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Submission by RESULTS UK

In response to 'Choice for women: wanted pregnancies, safe births' – A UK government consultation on reproductive, maternal and newborn health in the developing world

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RESULTS is a grassroots advocacy organisation working in the UK and internationally to generate the public and political will to end hunger and extreme poverty. We welcome the government's commitment to put women and mothers "at the front and centre" of DFID's efforts to fight poverty and to galvanise efforts to ensure that the three health Millennium Development Goals are on track to be achieved by 2015.

RESULTS UK is a member of the *Manifesto for Motherhood Coalition* and has endorsed the set of recommendations already submitted to DFID on behalf of the Coalition.

In addition to the recommendations made by the *Manifesto for Motherhood*, RESULTS UK would like to see the Department for International Development's Business Plan on reproductive, maternal and newborn health (RMNH) take the following recommendations into account:

- DFID's efforts to improve reproductive, maternal and newborn health should be delivered as part of a continuum of care approach that includes interventions to improve the health of children under five.
- Equity should be at the heart of DFID's response to RMNH with a focus on reaching the poorest and most marginalised women and children who are living in the parts of the world with the greatest need.
- DFID should help to scale up access to a package of cost-effective and proven interventions including misoprostol distribution for postpartum haemorrhage prevention at home deliveries and family planning services.
- DFID's strategy to improve RMNH should be integrated with efforts to tackle AIDS, TB, malaria and other diseases of poverty.
- DFID's approach to RMNH should also address the indirect causes of maternal and child deaths such as undernutrition, the availability of clean water and sanitation and girls empowerment and education.
- DFID should build on the ambitious commitments made at the UN MDG Review Summit by announcing further details on how it intends to deliver on these commitments. It should also continue to push other countries to set themselves equally bold targets backed up with additional resources.
- On completion of the Multilateral Aid Review, DFID should significantly increase its funding to the Global Fund to Fight AIDS, TB and Malaria and GAVI Alliance and encourage other donors to contribute their fair share to ensure that both mechanisms are fully funded.
- To assure the long-term effectiveness of its RMHN Business Plan, DFID should also seek to help remove barriers that prevent poor women and children accessing RMNH services, for example by supporting countries to train sufficient numbers of health workers and identify alternative sources of health financing to user fees.

1. The health of mothers and their children should not be separated

While worldwide longevity is increasing and child mortality is decreasing, childbirth is still very dangerous. The risk of a woman dying as a result of pregnancy or childbirth during her lifetime is about one in six in the poorest parts of the world. One mother dies every minute, resulting in the equivalent of five jumbo jets of mothers dying every day giving birth. Many of them leave behind children, whose chances of survival drop dramatically with their mother's death. However, there is a huge potential for helping women and their families because the majority of maternal, newborn and child deaths are preventable by simply providing access to a basic medical care and family planning.

The health of mothers and their children is inextricably linked. If international goals to reduce death rates for mothers and young children are to be met, they need to be addressed simultaneously and with substantially increased budgets.

In many cases maternal and child health are too closely linked to separate the issues:

- High child mortality is linked with high fertility and increased maternal mortality.
- Birth spacing increases the survival chances of a woman's children. Babies born less than 18 months after their preceding sibling are almost three times more likely to die than children born after a three-year gap.
- Pregnant adolescents aged 15-19 are twice as likely to die as women in their twenties and pregnant girls under 15 are five times more likely to die. Babies born to adolescents are also at a greater risk of being premature, which brings with it an increased mortality risk.
- Complications during pregnancy and labour are an important determinant of fetal and neonatal survival. Prematurity, asphyxia (lack of oxygen during birth) and congenital conditions account for approximately half of neonatal deaths. The mother's long-term nutritional status, and dietary intake and health during pregnancy are directly related to her baby's birth weight; babies weighing less than 2.5kg at birth account for up to 90% of newborn deaths.
- Survival of children is heavily reliant on the survival of mothers; a stark example of this comes from Afghanistan where 75% of infants who survive maternal death die within their first year of life.

DFID's response to improving reproductive, maternal and newborn health must therefore be delivered as part of a continuum of care approach that includes integrated service delivery for mothers and children from pregnancy to delivery, the immediate postnatal period, and childhood. Four million children die within their first month of life and a further five million die before their fifth birthday. Focusing only on newborns rather than all children under five would result in DFID missing the opportunity to save more than half of the children who are at risk. The integration of disease prevention and care for mothers, newborns and children also makes sound economic sense as it maximises the use of limited human and financial resources and minimises costs to mothers and their children.

2. The poorest and most vulnerable should be at the centre of any response

DFID should put equity at the centre of its Business Plan and target the most disadvantaged and vulnerable women and children in the parts of the world with the highest burdens of maternal, newborn and child mortality. Recent reports by UNICEF and Save the Children indicate that strategies focused on achieving

equitable reductions in mortality are more effective for meeting the MDGs over the long-term and also offer better value for money[i]. DFID should adopt a similar approach by encouraging and supporting countries to take a more equitable approach to reducing maternal, newborn and child mortality and to monitor progress towards equity objectives.

DFID should focus its efforts on the countries and sectors of a population that have the highest mortality rates and the greatest shortfalls in resources. There is clear geographical clustering of maternal deaths - in 2008 more than 50% happened in only six countries, which also had the highest burden of child and newborn deaths (India, Nigeria, Pakistan, Afghanistan, Ethiopia, and the Democratic Republic of the Congo). Sub-Saharan Africa as a whole accounted for 50% of the world's maternal deaths, and South Asia for another 45%. Most of the countries where maternal deaths are decreasing are also found in distinct regions. Currently the greatest declines in maternal deaths have been in Eastern Asia, Northern Africa, and South-Eastern Asia. These regions showed declines of 30% or more between 1990 and 2005[ii].

Apart from geographical location another factor which heavily influences maternal death rate is the age of the mother. Girls who give birth before the age of 15 are five times more likely to die in childbirth than women in their twenties. It is estimated that as many as 70,000 pregnant girls and young women aged 15-19 die every year[iii] - equivalent to a medium-sized European city worth of women disappearing every year. In fact, pregnancy-related problems are the most common cause of death of young women in this age range. When the mother does survive the birth her baby has a 60% higher chance of dying in its first year than if it were born to a mother older than 18. DFID should therefore ensure that its MNCH programmes incorporate efforts to reach adolescent girls with appropriate education, family planning, prevention and treatment services.

3. Tackling the direct causes of maternal, newborn and child deaths

The main causes of maternal, newborn and child deaths are largely preventable and/or easily treatable:

- According to new estimates, the leading causes of maternal deaths are hemorrhage and hypertension, which account for over half of maternal deaths. Both can be either prevented or treated without complex medical interventions.
- Preventable diseases such as malaria, HIV/AIDS, tuberculosis are also major causes of death and are blocking progress in reducing maternal mortality and child mortality in parts of the world.
- Almost one in ten mothers dies as a result of unsafe abortion. In fact, women are slightly more likely to die as a result of an unsafe abortion than sepsis. Annually around 20 million women resort to unsafe abortion, 97% of them live in developing countries. An estimated 68,000 dies as a result of the procedure being conducted in unsanitary conditions and by someone without appropriate medical training and millions are left with complications, many permanent, including infertility.
- Inadequate care before birth and delivery, including maternal undernutrition, contributes to 40% of child deaths.

3.1. Hemorrhage prevention and treatment

According to the latest available models, the most cost-effective interventions for tackling maternal mortality are antenatal care - including misoprostol distribution for postpartum hemorrhage prevention at home deliveries, family planning and safe abortion - followed by sepsis treatment and facility-based postpartum hemorrhage management. These results hold true irrespective of level of capital available for

health expenditures. That is to say that irrespective of whether the maternal health budget is US$ 0.5 or US$ 2.0 per capita, these interventions should be prioritised in order to prevent the greatest number of maternal deaths. In fact, providing misoprostol alone can lower maternal mortality by as much as 81%[iv]. Moreover, promotion of family planning in countries with the highest birth rates has the potential to avert 32% of all maternal deaths and 10% of child deaths[v].

Misoprostol is a cheap, safe, heat-resistant (i.e. does not require refrigerators for storage), off-patent drug initially used in stomach ulcer treatment, which has been shown to be extremely effective in treating obstetric hemorrhage. A life-saving dose costs less than US$1, is easy to administer and takes effect within a few minutes. Misoprostol can easily be taken by a woman on her own or it can be administered by a family member - this is important as over half of the deliveries in the developing world happen without a skilled birth attendant[vi]. Misoprostol has additionally been shown to safely induce medical (i.e. non-surgical) abortions and its life-saving properties are currently even gaining main-stream media attention[vii]. It is estimated that making this drug widely available can cut maternal deaths by over three quarters.

The key to preventing death from post-partum hemorrhage (PPH) - the single most common cause of maternal death - lies in prevention and the ability to quickly and effectively assess blood loss. In order to achieve these goals Pathfinder developed PPH bags to provide women who will be giving birth at home with all the essentials they require for a healthy labour. The bag is clearly labeled and brightly coloured, making it difficult to lose. It includes a safe delivery kit, misoprostol, the contact details for local health centres and a Blood Mat, which, when it becomes saturated, signals to those attending the women that they must seek help immediately. In India, Pathfinder partners are using a rubberised mat, called a Kelly Pad, which collects and funnels blood into a graduated measuring container. In Tanzania, the standard African length of cloth used for a dress called a Kanga serves as a benchmark for the presence of hemorrhage when it becomes saturated. Pathfinder's Nigerian office is using the Blood Drape which is placed under the woman and siphons the blood into a measuring pocket on the sheet. These are all simple measures which allow constant monitoring of the birthing women (not necessarily by a medical professional) and signal the need for seeking medical attention.

In Bangladesh where the Pathfinder delivery pack was first introduced, 85% of the deliveries happen at home. Every pregnant Bangladeshi woman in the project area is registered and tracked by a government or NGO community worker, and at 32 weeks gestation, she is given a PPH bag. As of March 31, 2010, more than 8,590 women had been registered, 4,298 had received PPH bags, and 3,879 had delivered using the bag contents and taking the misoprostol. Of these deliveries, eight cases of PPH were identified with the use of the blood mat and successfully managed[viii].

Similarly studies in Afghanistan, which has one of the highest maternal death rates in the world, has shown that supplying Community Health Workers (CHWs) with misoprostol can decrease maternal mortality by as much as 95%. The safety and effectiveness of the work done in Afghanistan provides a model for other countries where access to medical professionals is limited.

3.2. Family Planning

The lack of appropriate family planning methods causes a 60% reduction in disability-adjusted life years - or DALYs - of women and their newborns. Family planning can in fact save more lives than any other single

intervention - 70% of maternal and 45% of child deaths could be averted if evidence-based methods of family planning were made available to those who want it.

As a result of spacing pregnancies and giving women's bodies time to recover, more women would also survive hemorrhage and infection, and fewer would endure needless suffering from fistula, infertility and other health problems related to pregnancy or childbirth. Being born to healthier mothers, newborns would also have improved chances of surviving asphyxia, low birth weight and infection. Moreover, in a world with no unmet need for contraception unsafe abortions would decline by 73% (assuming no change in abortion laws) and the number of women needing medical care for complications of unsafe procedures would decline from 8.5 million to two million[ix].

Lastly, family planning can hugely improve the lives of women and their families by enabling them to take control of their fertility. The most recent research[x] corroborates decades of work and field experience and clearly indicates that providing family planning allows women to obtain education and employment drastically improving their health and quality of life. This also directly translates into healthier, better fed and better educated children.

The key issue in widening access to family planning is educating CHWs on the health benefits of spacing pregnancies to both mother and child. Examples from around the world (including Kenya, Nepal, Nigeria and Tanzania) show that CHWs can significantly reduce maternal and newborn mortality and morbidity simply through educating communities about the health benefits of pregnancy spacing. Moreover, they do not have to have sophisticated medical knowledge or even be fully literate to be highly successful. Studies have shown that knowledge about the health benefits of spacing pregnancies is a fundamental factor in community-wide changes of attitude towards contraceptives. This includes husbands and mothers-in-law who in many countries have substantial influence on a woman's reproductive health, as well as religious leaders. In Nigeria alone educating Muslim religious leaders led to their reaching almost 52,000 people in six months with their family planning messages included in sermons and Friday teachings. Women's meetings, schools, house to house visits, weddings and hospital waiting rooms have also proven to be good venues for family planning education[xi].

3.3. HIV/AIDS, TB and other diseases of poverty

The three health MDGs are interrelated. Success in achieving goals relating to reproductive, maternal and newborn health will be contingent, in many settings, on tackling the leading causes of death of women and children including the major infectious diseases. In many of the countries that are most off-track in reaching MDGs 4 and 5, HIV, tuberculosis and malaria are the largest causes of maternal and infant death. A South African study found that 38 per cent of maternal deaths were not directly caused by pregnancy and were primarily due to HIV, TB and pneumonia.[xii] Despite not being caused by pregnancy, these deaths merit attention in the maternal health strategy because they remain deaths of mothers and therefore have similar impacts on child survival as pregnancy-related deaths.

Women in developing countries are disproportionately affected by diseases such as HIV and TB[xiii]. AIDS is the leading global killer of women of reproductive age; in Sub-Saharan Africa around two-thirds of people living with HIV are women.[xiv] Countries in Southern and Eastern Africa with a high burden of HIV have experienced increases in maternal mortality of around 1% a year since 1990, largely attributable to the HIV pandemic. HIV infection in women has a significant impact on the health of their children regardless of whether the children themselves are also infected. Children of HIV-positive mothers are approximately three

times more likely to die than children of HIV-negative mothers. Mother-to-child transmission of HIV accounts for nearly 350,000 child deaths annually. Prevention of mother-to-child transmission of HIV (PMTCT) programmes can serve as an entry point for a range of sexual and reproductive health services.

TB kills over 700,000 women every year; more than all the causes of maternal mortality combined. TB primarily affects women of reproductive age and poses a substantial burden on children and families. Worldwide, some 900 million women of reproductive age are infected with TB, and at least 2.5 million every year develop active TB. TB can cause fertility and contributes to other poor reproductive health outcomes, especially for those with HIV co-infection. While men are more likely to have latent TB infection, women are more likely to progress from infection to active disease. Women are also more likely to develop extra-pulmonary forms of TB, which can be harder to diagnose and treat. TB poses a considerable risk for pregnant women and their babies. Delayed TB diagnosis in pregnant women heightens the chance of death during childbirth and causes danger to the child. Studies from Mexico and India indicate that TB positive women are twice as likely to give birth to a premature or low-birth-weight baby and four times more likely to die during childbirth.[xv] The Stop TB Partnership project that 5 million lives will be saved by 2015, including more than 2 million women and children, if the new *Global Plan to Stop TB* is fully implemented.

While pneumonia and diarrhoea are the primary causes of death for children under 5, diseases such as HIV and malaria account for 68 per cent of child mortality. AIDS is the leading cause of under-5 mortality in the six highest HIV prevalence countries, accounting for over 40% of under-5 deaths in those countries.[xvi] HIV infection exacerbates the impact of other life-threatening conditions in young children, including TB and pneumonia. Children under 15 years of age are estimated to make up 10-15% of the global TB burden.[xvii] TB in children is however likely to be under reported and there is a large need for better diagnostic tools and child-friendly formulations of TB treatment.

As part of a comprehensive approach to improving the health of mothers and children, DFID should help to ensure that efforts to achieve the three health MDGs are coordinated at all levels. Specifically, DFID should help to prolong the lives of mothers and help to reduce the risk of mothers passing the HIV virus on to their children by scaling up access to PMTCT programmes and making antiretroviral therapy and treatment for TB and malaria available to all who need it. Routine screening for HIV, TB and other diseases should be incorporated into maternal and child health programmes in countries where such diseases are endemic. All pregnant women in high disease burden settings should be tested and provided with appropriate treatment and care as part of their antenatal care.

Another area where DFID can make a significant long-term impact is to continue investing in research into new vaccines as well as diagnostic tools and drugs that will improve the diagnosis and treatment of HIV, TB, malaria and other diseases, particularly in young children.

3.4. Indirect causes of mortality

A number of underlying factors shape the survival prospects of the world's poorest women and children. In addition to tackling the direct causes of death highlighted above, DFID's approach should also address indirect causes of maternal and child death such as undernutrition, the availability of clean water and sanitation and girls education.

The deaths of 3.5 million children each year can be attributed to maternal and child under-nutrition. Pregnant women who do not receive proper nutrition are more likely to die in child birth or pass the

associated health risks on to their children, often resulting in poor fetal growth, stunting, severe wasting, micronutrient deficiencies, impaired cognitive development, and poor school performance. A lack of key micronutrients can damage the health of a mother and her child. For example, anemia - caused by iron deficiency - contributes to 20% of maternal deaths and is exacerbated by diseases such as malaria, TB and HIV.

Around one-third of child deaths are linked to poor sanitation and unsafe water. Many of these deaths relate to diarrhoea or respiratory diseases such as pneumonia. Interventions to improve women's access to clean water and sanitation are essential for the survival of mothers and newborns during and immediately after childbirth. Simple interventions such as promoting universal handwashing with soap could save over a million lives a year. Studies have shown that birth attendant and maternal handwashing with soap are associated with significantly lower neonatal mortality[xviii]. Since women and girls are responsible for collecting water in many parts of the world, improved sanitation facilities and access to clean water will reduce women and girls' vulnerability and increase the amount of time they can spend attending school or participating in income-generating activities.

Countless studies have shown a correlation between mothers' education and child survival rates. Even a few years of primary level education is advantageous for child survival. The children of illiterate mothers are more than twice as likely to die or be malnourished than the children of mothers who have secondary or higher education.

The UN Secretary General's *Global Strategy for Women's and Children's Health* recommends that partners should coordinate efforts with those working in other sectors to address issues that impact on health. DFID should therefore take a comprehensive approach to maternal, newborn and child health that incorporates health promotion interventions, nutrition, access to safe sanitation and clean drinking water, hygiene promotion, women and girl's empowerment and ensuring that more girls gain access to education.

4. Overcoming the barriers to delivery

Identifying the most successful interventions for reducing maternal, newborn and child mortality is just part of the equation. The next step is to make these interventions available on a large scale, including to those women and children in the poorest and hardest to reach settings. There are a number of international, national and community-level barriers to scaling up and introducing these interventions. DFID is well-positioned to contribute to the removal of many of these barriers.

4.1. Lack of political will and resources

At the international level, an overarching constraint to reducing maternal, newborn and child mortality is the lack of political will and resources. The recent MDG Review Summit and UN Secretary General's *Global Strategy for Women's and Children's Health* have helped bring the international community together to agree ambitious targets for the year 2015. The UK showed considerable leadership by making commitments to save the lives of at least 50,000 women in pregnancy and childbirth, 250,000 newborn babies and enable 10 million couples to access modern methods of family planning over the next five years. The UK government must continue to set the tone for accelerated action by outlining how it intends to achieve these targets, how much money it will allocate to the achievement of these targets and which mechanisms it will channel resources through. The UK should also continue to push other bilateral and multilateral agencies as

well as national governments to make equally bold commitments backed up by sufficient, additional resources.

Multilateral funders, such as the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria are two key mechanisms that can ensure more funds are channeled to women, girls and children through existing HIV/AIDS, TB, malaria and immunisation programmes. Both GAVI and the Global Fund are already making a significant impact on reducing maternal, newborn and child mortality through increasing access to a range of essential services such as immunisations for vaccine-preventable diseases, services to prevent the transmission of HIV and TB between mothers and their children, and interventions to prevent and treat malaria. Furthermore, both organisations are contributing to broader health system strengthening including the training of health workers which have a positive impact of MNCH programmes. The Government of Ethiopia has used funding from the Global Fund, for example, to train 30,000 community health workers who not only deliver services to fight HIV, TB and malaria but also provide a full range of integrated primary health services, including immunisations, family planning, antenatal care and treatment for pneumonia and diarrhoea .

The Global Fund and GAVI's success in helping countries to achieve the health MDGs has created a growing demand for financing, and as a result, both mechanisms face significant funding shortages in the remainder of 2010 and beyond. On completion of the Multilateral Aid Review, DFID should significantly increase its funding to both mechanisms and encourage other donors to contribute their fair share to ensure that both the Global Fund and GAVI are fully funded.

4.2. Weak and under-resourced health systems

In many low income countries, poor people struggle to access basic healthcare because services are not within reach, are under-staffed or ill-equipped, or because the direct costs of health care are prohibitive.

Lack of appropriately trained medical staff is one of the reasons for the current high rates of maternal mortality in parts of the developing world. It is, however, possible to reduce maternal mortality with community interventions. Real change can be brought about by implementing task shifting to empower local health workers, and focusing on interventions that maximise existing health infrastructure and human capacity. A pragmatic approach - which prioritises feasible and scalable interventions with the biggest potential to save lives - is essential. The most recent field research is providing models for including family planning and misoprostol dispensation into the array of services provided by community health workers (CHW).

Although Afghanistan is one of the poorest countries on Earth, in the last three years most districts have achieved the target of a least one CHW per 100-150 households. The community acceptance of CHWs as well as their significant field presence makes including them into maternal health programs the easiest and most helpful option. Moreover, the infrastructure to oversee them and keep them provisioned is already in place. It has been shown that 3 home visits to pregnant women made by CHWs are optimal. The first one takes place when the women are first registered, then during their eighth month of pregnancy, and lastly within a week after birth. During each visit, CHWs provide one-on-one education of the women and household members. CHWs use pictorial flip-charts to provide education on birth preparedness and complication readiness. They teach the pregnant women and their families how to recognise signs of danger - especially excessive blood loss - and what to do in the event of a complication, including details of

obtaining professional help. Additionally, the CHW provide all the relevant information about misoprostol, including the correct timing and risks related to taking it before the birth of the baby as well as common side effects and how to proceed in the event they occur. Lastly, they provide instruction on what to do if hemorrhage does nevertheless happen. During the second visit the pregnant the women receive a package containing 3 tablets of 200 μg of misoprostol, as well as pictorial and written educational materials with instructions on correct and safe use of misoprostol. The package is dispensed only after the women demonstrate an understanding of the purpose of the drug[xix].

This protocol has proved to be hugely successful - all women accepted the treatment and took the drug correctly, which led to a six-fold decrease in post-partum hemorrhage rate and correct management of hemorrhage that wasn't prevented[xx].

Providing antenatal visits are important in averting newborn deaths by treating and preventing underlying diseases such as malaria and hookworms, educating women about dangerous symptoms, possible complications and where to seek help. They can also be useful by providing HIV screening and treatment (in order to prevent mother to child transmission) and hygiene education, which reduces pneumonia infections and diarrhoea.

Most of the complications that happen during, or shortly after, delivery cannot be predicted or prevented through antenatal screening[xxi]. The addition of misoprostol distribution to antenatal visits for those women who are unable to have a facility-based delivery can prevent and treat the most common cause of maternal death worldwide - postpartum hemorrhage - and therefore greatly increases their cost effectiveness and life-saving potential.
Whilst CHWs are able to deliver a range of integrated health services, there is still a considerable need in many parts of the world for other health workers including doctors, nurses and laboratory technicians, to be recruited, trained and retained. DFID needs to increase its allocation of resources to governments for recurrent costs and improve the predictability of such support through budget support or other forms of health financing. DFID should support national governments to explore a range of funding modalities and support the provision of technical support through mechanisms such as the Centre for Progressive Health Financing.

4.3. Financial barriers to access

There is now a clear global consensus on the kinds of intervention that prevent the deaths of young children and their mothers. This package of interventions, available free to all at the point of use, would cut mortality rates dramatically. However, many poor families are frequently forced to base the decision on whether to access health-care on whether it can be afforded. Women tend to have less access to financial resources which often means that poor mothers wait until it is too late to seek medical care for themselves or their children. The removal of health user fees will therefore have a significant impact on women's use of health services. The removal of financial barriers is a common feature in countries that have been successful in improving health outcomes for mothers and children.

Even small medical expenses can push poor families further into a spiral of poverty and debt. Research in Ethiopia carried out by Save the Children found that most people did not go to a health worker when ill, and of those who did, two-thirds deepened their poverty by selling assets, borrowing money or mortgaging their crops. In 2004, the World Health Organization estimated that each year 178 million people would suffer destitution as a direct result of paying for healthcare and a further 104 million would be forced into poverty.

Over the past decade several countries have removed user fees from their health systems. The results have been astounding. In Uganda, outpatient attendance at health clinics showed a dramatic leap in the month in which fees were abolished (March 2001), followed by a improving efficiency by encouraging people to use primary health care rather than hospital services. This is because previous to the removal of fees, for many even the fees applied to primary health care were prohibitively high and therefore aren't seen as a low-cost preventative alternative to hospital admission. With the removal of fees fewer people delayed seeking treatment and more treatment could be carried out in lower-cost primary care settings. The launch of free health services for pregnant and breastfeeding women and children under 5 in Sierra Leone earlier this year resulted in a 179% increase in the number of people using outpatient services.

It is now widely accepted that removing user fees leads to better utilisation of health services by the poor. Using a simulation model, Save the Children has analysed how many child deaths might be prevented if user fees were removed in 20 African countries. They calculated that elimination of user fees could have an immediate and substantial impact on child mortality, preventing an estimated 233,000 deaths annually in children aged under 5 – an impressive 6.3% of such deaths in these countries. Most of these lives would be saved by increased use of simple curative interventions, such as antimalarials and antibiotics combating dysentery and pneumonia – hardly sophisticated medicine, but currently out of the reach of the poorest families.

At the MDG Review Summit this September, 16 countries (Benin, Cambodia, China, Congo, Ghana, Haiti, Indonesia, Liberia, Malawi, Mali, Nepal, Niger, Sierra Leone, Tanzania, Yemen and Zimbabwe) committed themselves to extend the provision of free health services, particularly for pregnant women and children. The UK should support these countries and others to find the means to provide healthcare free at the point of use. In addition to providing financial resources, the UK should continue to provide technical support to those countries wishing to remove user fees through the Centre for Progressive Health Financing which was established in March 2010.

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