and reproductive health that includes a strong focus on sensitive issues including access to contraceptive choices, safe and legal abortion and sex education. Promotion of safe and legal abortion is a highly neglected issue that we believe DFID should prioritise, given that, since the technology to perform most abortions safely exists, these deaths should be identified as human rights violations, since they are, for the most part, preventable. This approach should encompass action to encourage legalisation of abortion in countries where it is illegal or restricted, while working to ensure effective post-abortion care for women who have undergone unsafe abortions. Support and funding could be provided to women’s groups and other organisations campaigning for legal reform. Work with health workers, to address discriminatory and judgemental attitudes that can present a barrier to women receiving appropriate care, could also be a focus. In some countries that rely more heavily on surgical abortion it is also necessary to address the lack of access to medical abortion.

Sex and reproductive health education is a neglected yet critical aspect of sexual and reproductive health for empowering individuals, and particularly young people and women, to realise their right to health. The promotion of comprehensive sex education and sexual health programmes should be integrated with general education programmes. There is also a need to work to address religious barriers to sex education. Sex education and discussion about contraceptive choices should be integrated into the continuum of care, to seize the opportunities that exist to offer information to pregnant and postnatal women and women accessing abortion-related care while they are accessing other services.

We support a comprehensive approach to tackling violence against women and obstetric fistula, which requires addressing harmful cultural and sometimes traditional practices such as child marriage and FGM. These practices, as well as representing violations of women’s rights are also causes of fistula. We fully support action by DFID to both prevent and treat obstetric fistula, a condition that can be treated with a relatively high degree of success, but often goes without treatment with both physical and social lifelong consequences for women. An example of a successful project succeeding in both preventing and responding to fistula in Nigeria, supported by FORWARD, is available at: http://www.forwarduk.org.uk/what-we-do/african-programmes/nigeria

Issues associated with infertility and miscarriage are extremely neglected within the sexual and reproductive health promotion. This includes both clinical treatment for men and women experiencing fertility problems, and support to address the psychosocial implications, including those resulting from social attitudes which cause social ostracisation and blame of childless women. An estimated one in four ever-married women of reproductive age in most developing countries are infertile (ORC MACRO & WHO, 2004) and we encourage DFID to tackle the neglect of this issue. Attention to infertility issues is also valuable when increasing investment in family planning services, to emphasize that the constellation of services is about extending choice.
The need to increase access to a wide range of contraceptive choices is also a neglected issue within family planning. Please refer to Question 2 for further discussion and suggestions about this point.

7. How can we deliver better results through multilateral aid?

How can we deliver better results through multilateral aid?

Taking into account the list in the background information provided, who do you think DFID/UK should work with to improve reproductive, maternal and newborn health? Please give reasons for the organisations you have chosen.

Your response:

In Questions 1, 3 and 6 we have highlighted that population dynamics, such as rapid growth, high fertility levels, or high density, are often associated with poverty. For this reason including family planning and reproductive health in poverty reduction strategies would therefore maximise outcomes. We encourage DFID to provide effective leadership in the promotion of integrated family planning and poverty reduction strategies, which would help to achieve better results through multilateral aid.

DFID should encourage greater cross-sector cooperation on family planning and poverty reduction issues, to promote integrated strategies and increase understanding of the links between population dynamics (including migration, urbanisation and ageing as well as population growth) and poverty. This includes working and expanding partnerships with development, environment and health organisations, and governmental and non-governmental actors.

In addition to work with governments, DFID could demonstrate its commitment to maximize civil society engagement in international development work by promoting cross-sector cooperation and collaborative mechanisms to integrate family planning and poverty reduction strategies. Potential partners include:

- UNEP
Integrated projects and multi-sectoral collaboration offer the scope to increase aid effectiveness by linking a range of connected issues and should be promoted through flexible funding streams. Funding ‘silos’ on single issues present a barrier to an integrated approach. Funding streams should therefore encourage joint up, cross-sector thinking and planning on population dynamics and the implications for health, education and environmental sectors for example. An example project in Madagascar that integrates voluntary family planning with environmental conservation and poverty alleviation is provided in our response to Question 6 above. Funding streams need to be innovative and flexible enough to encompass multi-dimensional projects such as these; DFID could play an important leadership role in ensuring that, for example, climate change adaptation funding mechanisms identify family planning as being among a range of eligible strategies facilitating country efforts to adapt to the effects of climate change.

Developing countries which are characterised by rapid population growth and high vulnerability to climate change should be supported to integrate family planning into their adaptation programmes. Population growth has been identified as a factor contributing to climate change vulnerability in many countries. Increasing access to family planning offers opportunities to reduce vulnerability to climate change, and we encourage DFID to seize the opportunities that exist within the climate change agenda to increase awareness of and promote this strategy within climate change adaptation efforts. At the national level, incorporating this demographic perspective will require the integration of voluntary, rights-based family planning programmes into adaptation efforts, hence making climate change a priority that must be shared by departments of health as well as environmental ministries. Further explanation of the links between climate change, population dynamics and reproductive health is provided in Question 3.

Better results could be achieved through multilateral aid by making user involvement a requirement within funding provision to governments. Funding requirements could also encourage governments to form partnerships with local NGOs with proven track record of effective service delivery. This could promote accountability to the local population and help ensure services reflect local needs and priorities. Please refer to Question 4 where we have highlighted the potential that working with women’s groups offers to increase local participation and promote effective interventions at the local level.
8. How should we work with private and other non-state actors?

How should we work with private and other non-state actors more to deliver successful reproductive, maternal and newborn health outcomes?

For instance, who should we target to work with, what more could we do at global and country level, and how could we go about building better links and relationships?

Your response:

Please refer to our response to Question 7 in which we have highlighted the need to work with a range of multi-sector and governmental and non-government actors in order to promote integrated reproductive health and poverty alleviation strategies. We have also suggested how this can be done, including through promoting collaboration through integrated and flexible funding streams.

In our response to both Question 7 and 4 we have suggested increased funding and support provision to local organisations that have a proven track record for effective service delivery to the local population. This includes local women’s groups that have great capacity for innovative service delivery responsive to community needs. These groups often lose out to larger, sometimes international, organisations.

We agree that public-private partnerships can offer opportunities to increase access to sexual and reproductive health services, strengthen health systems and contribute to capacity building of local service providers. It is important that these models work with organisations that have a proven track record of high quality service delivery, are fully transparent to the local population and use performance tracking mechanisms that incorporate involvement of service users. To provide an effective means of addressing health inequalities it is critical that these partnerships uphold service delivery that is free at the point of delivery for those groups who would otherwise be unable to access services.

9. What are optimal models of service delivery for delivering reproductive, maternal and newborn health outcomes?
What can we learn from experience in delivering reproductive, maternal and newborn health outcomes around the world?

We think some of the lessons include the need to:

- Integrate health services that provide high-impact, cost effective interventions across the continuum of care
- Ensure health workers, including midwives and community health workers are trained, deployed, managed and supervised
- Improve commodity security – getting supplies in the right place at the right time and making drugs available and affordable on the market
- Invest in national and district health systems to deliver clinical and outreach/community services
- Work with private and other non-state providers, including non-governmental organisations, to deliver improved reproductive, maternal and newborn health outcomes

Your response:

We agree that the lessons above offer opportunities to improve reproductive, maternal and newborn health outcomes through service improvements. In our responses to other questions we have provided some information about useful, innovative models of service delivery. These include:

- **Innovative community-based models of service provision that can increase access to services in remote and rural areas, including partnerships between health workers and non-governmental organisations** – please see the example provided in Question 4 and 6 of Mobile Health Clinics in Kenya.

- **The capacity for local women’s organisations to contribute to rights-based awareness and improve health outcomes, encompassing non-medical, community based models of service provision** – see Question 4 and 7.

- **The benefits of focusing on increasing access to a wide range of contraceptives, including long-acting methods** – see example of Nepal in Question 4.

- **Models of service provision that integrate family planning with poverty reduction and environmental management strategies** – see the example of Madagascar in Question 6.

- **Microcredit schemes that are integrated with health education programmes** - see Question 4.

- **Task shifting** – see Question 4 for examples of the use of task shifting to increase access to contraception and improve other reproductive health outcomes at the same time as saving costs.
We also point to the need for models of service provision that are free at the point of delivery. The improvements in health outcomes that this can bring are demonstrated through DFID’s own support to Nepal in order to increase access to skilled attendance at birth. By paying transport costs to allow poor communities to access services, this case study also shows the benefits of reducing other barriers presented by costs (DFID, 2010). Information about free at the point of delivery services in Nepal supported by DFID was found at: http://www.dfid.gov.uk/Media-Room/News-Stories/2010/MDGs-in-focus-Maternal-health-in-Nepal/

Better integration of reproductive health services with HIV/AIDS programmes offers significant opportunities to increase efficiency and improve reproductive health outcomes.

10. How should we work in fragile and conflict affected states and humanitarian situations?

How should we work in fragile and conflict affected states? Are there particular interventions and issues we should be focusing on?

Should reproductive, maternal and newborn health be better included as part of the response to rapid onset emergencies?

You might like to consider the following options:

- Working bilaterally to strengthen national health systems if possible and as appropriate in fragile states
- Working through non-state actors to deliver reproductive, maternal and newborn health services, information and supplies
- Work through multilateral channels to deliver improved reproductive, maternal and newborn health outcomes
- Strengthening the humanitarian cluster system to deliver coordinated reproductive, maternal and newborn health services
- Include reproductive, maternal and newborn health as part of a response to rapid onset emergencies
- Are there other ways in which we could be working?

Your response:
PSN supports the prioritisation of fragile states for reproductive health interventions, including the need to integrate reproductive health into response to rapid onset emergencies. High rates of population growth can contribute to the potential for civil conflict, where they involve pressure on limited land or water resources, mass migration and high rates of youth employment. Of the top 20 failing states 17 have populations increasing at close to 3% a year (20-fold per century). In five of these 17 countries, women have an average of nearly seven children each (APPG on Population, Development and Reproductive Health, 2009). Given the links between high fertility, poor reproductive health outcomes and civil conflict, increasing access to voluntary family planning should be prioritised in conflict-prone countries. This is exemplified by the case study we provided in our response to Question 3 of population pressures exacerbating the conflict situation in Somalia.

Flexible, low-tech non-medical models of service delivery offer opportunities to increase access to reproductive health services, including voluntary family planning, in conflict-affected areas. An example is provided by the Mobile Health Clinics in Kenya discussed in Question 4 and 6. We also point to the need to integrate reproductive health interventions with response to gender based violence.

We would like to draw your attention to the following resource which contains a variety of good practice case studies of reproductive health services delivery by governmental and private organisations to displaced and conflict-affected populations in Sierra Leone, Colombia, Angola, Thailand and Liberia:


We also recommend the various resources by the Inter-agency Working Group on Reproductive Health in Crises, available at: http://www.iawg.net/

11. What should we support in terms of knowledge, research and innovation?

What are the key gaps in the global knowledge about how to improve reproductive, maternal and newborn health, and which should we seek to fill?

How can we ensure that high quality research, already conducted, is then effectively translated into policies and practices?
You might like to consider the following options:

- Continue to provide funding for high quality research to improve reproductive, maternal and newborn health programmes, along with implementation or operational research to ensure findings are effectively translated into front-line programmes
- Invest in data and information systems for registering births and deaths and for tracking results in developing countries
- Support innovation and development of reproductive health commodities, including family planning methods
- Improve the way that research findings are used and translated into policy and practice

Your response:

We have already highlighted (see Questions 1, 3, 6 and 7) the links that exist between population growth and other development priorities such as poverty alleviation and climate change. These links point to the need for integrated reproductive health and poverty strategies. Further research to clarify the exact relationships between population dynamics such as migration and urbanisation to climate change and poverty would be highly beneficial to inform these strategies. The identification of case studies demonstrating innovative projects integrating family planning with poverty alleviation and environmental management programmes, including adaptation to climate change, should also be prioritised. These case studies would help demonstrate and increase awareness of the wider economic, environmental and social benefits of investing in sexual and reproductive health and rights.

We would also recommend further investment in research to identify and develop further contraceptive methods, and effective models of service delivery for their promotion, particularly those that empower women and address other barriers to ensuring universal access to voluntary family planning. Further information about the need for a range of contraceptive methods in our response to Question 2.

12. If we could do only one thing to improve reproductive, maternal and newborn health outcomes, what should it be and why?

Your response:
In our response to Question 2 we have outlined why prioritisation of action to address the unmet demand for voluntary family planning (including a wide choice of contraceptive methods and access to safe and legal abortion), through rights-based approaches is a cost-effective strategy for promoting reproductive health. For this reason we strongly encourage DFID to promote this strategy to both finance and planning ministries in individual countries and to major multilateral funding institutions. Collectively these bodies have the power at the national and international levels to deliver the necessary policies and budgets to implement this strategy that has the potential to bring great progress towards achieving universal reproductive health, and the other MDGs.

To summarise and provide example messages for advocacy about the prioritisation of action to address the unmet demand for family planning an effective strategy:

- **There is a large unmet demand for family planning** - an estimated 215 million women worldwide who want to avoid pregnancy but do not have access to contraception and an estimated 40% of all pregnancies worldwide are unplanned. In many West African countries, including Niger and Nigeria, less than 10% of all married women are using modern contraception. Far greater investment in family planning is required, and would be highly cost-effective.

- **Family planning is extremely cost-effective and reduces the costs and difficulties of meeting the other MDGs.** For every dollar spent in family planning, between 2 and 6 dollars can be saved in interventions aimed at achieving other development goals (Moreland et al., 2006). Lower fertility results in reduced demand for services resulting from lower fertility, and brings additional cost savings and social and economic benefits by averting high risk pregnancies and the associated maternal and infant mortality and morbidities.

- **Increasing access to contraception is an extremely effective way of improving overall sexual and reproductive health incomes and realising basic human rights.** Including: reductions in maternal and infant mortality and morbidity, reductions in HIV transmission and unsafe abortions.

- **Increasing access to voluntary family planning, through reducing fertility rates will contribute to poverty alleviation, more sustainable use of natural resources and reduce vulnerability to climate change.** This makes achievement of all other Millennium Development Goals less costly and more attainable.

References


(Mobile Clinics Africa (date unknown). Website: http://www.mobileclinicsafrica.org/


Background information for question one

The key areas:

Unmet need for family planning
215 million women in the developing world who would like to delay or avoid pregnancy do not have access to modern family planning methods. Each year there are 75 million unintended pregnancies. One-third of all maternal deaths each year could be averted if women wishing to space or limit their childbearing used modern methods of family planning. It is estimated that meeting the need for family planning could also avert 20% of newborn deaths.

Adolescent fertility
The decline in the adolescent fertility rate in all developing regions has been very slow. Despite recent gains in access to contraceptive services, young women’s unmet need for modern family planning services is double that of older women. This unmet need is likely to grow as the world’s adolescents, of whom there are more than ever before, are about to enter their reproductive age. The risk of dying in pregnancy and childbirth for those aged 15-19 is twice that of those in their twenties. Girls under 15 are five times more likely to die.

Unsafe abortion
Failing to prevent unintended pregnancy leads some women and girls to seek an abortion. Every year 19% (35 million) of all pregnancies in the developing world end in induced abortion. The data are difficult to track but an estimated 20 million of these abortions are conducted under unsafe circumstances and result in up to 70,000 maternal deaths each year. An estimated 8 million women need medical treatment for complications following unsafe procedures each year but only 5 million receive that care.

Antenatal care
Antenatal care is crucial to help to detect and manage the health problems that can occur during pregnancy – whether the complications, diseases or unhealthy lifestyles that affect the pregnancy. If left unchecked, some of these may threaten health and survival of mothers and their babies. A substantial proportion of maternal deaths occur during pregnancy.

Skilled attendance at delivery
Quality professional care during and immediately after labour and birth can make the difference between life and death for both mothers and their babies, as some complications are largely unpredictable and may rapidly become life-threatening. Both maternal and newborn mortality are lower in countries where the majority of births take place with midwives, backed-up with access to a functioning referral chain and with the equipment, drugs and other supplies needed for the effective and timely management of complications. Indeed, quality care for normal births may happen at home or in a health facility if there is a skilled provider in attendance and ready availability of higher level care in the event of complications.

Emergency obstetric and newborn care
Ideally, as part of an integrated primary healthcare system, every birth, whether it takes place at home or in a facility, should be attended by a skilled birth attendant, backed up by facilities that can provide emergency obstetric care and essential newborn care and by a functioning referral system that ensures timely access to the appropriate level of services in case of a life-threatening complications.

Newborn deaths
The survival chances and wellbeing of newborn babies are intrinsically linked to the health and wellbeing of their mothers. Newborn survival is a crucial component for achieving MDG 4 to reduce child mortality. More than 3.5 million newborn deaths (accounting for more than 40% of deaths to children under 5 years of age) occur in the first month of life – up to 45% of these in the first 24 hours. Good newborn care starts before birth, by ensuring pregnant women are well nourished and receive quality antenatal care, including interventions such as tetanus immunizations. Safe delivery is essential for their survival as is effective post natal care which includes
early breastfeeding and approaches like Kangeroo care where babies are kept close to their mothers.

**Prevention of mother to child transmission of HIV**

HIV infection transmitted from an HIV-positive mother to her child during pregnancy, labour, delivery or breastfeeding is known as mother-to-child transmission (MTCT). Almost half of the 33 million people living with HIV are women of reproductive age. More than 2 million HIV positive women across the world are pregnant each year, over 90% of them live in developing countries. HIV infection and AIDS related deaths have become major causes of maternal mortality in many developing countries. Mother-to-child transmission accounted for an estimated 430,000 new HIV infections in babies in 2008. Without intervention, the risk of mother-to-child transmission ranges from 20% to 45%.

**Nutrition**

An individual woman’s risk of illness, injury or death during pregnancy or childbirth is in part determined by her overall health status, including nutrition. There is strong evidence that nutritional status during the period from pre-pregnancy through to 24 months after the birth is important not only for women’s own health and productivity, but also that of their young children. Where undernutrition is a problem, this should form a key part of pre-pregnancy and maternity care, along with other effective interventions, such as cash transfers and good water and sanitation.

**Malaria in pregnancy**

The most recent estimates suggest that there are 125 million pregnancies at risk of malaria and of these more than 30 million are in sub Saharan Africa. Malaria during pregnancy can lead to negative health consequences for the mother, for the outcome of pregnancy and for the health of the newborn.

**Background information for question two**

We know that no single intervention can reduce all causes of maternal and newborn deaths. In the Consensus for Maternal, Newborn and Child Health, the evidence shows that packages of high-impact, cost-effective interventions are needed across a ‘continuum of care’ from before pregnancy, during pregnancy and childbirth, then immediately after birth and toward care in childhood.\(^1\) Interventions include family planning, safe abortion, antenatal care, skilled attendance at birth, post-partum care and newborn care.

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Health interventions are most effectively and efficiently delivered when integrated into existing health service delivery packages along the continuum of care for women, newborns and children. Scaling-up coverage of health service packages depends on functioning health systems.

A health system consists not only of clinics, hospitals, doctors, nurses and midwives, but also the systems to procure drugs and supplies, to assure quality of care to finance the health system and pay health workers, and many other governance functions, including good data collection, management and use.

Lack of skilled health workers in the right place at the right time is a major challenge to the provision of quality reproductive, maternal and newborn health services. The global shortfall in trained professional health workers is more than 4 million. Health professionals with midwifery skills are the essential ingredients in the system for providing skilled care, particularly at birth. There is strong evidence that the availability of health personnel is directly linked to positive health outcomes. Health workers also need access to functioning referral chains and reliable supplies of essential drugs, medical supplies and other health commodities to save lives.

**Background information for question three**

DFID is currently reviewing its bilateral aid programme to determine how and where we can achieve better value for money for the taxpayer and accelerate progress towards the Millennium Development Goals. The outcome of the review will inform the development of our new Reproductive, maternal and newborn Health Business Plan.

Although family planning is a cost-effective intervention and provides good value for money, progress in meeting the unmet need for modern and effective family planning methods has been slow, especially in Africa and Asia where the unmet need is greatest.

The difference in the lifetime risk of maternal mortality between developed and developing nations is the largest of any health indicator. The chances of dying from maternal causes over a woman’s lifetime is 1 in 7 in Niger compared to 1 in 8,200 in the UK.

There are also substantial differences between and within developing countries in the ability of women to access quality care at the time of birth. The poorest women in all countries are those least likely to have skilled attendance at delivery.
Like maternal deaths, nearly all neonatal deaths occur in low- and middle-income countries. The rate of reduction of neonatal mortality has been much slower than the rate of overall under-five mortality. Numbers of deaths vary widely across regions, with most deaths recorded in Africa and southeast Asia. India, Nigeria, Democratic Republic of the Congo, Pakistan, and China have around half of global totals for neonatal causes of death.

We think we should focus our efforts in high burden countries. High burden can be defined both in terms of absolute numbers or in terms of relative risk of death. For example, India accounts for 20% of all maternal deaths and a woman in India has a 1 in 70 lifetime risk of dying as a result of pregnancy and childbirth. Sierra Leone has lower numbers of maternal deaths, with 1% of global maternal deaths, but a much higher risk rate. A woman in Sierra Leone has a 1 in 8 lifetime risk of dying as a result of pregnancy and childbirth.

Background information for question four

There are huge and persistent inequalities in reproductive, maternal and newborn health within developing countries, including between different socio-economic groups, different geographical areas (remote/rural/urban), different ages (eg adolescents) and marginalised groups such as those living with HIV.

In many developing countries, women in the top income bracket are twice as likely as the poorest women to use modern contraceptives. Poor women are more likely to have unintended pregnancies. The poorest women are almost three times less likely to have skilled care at delivery and up to six times more likely to die during pregnancy and childbirth than richer women.

Despite recent gains in access to contraceptive services, young women’s unmet need for modern family planning services is double that of older women. Girls aged 15-19 are twice as likely to die in pregnancy and childbirth than women in their twenties – and girls under 15 are five times more likely to die. Because of the many problems that adolescent girls face in trying to protect themselves against unwanted pregnancies, a disproportionate number of abortions occur in this age group.

Background information for question five
Achieving MDG 5 is more than a matter of health services. Women’s lack of control over their own sexuality and fertility and their poor access to reproductive health services is closely linked to a general lack of respect for women’s rights, including their right to health.

The slow progress in reproductive, maternal and newborn health is underpinned by the many burdens of gender discrimination, poverty and lack of economic opportunities, lack of education and other forms of exclusion that prevent women in poor countries from exercising their right to health. Social norms and practices can constrain girls’ and women’s ability to make choices over resources and their own bodies. There is growing evidence of the consequences of violence on girls’ and women’s reproductive health, including unintended pregnancies and HIV infection.

The level of educational attainment of girls and women is a significant determinant of fertility and health through pregnancy and childbirth. Completion of secondary education by girls - more so than primary completion - has a strong positive effect on women’s empowerment and is associated with higher age of marriage, lower fertility and mortality, better maternal care, and reduced vulnerability to HIV and AIDS.

Gender equality is both an aim and a determinant of reproductive, maternal and newborn health. Giving women the ability to make choices about if and when to become pregnant makes a vital contribution to their empowerment, both socially and economically.

**Background information for question six**

**Sexual and Reproductive Health and Rights (SRHR)**

The UK is fully committed to the 1994 International Conference on Population and Development (ICPD), which agreed that human rights and gender equality should guide population and development policy, including protection of the environment. This includes the respect for reproductive rights and provision of universal access to sexual and reproductive health services, including family planning.

**Women’s sexual and reproductive choices**

Women and adolescent girls should be empowered and enabled to have sexual and reproductive choices; to avoid unwanted sexual contact, injury and infection; to make informed decisions about childbearing; and to face fewer risks in the course of pregnancy and childbirth. But millions of women still do not have access to good quality contraceptives, or have no control over the circumstances in which they become pregnant.

**Adolescents’ sexual and reproductive health and rights**
Pregnancy among adolescents aged 15-19 years of age has fallen since 1990 in all developing regions, but this has been very slow. This highlights living situations that are not conducive to good reproductive health, including powerlessness and early marriage. Despite recent gains in access to contraceptive services, young women’s unmet need for contraception is double that of older women. Much of the slow progress in reduction of adolescent births is due to unmet need for contraception. Girls aged 15-20 are twice as likely to die in childbirth as those in their twenties, while girls under the age of 15 are five times more likely to die in childbirth.

Unsafe abortion
70,000 women die as a result of unsafe abortion every year; many more are permanently injured. Lowering abortion related maternal death is a key way to reduce overall maternal mortality given that nearly all maternal deaths from unsafe abortion are preventable. On top of this there is strong evidence of the high cost that unsafe abortion and post-abortion complications impose upon health services, women and their families.

Safe abortion
There are two main reasons for supporting safe abortion. First, it is a choice. Women should be in control of their reproductive health choices. Adolescents, unmarried girls and women who live in poverty, sparsely populated areas or vulnerable circumstances (such as refugees or internally displaced people) are at higher risk of unsafe abortion. Second, it is necessary. About 19% of pregnancies globally end in induced abortion; unsafe abortion accounts for 13% of all maternal deaths. Five million women every year receive care in health facilities due to serious health complications resulting from unsafe abortion. A further three million receive no care. This preventable mortality and ill-health due to unsafe abortion seriously undermines countries' abilities to improve maternal health and places a high burden on already over-stretched health systems.

But, in accordance with the Programme of Action of the International Conference on Population and Development, abortion should not be promoted as a method of family planning. In countries where it is legal, we support programmes that make safe abortion more accessible. In countries where it is illegal and mortality and morbidity are high, we help make the consequences of unsafe abortion more widely understood, and consider supporting processes of legal and policy reform.

Violence against women
Violence against women by a partner is a global public health problem and a human rights violation directly linked to women’s lack of status and power. Intimate partner violence in many settings increases during pregnancy, and can have damaging, even fatal consequences for the health of the woman and her baby. Women who are physically abused in pregnancy are more likely to suffer miscarriage or seek induced abortion and the violent partner is more likely to have multiple sexual relationships, so increasing the risk of HIV and other sexually transmitted infections.

Female Genital Mutilation/Cutting
Female genital mutilation/cutting (FGM/C) is a human rights and a health issue for both mothers and babies. While it has been known for decades that it causes severe pain and can result in prolonged bleeding, infection, infertility and even death, a 2006 landmark WHO study provided clear evidence that complications in deliveries are significantly more likely among women with female genital mutilation/cutting. It also found that female genital mutilation/cutting is harmful to babies: it leads to an extra one to two deaths per 100 deliveries.

Obstetric Fistula
Obstetric fistula is a largely neglected reproductive health concern in the developing world, despite the devastating impact on the lives of girls and women. It has remained a hidden condition largely due to the fact that it affects some of the most marginalized members of the population - poor, young, illiterate girls and women in remote regions. Obstetric fistula is a hole that occurs as a result of prolonged and obstructed labour, which leads to incontinence. It is an injury that leaves women and girls leaking urine or faeces from the vagina, usually uncontrollably. WHO estimates that more than two million women are living with fistula in developing countries; an additional 50,000 to 100,000 new cases occur each year.

Obstetric fistula is preventable and treatable - through ensuring access to adequate health care for all pregnant women and emergency obstetric care for those who develop complications in childbirth.

Background information for question seven

DFID is currently reviewing its multilateral aid programme to determine how we can achieve better value for money for the taxpayer and accelerate progress towards the Millennium Development Goals. The outcome of the review will inform the development of our new Reproductive, maternal and newborn Health Business Plan.
DFID currently supports work to improve reproductive, maternal and newborn health in the developing world through the following multilateral organisations:

- European Commission (EC)
- United Nations Population Fund (UNFPA)
- United Nations Children’s Fund (UNICEF)
- The Joint United Nations Programme on HIV/AIDS (UNAIDS)
- World Bank
- World Health Organization (WHO)
- Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM)
- UNITAID

Background information for question eight

In the vast majority of developing countries, the non-state sector already serves between 30 and 80% of poor women seeking healthcare. Non-state actors include private for-profit companies and a wider range of informal for-profit health care providers. Other non-state actors include non-profit organisations such as non-governmental organisations (NGOs), faith-based organisations and community-based organisations.

The private sector and other non-state actors represent an important source of health care for all socio-economic groups, including the poorest. However, poor people are more likely to use lower quality services and commodities. The lack of regulation of health services, medication, contraceptives and other health commodities is often a concern.

In some settings, the NGO sector is very active in providing not for profit services. This is often to fill a gap in service provision due to neglect of; a certain service (e.g. abortion/sexual and reproductive health); certain geographical locations (e.g. remote rural communities); or certain groups (e.g. adolescents or sex workers). In some fragile states NGOs work to bridge the gaps left by the breakdown of government-run services.

Civil society organisations play an important role in reaching the poorest and marginalised, promoting empowerment and social change, and in enhancing accountability in health.

Whether provided as budget support, bilateral support or multilateral grants, the vast majority of DFID funding for health is currently channelled to public sector health services. The case for the public sector role in health is clear: the nature of health care means it cannot be left entirely to the market; the state needs to be involved in order to protect the public, avoid excessive costs and reach the poor.
Internationally, there is consensus on the need for regulation of the private and non-state sector, but less agreement on how far private providers should be expected to contribute to health care for the poor in the medium term.

**Background information for question nine**

As presented elsewhere in this consultation, no single intervention can reduce unwanted pregnancies or reduce maternal mortality. Reproductive, maternal and newborn health interventions need to be embedded in functioning health systems for the improvement of health and reduction of mortality. This includes integrating interventions to tackle HIV and AIDS, malaria and other major diseases. For example, using field or community workers to deliver bednets combined with other tasks such as assessing a newborn or child for illness and even offering treatment close to home, could be a way of delivering improved reproductive, maternal and newborn health outcomes.

**Background information for question ten**

DFID/UK Government is currently reviewing its Humanitarian Response work to determine how and where we can achieve better value for money for the taxpayer and accelerate progress towards the Millennium Development Goals. The outcome of the review will inform the development of our new Reproductive, maternal and newborn Health Business Plan.

Many of the countries that have poor reproductive health outcomes and particularly high rates of maternal and newborn death are currently, or have been recently, affected by conflict. For example, in Afghanistan and Sierra Leone the lifetime risk of a woman dying from complications during pregnancy and childbirth is 1 in 8 – compared with 1 in 8,200 in the UK.

Women in situations of extreme threat and insecurity still have reproductive, maternal and newborn health needs. We need to consider whether we can do more to support better reproductive, maternal and newborn health outcomes.

**Background information for question eleven**

Reproductive, maternal and newborn health programmes need to be evidence-based to ensure the best outcomes for all. Data and information management systems play a critical role in providing health systems managers and governments with the knowledge they need to improve and invest in health services. Ultimately, this information should ensure that
reproductive, maternal and newborn health services respond to the needs of the population. This depends on the skills and capacity of health workers at health facilities at every level of the health system as well as of researchers, statisticians and data collectors in national, academic and other stakeholder agencies. There is an urgent need to strengthen this skill base in developing countries and to ensure that high quality research is translated into policy and practice.

DFID has funded a range of research programmes on reproductive, maternal and newborn health, including a new Research Programme Consortium (RPC) to collate evidence and assess the reasons for the high unmet need of family planning and safe abortion services.

Thank you for your contributions.