Valeria Estrada
Innovations for Peace and Development
Global Health Team
March 2014

MNCH Donor Review: United States

Saving Mothers, Giving Life and USAID's impact on maternal mortality

Saving Mothers, Giving Life (SMGL), one of United States Agency for International Development's (USAID's) flagship maternal health programs, is one of many initiatives to improve maternal health in developing countries. With Millennium Development Goal 5 (MDG 5)—reducing maternal mortality by three-fourths—lagging behind all of the other MDGs, we have seen a surge of maternal health projects worldwide. Planning for the project began in June of 2011, and the implementation of the project in pilot districts of Zambia and Uganda began in early 2012. Phase 1 of the project come to an end in early 2013, and in 2014 the program is just beginning Phase 2, which is concerned with "scaling up" and expanding in other districts of Uganda and Zambia. In order to do so successfully, however, SMGL's implementing partners will need to review the challenges incurred during Phase 1 and work towards minimizing these issues.

Program Background

The program is a $200 million, five-year initiative, with USAID providing $31.5 million. Its bilateral partners include the Governments of Norway, Uganda, and Zambia, while the private partners include the American College of Obstetricians and Gynecologists, Every Mother Counts, Merck for Mothers, and Project C.U.R.E.

	UGANDA	BOTH	ZAMBIA
Ways of working	▪ Mobile clinics for maternal health services ▪ Involvement of private facilities	▪ Onsite mentoring ▪ SMGL district coordinators ▪ Improved referral networks ▪ High-level partner coordination ▪ Data collection by VHTs & SMAGs	▪ Churches deliver safe motherhood messages ▪ Local leaders as Change Champions ▪ Phased implementation approach ▪ Emergency drills for mentoring ▪ Referral & feedback pilot ▪ Mothers shelter logs
Community mobilization	▪ Transport committee ▪ ANC4 incentive system ▪ Transport & service vouchers ▪ Income generating activities for VHTs ▪ Male involvement promoted at soccer ▪ Partnership with village savings association	▪ Safe motherhood day/week ▪ Mama Kits/Packs	▪ Incentives for postnatal care ▪ Culturally appropriate birth plans ▪ Incentives for traditional birth attendants ▪ Drumming group promotes safe motherhood ▪ Recognition meetings for exceptional facilities
Technology	▪ Phones for VHTs ▪ Bodas for mothers ▪ BABIES matrix for facility monitoring of newborn indicators	▪ Local radio programs ▪ Solar lighting	▪ Zambulances-terrain appropriate vehicles ▪ Kit (tackle) boxes for obstetric emergencies ▪ SMS pilot for following pregnant women in the community

Figure 1—Source: Saving Mothers, Giving Life External Evaluation: Interim Report Phase 1

SMGL's main goal is to reduce maternal mortality by 50% by improving women's use of high quality obstetric care during the 24 hour period surrounding delivery. To do so, they focus on increasing *demand* for care via community mobilization and birth planning, increasing *access*

to care via transportation and obstetric service expansions, improving the *quality* of care via training for health workers and ensuring drug supply, and improving health records and maternal death audits.

Midpoint Implementation Successes

Mid-point implementation results show that the program has enjoyed successes in both Uganda and Zambia thus far. SMGL's Interim Report predicts that facility deliveries have increased dramatically by providing several incentives. Two key components of Phase I that contributed to the increase in facility deliveries were the the introduction of vouchers for transport and private delivery care and the training of thousands of health workers. These health workers were organized into community health worker teams. Ugandan health workers are organized into Village Health Teams (VHTs), while those in Zambia are organized into Safe Motherhood Actions Groups (SMAGs). Further, there have been reportedly high levels of community engagement and enthusiasm in both Zambia and Uganda, both of which are essential for successful and sustained implementation. Table 1 (below) summarizes some of SMGL's successes in Uganda and Zambia.

An underlying concern throughout SMGL's activities, however, has been the issue of sustainability. Many respondents in the Interim Report were concerned that the program's short timeframe would hinder the sustainability of the project. They argued that in order to reach a point of sustainability, there would need to be at least a five-year timeframe during which the program could be handed over to the national government. Other respondents, however, seemed optimistic in the possibility of sustainability, noting that SMGL had strengthened the countries' district health systems, such as their health information systems.

Table 1 Midpoint Successes

	Uganda	Both	Zambia
Facility Deliveries	• 55.9% health facility coverage		• 31% increase in health facility deliveries
Health Workers	• 600 per district trained • 130 hired		• 120 – 210 per district trained • 46% increase in community SMAGs • 32% increase in low level health facility SMAGs
Items Distributed to Encourage Facility Deliveries		• "Mama kits" (bundles of newborn supplies) • Ambulances, motorized and bicycle • Transportation and private delivery care vouchers	
Improvements to Facilities	• 17 maternity wards renovated • Facilities with electricity increased from 58% to 94% • Facilities with no water shortages increased from 49% to 62%		• 24 hour delivery services in hospitals increased from 50% to 100% • 24 hour delivery services in lower level health centers increased from 15% to 91%
Data Management	• Improved integration of private sector data into district information systems	• Reported increased quality and timeliness of maternal and newborn data	• Substantial investment in electronic health cards linking patient databases • Community workers trained to perform verbal autopsies

Challenges in Phase 1

Despite these important successes, SMGL has faced a variety of challenges over the past year. Many of the challenges cited in project evaluations of Phase 1 of the project include time pressures, difficulties in implementation, and coordination issues. These issues were rooted in timeframe concerns, funding concerns, transport barriers, staffing shortages, and coordination issues between private and public agencies.

Contextual Issues

Transportation barriers, include rough terrain and inaccessibility of facilities due to inclement weather, and weak transport infrastructure, have compromised SMGL's efficiency. These types of issues were anticipated and planned for in the SMGL implementation process; however, they continued to hinder successful implementation and facility deliveries. For example, . In order to avoid these issues in future phases of the project, partners will need to consider implementing the use of different emergency vehicles.

A significant challenge cited in interviews was a general shortage of staff. The levels of health workers were reportedly low, with an estimated 48 skilled health workers per 100,000 people in the Zambian districts and 25 skilled health workers per 1000,000 people in the Ugandan districts. In an interview, Dr. Jesca Nsungwa-Sabiiti, Assistant Commissioner of Health Services in Charge of Child and Newborn Health Services of Uganda, cited human resource development as one of the biggest challenges facing Ugandan districts. SMGL's budget may be an underlying factor in this issue, as some respondents in the Interim Report were concerned that clinics would be unable to retain their staff after the project had ended.

Implementation Issues

Concerning timeframe issues, many people interviewed believed that one year was too short a time to implement Phase I of the project sustainably. They said it incentivized short cuts and made it difficult to involve in the Ministry of Health in the project implementation process. The reason for a short timeframe seems to be underlying issues with funding and uncertainty about its availability long-term. Ironically, many respondents noted that the short timeframe may hinder SMGL's efficiency and sustainability, which may discourage donors from continuing to fund the project. For example, voucher distribution in Uganda was limited to women in their third trimester of pregnancy to ensure that funding would be available when women actually delivered their babies because project implementers were afraid funding would be unavailable after the end of Phase I.

Those interviewed also cited coordination between the governmental and private agencies as an issue. In particular, there was a lack of clarity concerning the leadership roles of the Center for Disease Control (CDC) and USAID. The involvement of both created a large group of stakeholders, each of which had their own approaches to improving maternal health. For example, implementing partners on the ground already had maternal healthcare interventions in place and were reluctant to change them, especially if the program was only for a program with a one-year timeframe.

Many of these implementing actors expressed a desire for more direction from USAID, CDC, or even the Ministry of Health in the pilot country. They explained that their roles in the project were not clear, and felt that this led to poor coordination both between implementing partners on the ground, and between implementing partners and USAID, CDC, and the Ministry of Health. . This issue resulted in a variety of difficulties, particularly in the two following areas:

Surveys with implementing actors found duplication of multiple services. In Zambia, for example, Safe Motherhood Action Groups (SMAGs) were being trained by several implementing partners . This led to confusion about what roles each group had and what their activities were. Minimizing this type of duplicity could assist in increasing the program's efficiency, especially in the context of a short timeframe.

Additionally, communication between the pilot country capital and its districts was not as consistent as it could have been. Zambian district officials reported that SMGL partners and the Ministry of Health sometimes acted independently from one another without informing the other. For example, the district officials reported that the Ministry of Health sometimes made decisions centrally without consulting the districts. As with duplication of services, this type of behavior also has serious potential to hinder the project's progress and efficiency.

Moving Forward: Learning from Phase 1 Challenges

In spite of the challenges, SMGL possesses ample potential for achieving sustainable growth in its pilot districts. The project's external evaluation interim report makes several suggestions for the second phase of the project.

First, it recommends the continuation of community engagement in the project's implementation. This would work towards SMGL's goal of increasing demand for maternal care. Further, it suggests investing in higher levels of staff training in order to overcome the human resource development issues that SMGL faced in Phase 1. Finally, the report recommends expanding the focus of postpartum care beyond a 24-hour period. While the authors recognize that the first 24 hours after delivery are vital for maternal health, continued postpartum care with

the inclusion of family planning to reduce maternal mortalities due to unintended pregnancies and post-abortion complications.

Additionally, there must be improved coordination amongst SMGL partners and implementing actors. As aforementioned, lapses in coordination and communication have substantial potential to diminish the efficiency and progress of SMGL's sustainable and successful implementation. Especially with the project's short timeframe, efficiency is key in achieving SMGL's goal of reducing maternal mortality by half in its districts. USAID and its partner organizations must set and agree to clear guidelines and roles. Further, the partners must work to convince implementing actors to compromise their standing activities for the sake of the project's successful implementation. Finally, there must be clear communication between the partner organizations and the communities.

If SMGL can successfully implement these recommendations, continuing its successes from phase 1 and learning from its challenges, it will have a high potential of making a serious positive impact on maternal health, potentially expanding to other countries with high levels of maternal mortality in the future.