CARE'S PERSPECTIVE ON THE MDGs

Building on success to accelerate progress towards 2015
MDG Summit, 20-22 September 2010

MDG Goal 5: Improve Maternal Health

Target 1: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio
Target 2: Achieve universal access to reproductive health by 2015

Overview

Recently released data suggest that maternal deaths are declining globally. While this news is encouraging, the truth is that the number of women who will die this year in pregnancy and childbirth – whether that's 350,000 or 550,000 – is far too high. In fact, many countries, particularly in sub-Saharan Africa and Southern Asia, have made little or no progress at all in reducing maternal mortality since the MDGs were agreed to in 2000. These statistics are particularly devastating when you consider that a majority of these deaths can be prevented if women have access and are able to utilize proven, cost-effective, life-saving interventions. Urgent and decisive action is needed to accelerate progress on MDG 5, the MDG that has consistently been the most off-track. What is needed now are the financial resources and political will to make progress to save women's lives.

How Do We Achieve Success?

During the MDG Summit, global leaders have an opportunity to tackle one of the most basic human challenges the world faces – assuring the survival of women and newborns. UN leaders must adopt and take decisive action to implement a bold plan on maternal and newborn health, building on the G8 Muskoka Initiative on women, newborns and children's health and linking closely with the financial, political and programmatic commitments being made as part of the UN Secretary General's Global Strategy for Women's and Children's Health.

CARE believes any strategy to make progress on MDG 5 requires focusing on the following priorities:

- **Be comprehensive, cover the full 'continuum of care' and integrate/link with other health and development issues.** Any plan must cover the broad spectrum of healthcare services that connects home to community, to clinic, to hospital and back again and across the lifecycle. It must also support community-based approaches that integrate or link maternal and newborn health with child survival, sexual and reproductive health and family planning, nutrition, micro-finance, education and HIV/AIDS in a coordinated manner.
- **Focus on ensuring access for the poor and most vulnerable people, in the world's poorest regions.** Interventions must address the extreme inequity in receipt of quality health services by focusing on the most vulnerable and by removing barriers to women accessing services, including cost, transportation, discrimination and cultural beliefs. The UN must give special attention to responding to the needs in Africa and support the commitments and ongoing efforts of African countries.

- **Focus on empowering women and girls.** Women and girls are often the most vulnerable to poverty, poor health and social marginalization due to their social position and existing gender inequalities, yet do not have the resources, nor power needed to change their situation. Evidence has shown that by empowering women, you can increase their use of health and other services; improve their lives, the well-being of their children and the economic stability of their communities; and make governments more accountable to their needs.
- **Commit to accountability and tracking results.** A comprehensive approach needs to provide for regular reports on the progress made in implementing financial, programmatic and policy commitments, including measurable results/impacts and any needed midcourse corrections.
- **Invest in strategies focused on promoting civil society participation and mobilization.** Even when measures are taken to improve health care facilities and services, poor women still face additional barriers such as cost, discriminatory behaviors of health workers, and lack of understanding of their health rights that often prevent women from seeking or utilizing health services. An active and informed civil society can overcome these barriers by educating women and the broader community about their health rights, demanding improvements in policies and services, monitoring and reporting on the quality of health services and holding governments and decision-makers accountable to their commitments.
- **Engage communities as core partners in program design, implementation and evaluation.** Communities understand the barriers, including structural barriers, social norms and gender-related inequities, to improving health in their specific country context. It is through working in conjunction with the people on the ground that real and lasting change can be made.

What Do We Know Works?

Case Study (CARE Bangladesh): Safe Motherhood Promotion Project (SMPP), Bangladesh

In collaboration with the Japan International Cooperation Agency (JICA) and the Government of Bangladesh, CARE implemented the Bangladesh Safe Motherhood Promotion Project (SMPP) to reduce maternal and neonatal mortality and morbidity. SMPP seeks to improve maternal and neonatal health outcomes by working at the community and facility level to improve knowledge and behaviors by pregnant women and their families; increase the provision of antenatal, delivery and postnatal care; reduce delays in seeking emergency obstetric care (EmOC); and improve the availability and quality of that care. The project reaches 1.2 million people in two sub-districts in the Narsingdi district in Bangladesh.

CARE is implementing the community-based components of this project, while JICA is focused on health system strengthening. The key strategies of SMPP community mobilization are to:

- build the capacity of communities to demand, negotiate and use quality reproductive, maternal and newborn health services;
- enhance community participation in health and family planning service delivery management; and
- develop an effective monitoring, reflection and knowledge management system for establishing and replicating the model.

CARE has addressed these key strategies through implementation of a community support system (CmSS) model that had been developed previously by CARE Bangladesh and proved effective in increasing the met need for EmOC. The primary objective of CmSS is to create an enabling environment at the community and household levels to support pregnant women,

especially poor women, in accessing maternal health services in a timely manner and to facilitate timely referral, if there are obstetric complications, to appropriate EmOC facilities.

CmSS groups are formed through a community-led process supported by CARE. CmSS groups work to:

- increase awareness about danger signs of obstetric complications and availability of EmOC services in the district;
- promote birth preparedness planning and antenatal care;
- raise funds to cover the costs of transport and care for poor women; and
- monitor pregnancies and outcomes.

In addition to community members, participants in monthly CmSS meetings include a representative of the local government and a healthcare provider, ensuring active engagement between the community, government and healthcare system.

Total Cost and Project Duration: US$325,000 (CARE portion of SMPP) / 2006-2010.

Outcomes and Impacts: CARE Bangladesh, along with partners, has demonstrated that CmSS is an effective model of community participation[i]. The Government of Bangladesh agrees. Recognizing that the CmSS model effectively mobilized community participation in health care and improved maternal health outcomes, the Minister of Health and Family Welfare and other senior government officials have sought to replicate the model throughout the country as a part of the government's health system.

An impact study of CmSS found increased service utilization, particularly by the poorest women, mobilization of resources, registration of pregnant women, improved local leadership for health promotion, increased referrals and active involvement of the local government and health and family planning staff.

Data from a 2009 impact evaluation[ii] found that:

- Between July 2007 and April 2009, 133 CmSS groups were established in the two sub-districts.
- Antenatal care visits to a medically trained provider among women in CmSS areas were significantly higher (75.7 percent) than among women in non-project areas (48.7 percent). The difference was most striking among the poorest women (70.9 percent versus 29.7 percent).
- Knowledge of two or more danger signs during pregnancy, delivery and postpartum period among women in CmSS areas was 96.8 percent, compared with 78.5 percent in non-project areas.
- The amount and level of planning for birth and delivery (e.g., deciding location of delivery, saving money for an emergency, identifying transportation) was higher in areas with CmSS than in non-project areas (the number of women who made three or more preparations was 54.6 percent versus 13.5 percent).

Key Factors for Success, Scale Up, and Replication:
The major factors for success include:

- **Engage communities as a core partner.** CARE worked in partnership with community members to establish the CmSS group, thus increasing their buy-in to the approach. Ultimately, it was the CmSS members themselves who were responsible for helping women overcome some of the barriers to accessing health care services, such as lack of

information and transportation costs. As CmSS groups have matured, they also have begun to address issues beyond maternal and neonatal healthcare services, including adolescent marriage, dowry and education.

- **Promote civil society participation and mobilization.** The CmSS structure increased the capacity of communities to be more actively engaged in health service delivery. In addition, by including community members along with representatives of the Union Parashad and local healthcare providers in the monthly meetings, CmSS groups facilitated increased engagement between these groups and gave them the forum to exchange information and ideas. As a result of seeing the benefit of mobilizing the community, the Ministry of Health is exploring, with CARE's support, how to use the principles, lessons learned, and facilitation experiences of the CmSS to activate meaningful participation of community groups in improving the health status of the population in the community clinic catchment area.
- **Focus on ensuring access for the poor.** The impact evaluation suggests that the CmSS structure had the greatest impact on improving the behaviors of the poorest quintile of women. Addressing the needs of the poorest women ensures a more equitable system of healthcare and ultimately, it is only by addressing the needs of the poorest women, where maternal mortality tends to be the highest, that we will see the long-term improvements in maternal health required to meet MDG 5.

For more information contact:

Program Contact: Jahangir Hossain, Health Program Director, CARE Bangladesh (jahangir@carebangladesh.org).

Founded in 1945, CARE is a leading aid organization fighting global poverty. In nearly 70 countries, CARE works with the poorest communities to improve basic health and education, enhance rural livelihoods and food security, increase access to clean water and sanitation, expand economic opportunity, and help vulnerable people adapt to climate change. Women are at the heart of CARE's efforts, because experience shows that a woman's achievements yield dramatic benefits for her entire family. CARE also provides lifesaving assistance during emergencies, and helps rebuild communities after the disaster has passed.

CARE International is an independent, non-political, non-religious federation comprised of 12 member organizations: CARE Australia, CARE Canada, CARE Danmark, CARE Deutschland, CARE France, CARE Japan, CARE Nederland, CARE Norge, CARE Österreich, CARE Thailand/Raks Thai Foundation, CARE UK, and CARE USA. www.careinternational.org

[i] It is important to note that at the same time CmSS was being implemented, in one of the two sub-districts, the Government of Bangladesh was implementing a voucher scheme which allowed poor pregnant women to use a voucher to receive pregnancy-related services such as antenatal care (ANC), delivery care, treatment of complications and postnatal care (PNC) at health facilities. Quantitative

analysis has shown that the CmSS program had a synergistic impact on the uptake of services through the voucher system.

ii 2009 Evaluation Survey of the Impact of Community Support System (CmSS). Prepared by Associates for Community and Population Research for JICA. January 2010.