Submission from the Christian Medical Fellowship

to the Department for International Development Consultation on Maternal Health Strategy:

‘Choice for women: wanted pregnancies, safe births’

Introduction

The Christian Medical Fellowship (CMF) is an interdenominational organisation with over 4,000 British doctors as members, together with a growing number of midwives, nurses and allied health professionals as associates. All are Christians who desire their professional and personal lives to be governed by the Christian faith as revealed in the Bible. Members practise in all branches of their professions, and through the International Christian Medical and Dental Association and Nurses Christian Fellowship International are linked with like-minded colleagues in over 100 other countries.

We have over 150 members (doctors, nurses, midwives and allied health professionals) working long-term in the developing world. Nearly twice that number again are actively involved in international health issues, in ways such as making short term visits or teaching. It is from that pool of expertise that we make this submission.

CMF regularly makes submissions on ethical and professional matters to Government committees and official bodies. All submissions are on our website (*www.cmf.org.uk/ethics/submissions/*). For example, we have recently responded to Nuffield Council on Bioethics consultations on *Give and take? Human bodies in medicine and research* (2010), on *Dementia: ethical issues* (2008) and on *The Ethics of Prolonging Life in Foetuses and the Newborn* (2005); as well as to several House of Lords Select Committee consultations on the *Inquiry into The EU Commission's Communication on organ donation and transplantation: policy actions at EU level* (2007 and 2008).

General comments

Based on the most recent evidence, we emphasise the following:

1. In the last two decades **we have seen a marked reduction globally in maternal mortality** from 500,000 deaths per annum to 350,000 per annum. The vast majority of these are still in the developing world.[1, 2]

2. The interventions that have reduced this mortality rate have been multi-level: addressing social attitudes towards women, pregnancy and child birth; providing education for girls and the empowerment of women; increasing access to good quality obstetric and midwifery care (in the local community and in accessible secondary care institutions); and providing family planning services to allow better birth spacing, etc. **We hold that the evidence suggests that only such multi-level interventions will have significant or lasting success in tackling maternal mortality; and further, that strengthening health systems for maternal health will have collateral benefits for other areas of health need.**

3. **Positive engagement with religious leaders, communities and faith based organisations (FBOs) is vital**, as they are not only significant providers of services, but also hold the key to challenging and changing social attitudes and values that can devalue women and their health needs.

4. Empowering women, and changing socio-cultural and religious values that disenfranchise women and girls and deny them access to healthcare and education, are priorities. This requires **engagement** with community leaders in general, and religious leaders and communities in particular, **in their own terms and context, rather than imposing Western worldviews and values.**

5. Single issue interventions are damaging to wider health needs in the long term. **We advocate strengthening the broad range of health infrastructure and provision** (both primary and secondary) in developing nations. This includes appropriate training (undergraduate and postgraduate), professional support for healthcare staff, and adequate provision of properly maintained equipment with appropriate supply chains.

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[1] Trends in maternal mortality: 1990 to 2008 - Estimates developed by WHO, UNICEF, UNFPA and The World Bank (2010) ISBN: 978 92 4 150026 5

[2] Hogan M C, Foreman K J, Naghavi M *et al*. Maternal Mortality for 181 Countries 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5. *Lancet* 2010:375:1609-23

Responses to Specific Questions

1. Aim. 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?

Christian Medical Fellowship (CMF) holds that we need to be clear about the specific problem we need to address; what our specific aims are; and the specific, evidence based interventions that will achieve these aims.

CMF's submission comes from the experience and evidence presented by our members who work or have worked in maternal health in resource poor regions including Afghanistan, Bangladesh, Malawi and Nigeria.

Based on the most recent evidence, we emphasise the following:

1. In the last two decades **we have seen a marked reduction globally in maternal mortality** from 500,000 deaths per annum to 350,000 per annum. The vast majority of these are still in the developing world.[3, 4]

2. The interventions that have reduced this mortality rate have been multi-level: addressing social attitudes towards women, pregnancy and child birth; providing education for girls and the empowerment of women; increasing access to good quality obstetric and midwifery care (in the local community and in accessible secondary care institutions); and providing family planning services to allow better birth spacing, etc. **We hold that the evidence suggests that only such multi-level interventions will have significant or lasting success in tackling maternal mortality; and further, that strengthening health systems for maternal health will have collateral benefits for other areas of health need.**

3. **Positive engagement with religious leaders, communities and faith based organisations (FBOs) is vital**, as they are not only significant providers of services, but also hold the key to challenging and changing social attitudes and values that can devalue women and their health needs.

4. Empowering women, and changing socio-cultural and religious values that disenfranchise women and girls and deny them access to healthcare and education, are priorities. This requires **engagement** with community leaders in general, and religious leaders and communities in particular, **in their own terms and context, rather than imposing Western worldviews and values.**

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[4] Hogan M C, Foreman K J, Naghavi M *et al*. Maternal Mortality for 181 Countries 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5. *Lancet* 2010:375:1609-23

The phrase used in the title, 'Choice for Women', pinpoints one of the fundamental issues for millions of women; namely that they do not have any choices with regard to pregnancy and birth. Furthermore, they don't know that they *could* have choices.

Maternal and newborn health needs to be viewed in its entirety rather than its individual component parts. Much ill health stems from the position of women in society, so the biggest single issue here is the value placed by society on the lives of women. In many societies women are deemed of less value than goods or livestock, and it can be perceived that investing in their education, health and wellbeing is a waste of good resources when a new bride can always be found to replace one who has died or whose health has been ruined. Without changing these attitudes, no amount of infrastructure development or resource allocation will significantly reduce maternal and infant mortality rates.

Many of these beliefs have a religious base, so CMF would specifically urge DFID to look at faith based responses to this issue. Faith leaders can have a huge impact on behaviour, as we are learning from the HIV field,[5] but to reach them, change their attitudes and engage them with the issues requires an outreach from within their wider faith community. Such an outreach can refer to sacred writings, and draw upon traditions that support the value of women and good care for mothers to be. (It is worth noting that, certainly among the Abramic monotheisms, there are strong scriptural precedents for valuing women highly – it is usually the selection of particular texts out of context that has exacerbated gender inequalities.)

DFID needs to start by engaging with FBOs and faith communities already addressing these issues. To quote Steve De Gruchy of the African Religious Health Assets Programme (ARHAP): 'Though often hidden from Western view, religion is so overwhelmingly significant in the African search for wellbeing, so deeply woven in the rhythms of everyday life, and so deeply entwined in African values, attitudes, perspectives and decision-making frameworks that the inability to understand religion leads to an inability to understand people's lives'.[6] This is not unique to Africa, but is true throughout the non-Western world.

However, there also needs to be an engagement at governmental level to see good maternal health as a matter of national priority. A well mobilised civil society (and especially faith communities) and well motivated governments taking a strong lead, working in partnership with one another and with the international community have had the most significant impact on health. We would cite the examples of Uganda and Senegal in the response to HIV as good examples historically.[7]

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[5]Eg Faith in Action: Examining the Role of Faith-Based Organisations in Addressing HIV/AIDS. Catholic Medical Mission Board & Global Health Council (2005)

[6]ARHAP and World Health Organisation Research Project: Zambia and Lesotho (2006) *www.arhap.uct.ac.za/research_who.php*

[7]Green E (2003). Rethinking AIDS Prevention: Learning from Successes in Developing Countries. Praeger ISBN: 0 865569 316 1

Improving women's health needs to be rooted and grounded in the community. Increasing accessibility to contraception and appropriate family planning services, as well as good education about family planning and efforts to contextualise family planning services into local cultural practices and norms will reduce unwanted pregnancies and thus unsafe abortions; and will increase birth spacing, thus improving infant health. Investing in the training and ongoing support and resourcing of skilled birth attendants and midwives from the local population, to increase access to good maternal healthcare outside of healthcare institutions, will improve neonatal and maternal survival, especially if these trained birth attendants and midwives are seen as part of, and trusted by, the local community.

In addition, there is evidence that access to primary level education by girls has a significant long-term uplift in community health and development in general, and in the health, social status and empowerment of women in particular. CMF would emphasise that it is not just in the area of health-specific interventions that DFID can invest to see a long term improvement in maternal mortality rates.

While many women in poor communities do not access maternity services with skilled staff and adequate equipment, recent research has shown that community interventions can improve healthcare seeking behaviour. A systematic review of community-level interventions to reduce maternal mortality by Kidney *et al* (*BMC Pregnancy and Childbirth*, 2009, 9, 2) found two high quality cluster randomised trials aimed at improving perinatal care practices. They succeeded in reducing perinatal mortality and also showed a significant reduction in maternal mortality (producing an Odds Ratio of 0.62 with CI of 0.39 – 0.98).

Several additional trials such as those in India, Nepal and Malawi (eg by Lewycka *et al* in *Trials*, 2010, 11, 88) are showing similar beneficial results. The challenge for national governments and for DFID is how to support and scale up these pilot schemes. The practical experience of CMF members is that church based women's groups in many poor communities already provide such cadres of women who are highly motivated and experienced in encouraging women of reproductive age to be highly active in social action. In many situations such women's groups work in an *ad hoc* way; in others they use carefully produced training materials such as 'Guardians of Our Children's Health', produced by Tearfund, UK in association with their African church partners. Many of these programmes now involve fathers, as improvement in their understanding of reproductive health is critical to achieving improved access to safe delivery and contraceptive services.[8] (The Tearfund International Learning Zone (TILZ) website is at http://tilz.tearfund.org/).

Finally, we would stress that the majority of the world is community-orientated rather than individual-orientated, and we should focus on the health (in the wider physical, mental, spiritual, educational and socioeconomic sense) of communities rather than of individuals alone.

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[8] Rev Joe Kapolyo. The Role of the Father. Tearfund International Learning Zone, accessed at *http://tinyurl.com/36ypak8*

In summary, CMF would urge DFID to address:

- wider social attitudes and values
- empowering women
- engaging national governments and investing in strengthening health systems
- working with innovative projects (especially within the faith sector)
- and the wider health, education and empowerment of the local community

as the most effective ways in which maternal mortality can be reduced.[9]

2. Interventions
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?

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

1: Access to services
The whole is greater than the sum of the individual parts, and within reproductive and neonatal health the greatest impact occurs where there is an effective system which can be accessed by women as and when they need it. Many of the problems in pregnancy and childbirth can be neither predicted nor prevented, and therefore women need access to a continuum of care – in the community, in a secondary care institution; from family planning services and pre-conception care to the post-natal period. Accessibility involves more than just physical provision of services, and includes addressing the social and financial constraints.

From our members' experience in Afghanistan, Bangladesh, Malawi and Nigeria (among others) the majority of deaths occur in the rural areas, often because there is very limited access to quality health care. Women in rural areas often delay accessing care because of family pressures, fear of the potentially ruinous financial costs and the general demands of daily living. They are delayed in getting to care facilities by poor transport infrastructure or lack of affordable transport, and often are delayed in getting care on arrival because the health facilities are too thinly stretched, with too many mothers seeking access to too few staff and treatment facilities. Most deaths occur at this last stage...[10]

2: Training of professionals
For that reason we would also emphasise the vital importance of high quality training for healthcare professionals and birth attendants. Sometimes training schemes, especially those run by governments, concentrate simply on numbers receiving theoretical instruction and getting a qualification at the end of the course, rather than insuring that those in training gain adequate clinical experience. We also need to invest in strategies to encourage these professionals to stay working in the areas of greatest need. These encouragements include resourcing postgraduate/post-registration training and continuing professional development, salary top-up schemes, etc.

Birth attendants in the local community need to be skilled to recognise normal pregnancy, labour and childbirth and as a result to be able to identify abnormality with an acceptable pathway to deal with such issues as anaemia, malnutrition, infection, ante partum haemorrhage, post partum haemorrhage, slow progress in labour, retained placenta, etc.

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[9] Bhutta Z A *et al* (2010). Countdown to 2015 decade report (2000-2010): taking stock of maternal, newborn and child survival. *Lancet* 2010;375:2032-44
[10] Trends in maternal mortality (2010) *Ibid.*

CMF would urge DFID to ensure that such training and ongoing support is provided by women who are familiar with, and have a willingness to learn about, local beliefs/ customs and traditional practices. Only from that point can there be mutual respect and an exploration of both traditional and 'western' midwifery practices with the potential for integration of the two where possible. This addresses the erroneous concept of ethnocentricity, and allows for mutual respect and flexibility without total abolition of centuries-old traditional practices.

Resources for these skilled birth attendants need to be current, culturally appropriate/acceptable and ongoing, with the provision of clean basic equipment, eg umbilical cord clamps and cutters. A basic method of documentation/record keeping needs to be agreed at a national level – this may not necessarily demand maths or writing skills but will be an understood method of communication.

3: Monitoring

The specific interventions needed to deal with the direct causes of maternal deaths are well documented, eg the crucial importance of the use of magnesium sulphate in eclampsia, and prostaglandins to treat post partum haemorrhage. However, in reality even basic equipment and drugs are often not in fact available in maternity units, although officially they are. Educational programmes are of little use unless change of practice takes place. CMF would urge DFID to ensure on site follow-up monitoring is in place for all medical facilities which receive funding.

4: Addressing female genital mutilation

Female Genital Mutilation is a major cause of morbidity and mortality among girls in North/Central Africa, This is not a religious expectation for any faith, but rather an age old tradition which needs to be challenged by personnel who recognise the rationale behind the practice, and who are able to negotiate with local and national leaders to reach a mutually acceptable conclusion. CMF would encourage DFID to work in particular with faith leaders in this region to address this issue.

5: Treatment and support of women with vesico-vaginal fistulae (VVF)

Another neglected area is that of vesico-vaginal fistulae (VVF) following traumatic child birth (and violent sexual assault), and its subsequent social stigma and isolation for affected women. While the incidence of this condition can be markedly reduced by access to good maternal health services, there still needs to be good care for those affected. We would cite the example of *Heal Africa* in Kagoma, DRC as a key example of a faith based organisation that has addressed VVF through surgical, social, psychological and spiritual interventions, and had a dramatic impact on the health and wellbeing of women. CMF would encourage DFID to identify and support such initiatives, as they help address some of the social attitudes towards women in many societies as well as addressing the direct physical needs, with a collateral benefit in terms of maternal health.

6: HIV treatment and prevention

Finally, recent research has re-emphasised that a major cause of the higher maternal mortality rates in Southern and Eastern Africa is the incidence of HIV – accounting for 9% of maternal deaths, or 60 deaths per 100,000 live births.[11] CMF urges DFID to put an emphasis on testing all pregnant women for HIV, and where this is not being done – because of the lack of service delivery to rural areas for instance – DFID should support partnerships between faith based organisations, including churches, and government. Further, as testing for HIV is not enough – all HIV +ve women should go onto prophylactic ARVs and women with CD4 counts below 350 should go

onto HAART for their own disease – DFID should support community programmes which enable women in rural areas to access comprehensive testing and treatment.

3. Where we work
Where should we work?

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

When posting your comment, please state whether it is an individual, group or organisational response.

While it is very difficult to decide from the list given, CMF feels it preferable to choose areas where there is evidence of:

- personnel and institutions in place who will be receptive to change in terms of maternity care and attitudes to women
- governments willing to be proactive on maternal health
- strong and engaged civil society
- faith leaders and institutions open to engage with the issue

As rural areas often suffer the most in terms of both care provision and maternal mortality rates, we would suggest an increased emphasis on addressing needs comprehensively in rural areas of countries that have shown progress in urban contexts.

Sadly, this may not always be in the areas of greatest need, so we would not see this as an absolute.

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[11] Trends in maternal mortality: (2010) *Ibid*.

4. Inequalities
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?

When posting your comment, please state whether it is an individual, group or organisational response.

Mechanisms that remove financial barriers faced by the poorest and offer choice where relevant (such as vouchers and services that are free at the point of use to pregnant women and children) can have a significant positive impact. However, they may have a negative impact as well; eg by increasing the number of caesarean sections that are undertaken without good obstetric indications.

5. Rights, empowerment and choice
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?

Read background information. Read options to consider. When posting your comment, please state whether it is an individual, group or organisational response.

Social change comes about slowly. We need to be careful not to impose Western social norms, values and worldviews on non-Western communities – Western secular feminism is not necessarily the answer to the majority of the world's women's problems. However, as we argued in our response to question 1, CMF would encourage DFID to use an approach that comes from the religious perspectives and cultural values of the community, particularly through the engagement with faith communities and religious leaders.

It will be more acceptable within the culture and society than imposing Western values, and can lead to a locally led agenda for women's rights and empowerment. Again, we would emphasise that the individualised approach to human rights in the West does not always translate to more communitarian cultures in the South and East.

6. Neglected and sensitive issues
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?

Read background information. Read options to consider. When posting your comment, please state whether it is an individual, group or organisational response.

We emphasise that recent research has shown that approaches focusing on multi-level interventions (such as education of girls, challenging social attitudes and values towards women, increasing access to good obstetric care and trained birth attendants, etc) have had the most discernable impact on the significant reduction in global maternal mortality in the last three decades.[12]

While we know there has been much debate on access to 'safe abortion', this research suggests that legalising abortion has not had any discernable impact on maternal mortality in any country,[13] and indeed that good access to family planning, education and empowerment of women, and access to good obstetric care reduces the numbers of abortions – 'safe' or 'unsafe'. We would therefore encourage DFID to look at a more multi-level and community oriented approach than focusing on one or two issues such as abortion.

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[12]Hogan M C *et al*. *Lancet* (2010), *Ibid*.
[13]Leiva R. Maternal Mortality and Abortion. Letter: *Lancet* 2010, 376;515

7. Working with multilaterals
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?

How can we work in order to deliver better results through multilateral aid?

Please give reasons for the organisations you have chosen.

Working with UN agencies and Bretton Woods bodies such as the World Bank and IMF is doubtless of value, and will be essential to addressing the infrastructural issues facing the poorest nations. However, the danger of the big multilateral agencies is that they tend to adopt a 'one size fits all' approach that has in the past been (arguably) deleterious to health infrastructures at local and national levels.

This can be through 'structural readjustment' programmes from the IMF forcing national governments to disinvest in their healthcare systems,[14] or through the high level funding for single disease programmes which has brought major resources that are only available for a single, narrow dimension of healthcare (eg HIV treatment up-scaling). These draw professionals and infrastructure away from other areas of national and local health infrastructure (often due to better wages and greater prestige of working with the internationally funded project).

Many of our members report anecdotally on the huge damage to maternal health services of such single issue investment, and the immense disempowerment of health professionals working in the less well funded and recognised areas of the local health service (in particular, maternal health services).

CMF would urge DFID to work with all these bodies towards strategies that strengthen national and local health systems across the board, rather than in single issue exceptionalism, which can be disastrous for other areas of health need. Over-emphasis on single interventions to deal with maternal health is a particular concern, and over-emphasis in some bodies on access to 'safe abortion' rather than a more multi-level approach would be one area DFID should avoid.

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[14] Stiglitz J (2003). Globalization and its Discontents. Penguin, ISBN-10: 014101038X

8. Non-state actors
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?

CMF has links with over 150 of our members working in NGOs and faith based organisations (FBOs) across the breadth of the developing world, and anecdotal evidence suggests that many of the most effective and innovative developments in healthcare provision are coming through such 'non-state actors'.

Church based organisations, including traditional mission hospitals and clinics, and more innovative primary care projects, are major players in healthcare across much of the developing world. In sub-Saharan Africa such groups are providing a significant proportion (and in some countries, the majority)[15] of health services, including maternity services. DFID must engage constructively with these FBOs if it is to have a significant impact on developing services to address maternal mortality.

But we believe it goes deeper than this. 'The failure to understand the influence of religion in African health worlds, or the failure to reflect on certain assumptions of Western health worlds threaten the important work of organizations like WHO.' ARHAP (2006).[16] As stated before, in most parts of the world, religion forms the underlying worldview that shapes beliefs about health, the role of women and childbirth, and attitudes to maternal and newborn health and health services. This is borne out by the experiences of our members in Africa, Central and South Asia, rural East Asia, Latin America and elsewhere.

DFID must work with faith leaders, religious scholars and faith communities as well as FBOs if it is to have a real impact in tackling maternal mortality. Only a faith based approach, taking into account sacred texts and traditions can be really effective in mobilising religious communities and religious assets to change religiously based attitudes to the health, status and wellbeing of girls and women.

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[15]Pear E, Chand S *et al*, African Christian Health Associations: Joining Forces for Improving Human Resources for Health, USAID, The Capacity Project 2009
[16]ARPHAP (2006) *Ibid*.

9. Service delivery models
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?

Read background information. Read options to consider. When posting your comment, please state whether it is an individual, group or organisational response.

Improving the national health services is obviously essential and, in particular, training and empowering health professionals to provide the best level of care possible is vital.

In many countries, levels of knowledge and skills among medical professionals are often very basic at best, and not necessarily up to an acceptable standard. The attitudes of staff are also often shaped by local beliefs, by working in a resource poor context where their work is not valued (or perceived to be valued) by government or wider society. And while many health professionals desire to do good, they are often overwhelmed by the need, and worn down by the lack of supplies available. As we have stated before, we also see the vital need to have not only good supply chains, but means of monitoring and ensuring that essential and basic supplies (such as magnesium sulphate and prostaglandins) are actually available in maternity hospitals.

As one of our members says: ‘The doctors we trained in Cure Hospital in Kabul all, without exception, expressed gratitude for the opportunity and responded well to the discipline and structure of accountability put in place. Good mentoring and modelling makes all the difference. We watched these young doctors blossom and grow in astonishing ways during their years with us.’

However, we have seen from many different examples that just focusing on training individual health practitioners rather than focusing on teams has less impact. If health workers are selected by, and then serve within, their own communities and are trained as a team, then these health workers and professionals become agents for change in their own communities, and engage in local political activity, including addressing violence against women. Training needs to be practical and ‘hands on’, as well as theoretical, depending on the skills mix needed. These approaches lead to lower staff turnover and staff who are more empowered and motivated.

We would argue that first training and then establishing family doctors in rural health facilities can make a significant difference to maternal and child mortality in that area. Obviously that is only the case if the health facility (and personnel) continues to be supported and supplied, and there are referral options. Experience suggests that it is far more cost effective to have two well trained family medicine doctors locally who have basic training in obstetrics, gynaecology and paediatrics, than to have a few ‘specialists’ in each of these fields in a remote secondary care institution. Family medicine doctors can be trained to perform caesarean sections, give spinal anaesthetics or ketamine, and resuscitate the newborn, etc.

However, our members' experiences suggest that it is almost impossible to get funding for postgraduate and post-basic training for health professionals or for community health workers. DFID could definitely do more to indentify training

schemes for community health workers and post-registration doctors, nurses and midwives that will directly address maternal and child mortality, and which are already running in country, and help fund and expand them.

Some of our members have worked at the LAMB project in northwest Bangladesh, a Lutheran Mission Hospital which has developed a Home to Hospital continuum of care, including:

- the training of village health workers in basic health education for pregnancy, birth planning, child care and family planning

- training of community skilled birth attendants

- the provision of safe delivery units within the community, with transport to comprehensive emergency obstetric care (CEOC) in the hospital

- the provision of 24/7 CEOC – including advanced trained midwives and non-physician anaesthesia providers (the lack of anaesthesia provision is a major barrier to the provision of emergency obstetric care)

This continuum of care, which empowers the communities themselves to take responsibility for the health of their own women and children, has been shown to reduce perinatal and maternal mortality significantly. This has been achieved by making health care accessible by the rural poor – LAMB has reduced the rich-poor gap in accessing maternal health care.

This is one example of a continuum of care approach, and the success of such projects is due in part to the holistic approach, to addressing the system as a whole, not in a piecemeal fashion. Each part of the system works, and each health worker feels a part of the bigger picture.

10. Fragile states and humanitarian situations
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?

There is disturbing evidence of violence against women in humanitarian situations – the publicity given to severe abuse in DRC is widely recognised but there are likely to be similar, undocumented situations where rape and transmission of STIs during times of conflict occur to the detriment of maternal health.

UNAIDS and World Vision have reviewed the rationale for including HIV within humanitarian relief. It should be recognised that it is not only the military who are involved in sexual violence. Jewkes *et al* (in the *Lancet* 2010 376, 41-48) describe the problem of intimate partner violence and HIV in South African women. It seems likely that where the culture of violence against women is strong, as in DRC for example, there will be many cases of women being raped by neighbours and partners.

Heal Africa, a church based NGO in Kigoma, DRC has extensive experience of dealing with trauma against women and has shown that the support of church based volunteers is crucial in the support of women who need emotional and spiritual support as much as medical assistance. Emergencies, with their associated problems of translocation and difficulty in access to neonatal health services, require much greater attention to the health of women and their neonates. Water, shelter, sanitation and food are often provided, but specific women- and child-focused services are, in practice, often neglected.

CMF urges DFID to put greater emphasis on inclusion of services for women in humanitarian response. In practical terms, as it is in many cases the INGOs, and their associated church partners, who will provide the humanitarian relief and services, CMG urges DFID to ensure that specific maternal health and perinatal health targets are written into the Terms Of Reference for contracts with INGOs.

11: Knowledge, research and innovation
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 in policies and practices?

The strength of CMF opinion is in the extensive network of its members, about 150 of whom are in day to day practical 'hands on' practice in the developing world – whether clinical or community, with around two thirds working in association with church groups or Christian faith based organisations.

There are many undocumented examples of Good Practice. CMF notes that the evidence referred to in this Submission is nearly always obtained from randomised controlled trials of carefully performed community interventions, published in peer reviewed journals. These are vital and often supported by the Wellcome Trust and the Gates Foundation. But there is very little data about what happens when such pilot schemes are scaled up – if they ever are. This is largely because funding sources do not support such operational research. CMF urges DFID to be more proactive in support of research which analyses what can happen when civil society (in very many if not most cases this means faith based organisations) is given support to target, support and enable access to maternal health services for those not able to receive them.

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