Saving Mothers, Giving Life (SMGL) is a public-private partnership to dramatically reduce maternal and newborn mortality in sub-Saharan Africa.

Launched in 2012, SMGL is a five-year initiative that strengthens health services in countries facing high levels of maternal and newborn mortality by increasing demand, facilitating access to lifesaving care and strengthening health systems at the district level. The initiative’s founding partners include the governments of Uganda, Zambia, the United States and Norway as well as Merck for Mothers, Every Mother Counts, Project C.U.R.E. and the American College of Obstetricians and Gynecologists.

The initiative’s “proof-of-concept” phase delivered remarkable results, contributing to a rapid decline in the number of women who die during pregnancy and childbirth in SMGL program areas in Uganda and Zambia.

A quantitative evaluation of the initiative’s first year by the Centers for Disease Control and Prevention revealed a 30% decrease in the maternal mortality ratio in target districts of Uganda and a 35% reduction in target facilities in Uganda and Zambia.

### SMGL PHASE 1 KEY RESULTS

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Uganda</th>
<th>Zambia</th>
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<tbody>
<tr>
<td>Institutional maternal mortality ratio</td>
<td>-35%</td>
<td>-35%</td>
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<tr>
<td>Institutional perinatal mortality ratio</td>
<td>-17%</td>
<td>-14%</td>
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<tr>
<td>Institutional stillbirth ratio</td>
<td>-20%</td>
<td>-19%</td>
</tr>
<tr>
<td>Obstetric case fatality rate in facilities providing emergency obstetric and newborn care (EmONC)</td>
<td>-18%</td>
<td>-35%</td>
</tr>
<tr>
<td>Availability of 24/7 services provided at health centers</td>
<td>+24%</td>
<td>+44%</td>
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<tr>
<td>Deliveries taking place in a health facility</td>
<td>+62%</td>
<td>+35%</td>
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<tr>
<td>Facilities able to manage basic maternal and newborn complications</td>
<td>+200%</td>
<td>+100%</td>
</tr>
<tr>
<td>Cesarean section rate</td>
<td>+23%</td>
<td>+15%</td>
</tr>
<tr>
<td>HIV-positive pregnant women receiving antiretroviral treatment</td>
<td>+28%</td>
<td>+18%</td>
</tr>
<tr>
<td>Infants receiving HIV prophylaxis</td>
<td>+27%</td>
<td>+29%</td>
</tr>
<tr>
<td>Hospitals providing at least one long-acting family planning method</td>
<td>+10%</td>
<td>+50%</td>
</tr>
<tr>
<td>Hospitals conducting maternal death audits</td>
<td>+223%</td>
<td>+100%</td>
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</table>
Dear Health and Development Colleagues,

I am pleased to share a mid-year update on the progress of SMGL as we transition to Phase 2 of the partnership.

SMGL was launched two years ago with high hopes and even loftier goals. Thanks to committed partners, strong leadership from the Ugandan and Zambian governments and effective coordination on the ground, we have achieved remarkable results to date. Our “proof-of-concept” phase has clearly shown that by working in support of national health strategies and plans, we can make a significant difference—and we can make that difference in just one year.

We’ve learned some important lessons through the robust (qualitative and quantitative) monitoring and evaluation undertaken during the first year of full implementation of the SMGL model. We believe these results confirm that it takes a functioning healthcare system to keep women and newborns alive; one or two interventions alone won’t put an end to preventable maternal and newborn deaths. Health system strengthening is a public health investment and a strengthened system is a public health good.

In addition, the system must bring together the resources and strengths of both the public and private sectors to address the three delays in receiving lifesaving maternal and newborn care: delays in, 1) seeking appropriate care, 2) reaching care in a timely manner and 3) receiving quality, respectful, normal and emergency care at a facility from a skilled birth attendant. And, with the proportion of maternal deaths due to indirect causes rising, it is imperative to integrate HIV counseling and testing and increase the use of antiretroviral therapy by HIV-positive pregnant women while expanding services for preventing mother-to-child transmission. We also learned the value of focusing on the most vulnerable period for mothers and newborns: labor, delivery and the first 48 hours post-delivery—the critical “survival convergence,” when our efforts can maximally save both women and newborns.

Put simply, we believe that every woman should have access to clean, safe, normal delivery services as close to her home as practical and to lifesaving care within two hours of the onset of a complication. “Access to emergency services within two hours”—that has become our mantra.

As we move into Phase 2, we will continue to support what has worked while focusing more intently on building district capacity for capturing pregnancy outcomes, improving quality of care, increasing customer satisfaction and strengthening both essential and lifesaving newborn care. We’re confident that the success we’ve seen in reducing stillbirths during Phase 1 will translate to progress in newborn survival in Phase 2. And thanks to additional support from new global partners, we will be expanding our model to many more districts in both Uganda and Zambia.

The global health and development community is setting bold new targets for ending preventable maternal, newborn and child deaths by 2035, and achieving an AIDS-free generation. Based on our progress to date and our vision for the next few years, we believe SMGL has an important part to play in reaching these ambitious goals.

With best regards,

Claudia Morrissey Conlon, MD, MPH
USAID Senior Maternal Newborn Health Advisor
U.S. Government Lead, Saving Mothers, Giving Life
During Phase 1, Saving Mothers, Giving Life employed a range of evidence-based interventions to strengthen existing district-level health networks to help overcome the three delays that often prevent women from receiving lifesaving care during pregnancy or childbirth. Some of these activities included:

**DELAY 1 / Seeking Care**
- Deploying community-based health teams (e.g., Village Health Teams in Uganda and Safe Motherhood Action Groups in Zambia) to engage community leaders in generating demand for facility-based maternal and newborn care and to educate women and families on the importance of creating birth plans, attending four antenatal care visits, being tested for HIV, considering options for postpartum family planning and utilizing delivery services

**DELAY 2 / Reaching Care**
- Establishing reliable communications and emergency transportation networks—utilizing both public and private resources—between facilities and communities to improve access to facility-based maternal healthcare and emergency referral services
- Designing new, more sustainable models for maternity waiting homes to ensure that pregnant women in remote areas can access lifesaving maternal and newborn health services (MNH) in a timely manner

**DELAY 3 / Receiving Care**
- Using routine visits from mentors to reinforce clinical skills among healthcare providers
- Ensuring reliable supplies of lifesaving MNH commodities such as oxytocin, magnesium sulfate and gentamycin
- Equipping facilities to provide high quality emergency obstetric and newborn care (EmONC) in a geographically strategic way, enabling women with complications to receive care within two hours
- Training and mentoring skilled birth attendants to provide quality, respectful delivery services and stabilize, treat and refer emergency cases as necessary
- Encouraging policies to ensure fair compensation for skilled providers at lower-level facilities to retain talent and increase access to lifesaving care
- Improving data collection systems to record pregnancy and birth outcomes, including complications and deaths, and strengthening host country health management information systems
Lessons Learned

SMGL’s impressive progress in its first year is a testament to what can be accomplished when governments, NGOs, faith-based organizations and the private sector zero-in on a public health problem with a coordinated, comprehensive approach. An evaluation of Phase 1 conducted by Columbia University highlighted several lessons that will be pivotal to the initiative’s ongoing success in Uganda and Zambia. The findings from the evaluation are outlined below:

+ **Country ownership was critical to promote long-term sustainability.** SMGL was designed to build on the host country governments’ MNH plans. In the evaluation, stakeholders in both Zambia and Uganda cited that the strong alignment between SMGL and national health policies and well-functioning national partnerships among host country government officials, U.S. government representatives and a range of implementing partner organizations were key success factors of the initiative. SMGL gave the Ugandan and Zambian health ministries a way to operationalize their national commitments to reducing maternal mortality by bringing visible improvements in services for mothers and newborns in intervention districts within a short time.

+ **Leveraging preexisting platforms enabled rapid roll-out.** SMGL was built on preexisting HIV/AIDS and maternal and child health (MCH) service delivery platforms, rather than creating parallel systems. This approach produced important insights into the use of existing development assistance platforms (e.g., PEPFAR and MCH) to rapidly scale new programs.

+ **Taking a systems approach was essential to achieving reductions in maternal and perinatal deaths.** SMGL adopted a comprehensive health system strengthening approach that coordinated inputs and utilized solutions from both the public and private sectors. Involvement of the Ugandan private sector improved access to services through transport and the rapid expansion of the availability of obstetric services for pregnant women. The combination of trained, confident staff and functioning facilities with adequate medicines and reliable equipment was highly synergistic. The majority of Ugandan providers and women interviewed rated the quality of care in the SMGL districts much higher than in non-SMGL districts.

+ **Community involvement was instrumental to promoting facility delivery.** SMGL trained more than 6,000 community workers, local leaders and advocates to promote key behavior change messages and generate demand for facility-based services. We found that working with community-level groups to promote birth planning, encourage facility deliveries and support timely referrals was a game-changer in both countries. The high level of participation by community leaders was credited with changing community perceptions and building demand.

+ **Robust monitoring and evaluation are needed to demonstrate impact.** SMGL sought to enumerate all perinatal and maternal deaths that occurred in the community and facilities, as well as track changes in key inputs, service utilization and quality of care. Capturing mortality as part of the “proof of concept” phase was important to understand if the approach was working and for garnering support. Stakeholders in both countries cited improvements in health information systems that resulted in better and more timely data on mothers and newborns. For example, in Zambia, CDC reported that all the hospitals were able to conduct maternal death reviews by the end of Phase 1. In Uganda, there was better integration of data from private-sector facilities into district information systems.

+ **Inter-agency collaboration strengthened implementation.** SMGL adopted a U.S. government (USG) inter-agency collaborative approach, maximizing the core competencies of the various agencies. Stakeholders often noted the collegial and productive relationship between USG agencies in both countries as an essential ingredient to the early success of such a large program.

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**PHASE 2 OVERVIEW**

Saving Mothers, Giving Life is expanding to six new districts in Uganda and 12 new districts in Zambia with a long-term goal of national scale-up to save more women’s and newborns’ lives. Building on the experience from Phase 1, Phase 2 will:

- **Increase Attention to Newborns:** SMGL will expand the package of interventions to increase its focus on the newborn (See Table 2). During Phase 1, SMGL trained providers on newborn resuscitation and essential newborn care (ENC), which resulted in reductions in stillbirths but no statistically significant reduction in the neonatal mortality ratio. SMGL will place greater emphasis on newborns to help achieve more notable reductions in newborn mortality. For example, the BABIES monitoring methodology (See Table 2) that was used in SMGL facilities in Uganda will be introduced in Zambian facilities.

- **Prioritize the “M” in M&E:** SMGL will focus more on monitoring than on evaluation. We will work with government, non-profit, private-sector and community counterparts to strengthen public health surveillance in districts to better inform real-time responses in order to improve MNH services. This will include: 1) strengthening enumeration of maternal and newborn deaths in communities and facilities, 2) institutionalizing the maternal and perinatal death surveillance and response systems, including verbal autopsies in the community and 3) enhancing routine data collection and health management information systems to improve service performance.

- **Streamline Implementation:** SMGL will work with partners to streamline implementation and

![Image of newborn care](image1.jpg)

![Image of newborn care](image2.jpg)
reduce duplication. In Phase 2, we will focus on clarifying roles and responsibilities, standardizing tools and approaches (particularly for M&E) and simplifying reporting requirements.

- **Enhance Customer Focus:** SMGL will focus on client satisfaction as a key measure of quality of care. As a result, client exit interviews will be conducted to assure that the services provided are appropriate.

- **Expand the Partnership:** SMGL will continue to recruit new partners and donors to achieve national-level scale-up in Uganda and Zambia, and expansion to additional sub-Saharan African countries.

- **Contribute to a Global Movement:** SMGL will contribute its lessons learned to accelerate the global movement to end preventable maternal and newborn deaths. To that end, SMGL leaders will present the initiative’s successes and challenges at upcoming global HIV and MCH meetings.

### TABLE 2 | Increased Attention to Newborns

Despite global progress in reducing newborn deaths since 1990, each year nearly three million newborns do not survive the first hours and days after birth. *Saving Mothers, Giving Life* is scaling up low-tech interventions to help improve newborn survival, such as:

- Training health providers on newborn resuscitation and care through the Helping Babies Breathe and Essential Care for Every Baby curricula, endorsed by the World Health Organization.

- Mentoring providers and using skill drilling exercises to help maintain their clinical skills, particularly in newborn resuscitation and essential newborn care.

- Enabling providers to use antenatal corticosteroids for women at risk of preterm birth to decrease neonatal health risks.

- Encouraging providers to adopt kangaroo mother care (skin-to-skin contact and breastfeeding) for low-birth-weight babies.

- Ensuring a reliable supply of newborn medicines, supplies and equipment (e.g., topical chlorhexidine, antibiotics, newborn bag and mask resuscitators) to provide quality newborn care services.

- Conducting home visits within two days of birth to evaluate the health status of mothers and newborns and link them to care if needed.

- Supporting districts to conduct perinatal death reviews and utilize the BABIES Methodology, a simplified method for collecting and analyzing data on perinatal deaths to inform the interventions needed to address the key causes of death.
Midwives in Uganda play a crucial role in providing affordable, high-quality antenatal care and childbirth services in both the public and private sectors."

“Saving Mothers, Giving Life is built on the PEPFAR platform, which allowed us to hit the ground running and attain the immense gains in access to facility-based services for pregnant women in Phase 1. As we enter Phase 2, we plan to roll out a digital communications platform to better connect women in remote regions to facility-based services, similar to strategies used in HIV/AIDS. I'm very excited that in SMGL's second year we will continue to leverage successes from the HIV/AIDS field to save women's and newborns' lives.”

DANIEL MUROKORA, Baylor University

“Midwives in Uganda play a crucial role in providing affordable, high-quality antenatal care and childbirth services in both the public and private sectors.”

One of the private-sector midwives I work with had just set up her private health facility when I visited in early 2013 to integrate her clinic into our ProFam franchise network. Her clinic is immaculate and offers a wide range of services, including family planning, antenatal care, labor and delivery, routine immunizations, basic newborn care and referrals to higher-level facilities in case of emergencies. She typically manages between 15 and 20 deliveries a month and, since she lives in the community she serves, women love coming to see her because she understands their needs and customs and they view her as a trusted source of information. This relationship helps women stay connected to care before, during and after childbirth to maximize maternal and newborn health outcomes.”

HANNA BALDWIN, Program for Accessible Health Communication and Education (PACE)
The ELMA Foundation recently joined SMGL as the newest partner in Uganda. ELMA will provide US $3 million over three years to Baylor College of Medicine Children’s Foundation–Uganda and the Infectious Diseases Institute to enhance newborn care programs in the four pilot districts in western Uganda.

**SPOTLIGHT | New Partner**

**PHASE 1**
- Kabarole (1)
- Kamwenge (3)
- Kibaale (2)
- Kyenjojo (4)

**PHASE 2**
- Nwoya (5)
- Gulu (6)
- Pader (7)
- Lira (8)
- Apac (9)
- Dokolo (10)

**PHASE 2 UGANDA**

<table>
<thead>
<tr>
<th><strong>Increased Reach</strong></th>
<th>Spreading from four contiguous districts in western Uganda to six additional contiguous districts in northern Uganda</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expanded Focus on Newborns</strong></td>
<td>Focusing on improvements in intrapartum care, including prevention of preterm labor through the use of antenatal corticosteroids, neonatal resuscitation with the Helping Babies Breathe curriculum, enhancing essential newborn care, strengthening the management of low-birth-weight babies with kangaroo care and using the BABIES methodology to track deaths and improve the quality of care</td>
</tr>
<tr>
<td><strong>Health Worker Training</strong></td>
<td>Working with the Ugandan government to implement strategies for enhancing district-based training and mentoring and retaining health workers</td>
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<tr>
<td><strong>Maternal and Newborn Mortality Surveillance</strong></td>
<td>Supporting health facilities, district officials and provincial officials to fully implement and utilize the maternal/perinatal death surveillance and response system</td>
</tr>
<tr>
<td><strong>Program Monitoring</strong></td>
<td>Supporting community workers, health facilities, district officials and provincial officials to collect, analyze and use data to improve service use and performance</td>
</tr>
<tr>
<td><strong>Health System Support</strong></td>
<td>Working with government and private-sector facilities to improve infrastructure, provide equipment and strengthen supply chain to ensure adequate availability of medicines and supplies</td>
</tr>
<tr>
<td><strong>Private-Sector Approaches</strong></td>
<td>Supporting a voucher program that covers the cost of transportation and care to expand access to private-sector services; expanding the social franchise network</td>
</tr>
<tr>
<td><strong>Access to Quality Services</strong></td>
<td>Engaging the Ugandan Society for Obstetricians and Gynecologists to provide mentoring and on-the-job training for midwives and doctors</td>
</tr>
</tbody>
</table>
“We are helping to create a culture of seeking care when it’s necessary by instilling faith in and acceptance of the health system.”

CLAIRE-HELENE MERSHON, Center for Infectious Disease Research in Zambia

“Saving Mothers, Giving Life’s investments in healthcare infrastructure improve the Zambian healthcare system’s ability to respond to an array of health needs far beyond maternal health. When we procure emergency medical transport we ensure that any critically-ill patient can get to a healthcare facility in a timely manner. When we install solar panels on top of a facility to ensure a reliable source of electricity, we enable its staff to conduct surgical procedures at night. When a pregnant woman comes in for antenatal care or delivery, we use it as an opportunity to talk to her about immunization, HIV prevention and malaria prevention for her and the rest of her family.”

DR. KENNEDY MALAMA, Provincial Medical Officer, Eastern Province, Ministry of Health, Zambia

“Through our ‘Change Champions’ program, which mentors community leaders to become maternal health ambassadors, we’ve seen incredible local investment in improving access to maternal health services.”

One of our champions recognized that his community needed an emergency response vehicle, so he successfully lobbied the Ministry of Health for an ambulance for his village. Another secured cement donations from local companies and led her community in building a maternity waiting home.

We’ve also seen multiple leaders start gardens in their communities to provide food for pregnant women, particularly those living with HIV/AIDS. There was even a local leader who built a rural health post where district-level healthcare workers come every month to provide antenatal care so pregnant women in his community don’t have to travel for services.

Our “Change Champions” have also emphasized the importance of male involvement in maternal health, teaching their communities that pregnancy is not just the woman’s responsibility. This effort has been extraordinarily powerful in changing social norms and rebranding pregnancy as a family responsibility.

CHRISTINA WAKEFIELD, Communications Support for Health
The Swedish International Development Cooperation Agency (SIDA) recently joined SMGL as the newest partner in Zambia. SIDA is providing US$ 3.2 million to the Zambian Ministry of Health to implement MNH programs in five districts in Eastern Province and support the Provincial office.

35% DECREASE IN INSTITUTIONAL MATERNAL MORTALITY RATIO

**PHASE 2 ZAMBIA**

- **Increased Reach**: Expanding from four districts to 12 additional districts, linking district and provincial facilities and offering services to urban as well as rural populations.
- **Expanded Focus on Newborns**: Focusing on improvements in intrapartum care, including prevention of preterm labor through the use of antenatal corticosteroids, neonatal resuscitation with the Helping Babies Breathe curriculum, enhancing essential newborn care, strengthening the management of low-birth-weight babies with kangaroo care and using the BABIES methodology to track deaths and improve the quality of care.
- **Health Worker Training**: Coordinating with the Zambian government to integrate the HIV- and MNH-related curricula; streamline the EmONC curriculum and reinforce supportive supervision and mentoring visits.
- **Maternal and Newborn Mortality Surveillance**: Supporting health facilities, district officials and provincial officials to fully implement and utilize the maternal/perinatal death surveillance and response system.
- **Program Monitoring**: Supporting community workers, health facilities, district officials and provincial officials to collect, analyze and use data to improve service use and performance.
- **Health System Support**: Working with government and local facilities to improve infrastructure, provide equipment and strengthen supply chain to ensure adequate availability of medicines and supplies.
- **Private-Sector Approaches**: Testing and rolling out financially sustainable models of maternity waiting homes where women can stay in the late stages of pregnancy.
- **Access to Quality Services**: Working with the Zambian government to enhance onsite training and mentorship programs at facilities.

**Support from SIDA to provincial health office**

**PHASE 1**
- KALOMO (1)
- ZIMBA (2)

**PHASE 2**
- MANS A (3)
- CHEMBE (4)
- NYIMBA (5)
- LUNDAZI (6)
- SAMFYA (7)
- LUNGA (8)
- KABWE (9)
- CHEMA (10)
- PEMBA (11)
- CHIPATA (12)
- METWE (13)
- SINDA (14)
- VUBWI (15)
- MAMBWE (16)

| PHASE 2 LAUNCH REPORT 2014 | 9 |
Local community members have assumed roles as Village Health Team (VHT) members and Maama Ambassadors in Uganda and Safe Motherhood Action Group (SMAG) members and “Change Champions” in Zambia to help improve maternal and newborn health outcomes. Men, in particular, have played important roles in encouraging women to seek care, helping them reach health facilities and improving the quality of services delivered.

“Women are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving.”

DR. MAHMOUD FATHALLA, Professor of Obstetrics and Gynecology, Egypt

**SEEKING CARE** | In their roles as VHTs, Maama Ambassadors, SMAGs and “Change Champions,” local community members have contributed to elevating the importance of and generating demand for facility-based MNH services among women, their male partners and family members. Activities included:

- Registering local households with pregnant women and conducting follow-up visits to ensure healthy progression of pregnancy
- Raising awareness of the value of facility-based MNH services through the use of behavior change communications activities like musical performances and other events
- Educating pregnant women, their male partners and family members about the importance of budgeting for maternal health services and knowing the danger signs during pregnancy, childbirth and for newborns
- Distributing pregnancy care planners with information on birth planning, transportation, antenatal care, danger signs and nutrition during pregnancy
“All of us are responsible not only for our own health, but for the health of the people around us. If one family is able to support their neighbor when she’s having problems, the same will happen when this family is having problems. At the end of the day, you have a happier community.”

PATRICIA PIRIO, New Heights, Uganda

SMGL has enlisted the support of local community members in Uganda and Zambia to ensure that women reach facility-based maternity services in a safe and timely manner. Activities included:

+ Selling vouchers to women to cover transportation for a facility-based delivery and a referral if a complication should arise
+ Leveraging preexisting local transportation networks in remote areas to transport women to nearby facilities for antenatal, childbirth and emergency care
+ Participating in the development of financially sustainable, community-based maternity waiting home models—places where women can stay in the late stages of pregnancy so they are closer to care

Motorcycle operators in Uganda called “boda boda” drivers are male entrepreneurs who are enlisted to transport pregnant women from their communities to health facilities during labor

“My involvement is to see to it that the mothers should be giving birth in very healthy facilities, and we should monitor these.”

Chief Mpamba VI, Lundazi District

The local community in SMGL districts in Uganda and Zambia have played an integral role in incentivizing health providers to come to rural areas to practice. Activities included:

+ Communities have mobilized to contribute funding and labor for the construction of staff housing

In Zambia, male chiefs from local villages have become “Change Champions” — maternal health ambassadors who advocate for institutional delivery and higher-quality maternity services.

“In Zambia, male chiefs from local villages have become “Change Champions” — maternal health ambassadors who advocate for institutional delivery and higher-quality maternity services.

“Safe motherhood is not a standalone activity, say for instance with the traditional birth attendants or the health centers or the hospital staff. It’s about the whole community taking cognizance of the fact that we all need to play a role.”

CHIEF JONATHAN MUMENA, Solwezi, Zambia
"If you want to go fast, go alone. If you want to go far, go together." AFRICAN PROVERB

The governments of Uganda and Zambia have made significant commitments to improving maternal and newborn care in their countries, articulated through their national-level plans and strategies. The Saving Mothers, Giving Life model is aligned with these country plans and aims to build the capacity of the government, local institutions (in both the public and private sector) and communities to generate demand for and access to high-quality maternal and newborn healthcare.

During Phase 1, SMGL achieved dramatic results, contributing to the countries’ overall progress toward reductions in maternal and perinatal mortality.

While progress has been made, there is more to do. In May 2014, the World Health Assembly—strongly supported by the global health community—endorsed more ambitious global targets for maternal mortality (70 deaths per 100,000 live births), newborn mortality (10 deaths per 1,000 live births) and stillbirths (10 deaths per 1,000 live births) by 2035. These goals will continue to challenge Uganda and Zambia to make further investments to improve maternal and newborn care.

Country ownership—at the national, provincial and district levels of the government; among local institutions including the private sector; and within communities—is essential to improve and sustain MNH efforts. During Phase 1, SMGL began to see promising signs of country ownership that will contribute to a sustained demand for and supply of quality MNH services.

Over the next three years, there will be a gradual phase out of SMGL’s support, providing the Ugandan and Zambian governments, local institutions and communities the time required to fully incorporate their strengthened capacities and help ensure that the health system consistently provides quality MNH services.
In the past two years the partnership between Saving Mothers, Giving Life and our Government has led to improved access to quality maternal and newborn health services. This has resulted in better survival for mothers and fewer stillbirths in four districts. In Phase 2 we will expand to 12 additional districts and apply the lessons learned to other parts of the country so that we can end preventable maternal and newborn deaths. By strengthening district health structures, involving communities, especially men, engaging traditional leadership, and giving health workers the skills and tools to respond to obstetric and newborn emergencies, we can sustain and improve on these early successes with Saving Mothers, Giving Life."

PROFESSOR ELWYN CHOMBA, Zambian Ministry of Community Development Mother and Child Health

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**HOST COUNTRY GOVERNMENTS**

- Focused investments in specific geographic areas (SMGL districts) with a clear target (50% reduction in maternal mortality) enabled local governments and partners to effectively align interventions and harness resources to produce quick and potentially sustainable results.

- Adoption of a Wage Bill that increased salaries of rural health workers.

- Absorption/employment of health providers previously hired by implementing partners into the government system.

- Encouragement from national and district health officials that other donors adopt the SMGL approach in their project areas.

- Mentorship and on-site clinical support from the District Community Medical Officers helped foster the consistent delivery of high-quality EmONC at health facilities in SMGL districts.

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**PRIVATE-SECTOR SERVICE PROVIDERS**

- Reinvestment of funds—from vouchers—enabled providers to enhance their infrastructure, hire more staff and procure equipment and supplies.

- New revenue streams supported the introduction of new MNH services.

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**COMMUNITIES**

- Demand generation activities to promote facility-based health care resulted in significant increases in use of MNH services.

- Support for health services, including building maternity waiting homes and staff housing.

- Development of effective transportation and communications systems supported women in accessing health services.

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1 / What enabled the initiative to achieve such dramatic results in one year?

SMGL followed and strengthened national MNH plans already in place in both Uganda and Zambia, thanks to extensive engagement with government officials, particularly at the district level. We implemented a district-level health systems strengthening approach that prioritized inputs to both the public and private sectors that improved the functioning of the entire system, rather than just providing discrete benefits. As part of this approach, we leveraged existing service delivery platforms to integrate MNH- and HIV-related services and accelerate outcomes of interest to both the MCH and HIV/AIDS communities. Along with private-sector partners that focused on private providers within our target districts, SMGL’s inter-agency approach also brought together different resource streams to support a shared goal of saving the lives of women and newborns.

2 / Is there a critical finding from this first year of SMGL?

Yes. To significantly decrease maternal and newborn mortality, women must have access to clean, safe and respectful, normal delivery care from a skilled provider at a facility as close to their homes as is practical, as well as access to quality, appropriate (only medically-indicated) emergency obstetric and newborn care within two hours of the onset of a complication. If we bring lifesaving care closer to women, ensure expedited travel times to care and/or bring women closer to lifesaving care, we can foster significant improvements in maternal and newborn health outcomes.

3 / SMGL utilized a comprehensive approach to save mothers’ lives. Are there two to three key interventions that could produce the same results at much less cost and intensity?

No. The maternal mortality ratio is a sensitive indicator of a healthcare system’s functional status for a reason: it takes a system to save these women’s lives. Focusing on only one or two key interventions like training or transport will not end preventable maternal and newborn deaths. Fortunately, once a functioning system is created, it will also save the lives of children, adolescents, adults and the elderly—men and women. System strengthening is a public health investment and a strengthened health system is a public health good.

The SMGL expenditure study, conducted by the Futures Group, characterized the initial investments and recurring costs of our district-strengthening approach as modest. These expenditures led to dramatic decreases in maternal mortality in a very short time. Unfortunately, 25 years after the initiation of the Safe Motherhood Initiative, we have little data on how other approaches compare on value for money. As we transition into Phase 2, we do not recommend jettisoning lifesaving elements of the SMGL approach simply to decrease cost. Rather, we are committed to providing the system-wide care that is needed to keep women and newborns alive in the most cost-efficient way.
4 / Is SMGL funded primarily by donors?

No. By far the largest outlays in support of the SMGL approach are provided by the governments of Uganda and Zambia. Our initiative builds on the countries’ existing public and private healthcare systems, with support for interventions and oversight from USAID and PEPFAR. Additionally, throughout Phase 1, both countries picked up an increasing number of inputs, including provider salaries, ambulances and training.

5 / How does the SMGL approach promote government ownership, scalability and sustainability?

From the very beginning, we focused on the needs of host country governments, building the program around existing national MNH plans, and sought to strengthen local partners’ and institutions’ ability to manage program activities. In order to be successful, our partners recognized the importance of developing a true partnership with governments and local institutions to ensure sustainable co-investment. The success of SMGL has bred a deeper commitment by host country governments as noted in the independent evaluation conducted by Columbia University: “The increased political priority for maternal survival and the sense that action is possible may be among the most potent legacies of SMGL.” In Phase 2, host country governments will increasingly lead in oversight and investment. Government officials have also been extended a seat on the SMGL Leadership Council, the governing body of the initiative.

6 / What are lessons learned from the collaboration of multiple U.S. Government (USG) agencies?

SMGL is largely rooted in the spirit of the Global Health Initiative’s approach to solving complex health problems: focusing on women, girls and gender equity; building country ownership and capacity; strengthening health systems; promoting global health partnership; integrating multi-sectoral interventions; promoting research and innovation; and improving metrics, monitoring and evaluation. In Zambia, a partner commented that the “fabulous inter-agency collaboration” during SMGL was a key driver of its success. This sentiment was echoed by a senior MOH official in Uganda, who observed that the collaboration among USG agencies in SMGL was “the best I’ve ever seen” of any U.S.-funded health program.

The complexity of an all-USG approach should not be underestimated—it is labor-intensive and actors must rise above historic agency differences. But, when USG agencies work together with clearly defined roles, the advantages are great—each agency is able to bring its own platform, resources and areas of expertise to the partnership. Collaboration serves as an important opportunity to make linkages between technical areas such as HIV and MNH and provide integrated care. This is particularly salient in light of the HIV epidemic in sub-Saharan Africa where indirect causes of maternal mortality are increasing.

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