Submission to AusAID Aid Effectiveness Review
Maternal Health

This submission has been prepared by **Burnet Institute, CARE Australia, International Women's Development Agency and Marie Stopes International Australia** who formed a Maternal Health Reference Group in 2010 to actively engage with and monitor the Australian Government's renewed commitments to maternal health. This submission will specifically look at the sectoral focus of the aid program as it relates to maternal health[1].

The Australian Government's $225 million commitment (September 2010) to improve reproductive, maternal and newborn health in Africa and the Pacific is timely. Ten years on from the Millennium Declaration of 2000, it is well recognised that MDG 5 - Improve Maternal Health – is the MDG towards which least progress has been made. It is unlikely that the majority of developing countries will be able to ensure universal access to reproductive health care and reduce their maternal mortality ratio by three quarters by 2015. Every year, more than 350 000 women, 99 percent of whom live in the developing world, still die needlessly from complications of pregnancy and childbirth, and ten million more suffer ongoing illness and disability.

Although the causes of maternal deaths, and the interventions required to prevent them, are well known, the reasons why women continue to die are complex. The low status of women and girls, poverty, limited educational opportunities, early marriage and pregnancy, poor nutrition, violence against women, lack of autonomy over sexual and reproductive health (including deciding if and when to have children), and poor access to basic health services such as family planning, skilled attendance at birth, emergency obstetric care, safe abortion, and post-abortion care, all contribute to the failure of most developing countries to make equitable progress towards the achievement of MDG 5.

Despite this, more than 70 percent of the global funds committed to maternal and child health to date have been directed to child health. The resounding commitment to maternal health expressed by world governments at the recent MDG Summit provides recognition of, and a renewed political and financial commitment to addressing, this major shortcoming.

The Maternal Health Reference Group was formed in recognition of both the Australian Government's renewed commitment to maternal health and our complementary strengths. We wish to engage with AusAID to collectively contribute to maternal health policy and implementation.

We see a number of components, outlined below, as essential in any effective maternal health delivery strategy.

1. Comprehensive and integrated approaches

Responsive health systems that provide family planning, skilled attendance at birth, emergency obstetric care, safe abortion and quality post-abortion care are critical. However, maternal mortality is not just the result of weak health systems. Other factors including social norms, the exclusion of women and girls from education, health information and decision-making, violence against women, and a lack of commitment and dialogue between and by communities and policy makers, have to be simultaneously addressed. This requires interventions with a range of stakeholders (e.g. poor and remote communities, NGOs, policymakers, and government and health systems at all levels within a country). NGOs are well placed to support these initiatives, and can complement health systems strengthening efforts.

[1] A note about terminology: we have used the term maternal health but could equally use sexual and reproductive health to indicate that many women and girls are trying to delay or avoid pregnancy. The reality is that many women and girls actually die trying to prevent becoming pregnant.

2. Women's empowerment

Key to a comprehensive approach to improving maternal health is women's empowerment, including girls' and women's access to education. Gender equity and women's empowerment should not just be cross-cutting issues but should be the lens through which all maternal health interventions are viewed.

3. Women and men must have the right and ability to control their own sexual and reproductive health

There are currently 215 million women globally who wish to avoid a pregnancy but are unable to access an effective method of contraception. Meeting this need would itself save the lives of one third of the 350 000 women who die as a result of pregnancy and childbirth each year (MDG 5). In addition, investment in family planning has been shown to lead to significant returns in terms of poverty reduction (MDG 1), prolonging girls' education (MDG 2), women's empowerment (MDG 3), child and newborn health (MDG 4), the prevention of HIV (MDG 6) and environmental sustainability (MDG 7). Scaling up evidence-based interventions to increase access to family planning at the community level is achievable and affordable. Indeed, investing in a comprehensive women's health package that includes family planning as well as maternal and newborn care is *more cost effective* than providing maternal and newborn care alone.[2]

4. Mobilise communities

Mobilise communities to claim ownership and shared responsibility for women's access to quality health care. Communities have to be engaged to support and advocate for the right of women and girls to family planning, safe pregnancy and delivery, and post-partum care. The right of adolescent girls to sexual and reproductive health information and services must be specifically targeted in all community activities.

5. Long term and sustained commitment

The Maternal Health Reference Group strongly endorses ACFID's pre-budget submission recommendations (i) to set a clear timetable for providing $1.6 billion in ODA for women's and children's health from the 2011-12 to the 2014-2015 budgets; and (ii) that 15% of ODA directed towards health should be specifically targeted at family planning measures.[3] In addition, a longer-term commitment is required (the Government's current five-year commitment aligns with the remainder of the MDG period). As recent history has shown there is no quick fix to maternal health – widespread economic, social and political transformations are required. Funding commitments similarly need to be long term and predictable. In the Asia Pacific region an additional US$7 billion from 2007 levels is required from donors over the next 5 years to address the funding shortfalls for sexual and reproductive health[4]. Given AusAID is one of the largest donors in the region, the Australian Government's new commitment is welcomed, but it still falls short of this target.

6. Common Performance Indicators

Common indicators aggregated across countries, programs and implementing partners should be set to measure progress and impact of Australia's contribution. These should be based on the MDG5 targets, be reported disaggregated by age and marital status.

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[2] Singh S, Darroch J, Ashford L, Vlassoff M. Adding it up: The costs and benefits of investing in family planning and maternal and newborn health. New York: Guttmacher Institute and UNFPA, 2009.

[3] Australian Council for International Development, 2011-12 Pre-Budget Submission, Budget Recommendations, Fact Sheet 2, Improving Health Outcomes, November 2010, Recommendations 2.2 and 2.4.

[4] Making Sexual & Reproductive Health and Rights Count, Asia and Pacific Resource Flows Project 2010 conducted by Asia Pacific Alliance.