



Saving Mothers, Giving Life

Primer

May 2014

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Saving Mothers, Giving Life Overview

History

The impetus for the *Saving Mothers, Giving Life* (SMGL) initiative came during former Secretary of State Hillary Clinton's visit to Lusaka, Zambia for the 2011 African Growth and Opportunity Act Forum. Clinton perceived that while the burden of maternal and newborn deaths was high in sub-Saharan Africa, a concerted global effort to harness evidence-based, low-cost interventions could save these lives.

Inspired by this call to action, the U.S. Government (USG) took the lead to design a new initiative that would help end the tragic and largely preventable deaths of women and newborns in Uganda and Zambia – two countries with high maternal and neonatal mortality and the political will to address these critical health challenges. Building on the Global Health Initiative (GHI) whole-of-government approach, the USG created an interagency headquarters and country support team comprised of senior maternal health and PEPFAR experts from the U.S. Agency for International Development (USAID), the Office of the U.S. Global AIDS Coordinator (OGAC), the Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention (CDC), Peace Corps and the Department of Defense (DOD). This team worked with the Ugandan and Zambian ministries of health to build a programming model that would accelerate collective action to end preventable maternal and newborn deaths in the critical period around labor, delivery and 48 hours postpartum.

The USG soon recognized that, in order to maximize its impact, a multidisciplinary team of global partners would need to be engaged. SMGL emerged as a public-private partnership by including the Norwegian Government, *Merck for Mothers*, Every Mother Counts, the American College of Obstetricians and Gynecologists and eventually Project C.U.R.E. to amplify its on-the-ground efforts. On June 1, 2012, Secretary Clinton formally launched SMGL, catalyzing the global movement she envisioned just a year prior.

Global Partners

- **The United States Government**, through USAID, leads SMGL in partnership with CDC, PEPFAR, the Department of State, the Department of Defense and the Peace Corps. Together, these agencies lead implementation, monitoring and evaluation (M&E) activities for the initiative.
- **Merck for Mothers** supports programs to strengthen local private health providers in Uganda and programs to develop entrepreneurial models for maternity waiting homes in Zambia.
- **Government of Norway** supports efforts to enhance access to low-price maternal health commodities and ensure critical hospital supplies and equipment are available.
- **Every Mother Counts** supports efforts to strengthen emergency transportation and referral systems in Uganda and advocate for increased support for maternal mortality reduction globally.
- **American College of Obstetricians and Gynecologist** provides scientific, technical and clinical expertise to SMGL, and will undertake emergency obstetric training and mentorship for health providers across SMGL districts.
- **Project C.U.R.E.** leads efforts to upgrade SMGL facility infrastructure and provides customized medical supplies, equipment and related program services to SMGL facilities.

Implementing Partners

Saving Mothers, Giving Life programs works with implementing partners that support in-country activities and M&E:

- **Uganda:** Baylor College of Medicine, Jhpiego, Uganda Health Marketing Group, Engender Health, Makerere University Infectious Disease Institute, MSH, PACE, Uganda MOH, Association of Obstetricians and Gynecologists of Uganda, Cardno Emerging Markets, Catholic Relief Services, Engender Health, IntraHealth International, Medical Access, Marie Stopes International Uganda, Stop Malaria Project, Uganda Blood Transfusion Services, Uganda Episcopal Conference, Uganda Pediatric Association, Uganda Protestant Medical Bureau, Uganda Society of Anesthesiologists, University Research Co.
- **Zambia:** Center for Infectious Disease Research in Zambia, Boston University, Jhpiego, Zambian Defense Force Medical Services/Department of Defense, Abt Associates/Zambia Integrated Systems Strengthening Program, Zambia Ministry of Health and Ministry of Community Development Mother and Child Health, Africare, Chemonics, Elizabeth Glazer Pediatric AIDS Foundation, Family Health International, John Snow, Inc., Marie Stopes International, Population Services International, Project Concern International, RTI International, University of Zambia, Zambian National Blood Transfusion System

The SMGL Approach

Driven by the audacious goal of decreasing maternal deaths by 50% in one year in 8 pilot districts of Uganda and Zambia, SMGL uses a district-strengthening systems approach to ensure that every woman has access to clean and safe normal delivery services as close to home as is practical and, in the event of an obstetric complication, emergency care within two hours. The model strengthens the existing health network – both public and private – within each district to help overcome the three delays that often prevent women from receiving life-saving care during a pregnancy or childbirth emergency:

Delay 1 | Delay in seeking care

SMGL addresses the first delay primarily through community education and mobilization to generate greater demand for care. We are:

- Training community health workers
- Helping women and families develop birth plans
- Distributing clean birth kits
- Raising awareness of maternal healthcare through radio broadcasts and drama skits
- Sensitizing community leaders to maternal health issues and recruiting them as ‘Change Champions’

Delay 2 | Delay in reaching services

SMGL addresses the second delay by bringing life-saving care closer to women, ensuring faster travel times to care, and by bringing women closer to care. We are:

- Increasing the number of functional service delivery sites in a given catchment area by upgrading facilities so they provide emergency obstetric and newborn care (EmONC)
- Strengthening the functionality and affordability of transportation systems and communication networks by procuring vehicles and motorcycle ambulances and distributing travel and service vouchers
- Establishing and renovating maternity waiting homes next to facilities that provide emergency obstetric care

Delay 3 | Delay in receiving quality, respectful care

SMGL addresses the third delay by training, deploying, equipping and motivating health providers to provide quality, respectful care during the most dangerous period for mothers and newborns – labor, delivery and the first 48 hours postpartum. We are:

- Hiring and training additional doctors, midwives and nurses in EmONC
- Training doctors and nurses in obstetric surgery and anesthesia
- Training, testing and mentoring providers in EmONC, newborn resuscitation, and maternal death reviews and audits
- Training facility staff in supply chain management to ensure reliable stocks of essential medicines
- Enrolling facilities in district health information systems and training providers in data collection, analysis, and reporting
- Upgrading blood banks

The Saving Mothers, Giving Life Model

To accelerate saving the lives of mothers and newborns, the *Saving Mothers, Giving Life* model employs a systems approach focused at the health district level to ensure that every pregnant woman has access to clean and safe normal delivery services and, in the event of an obstetric complication, life-saving emergency care within two hours. The model serves to strengthen the existing health network (both public and private) within each district to address the delays in seeking appropriate services, reaching those services and receiving timely, quality care.

Attention is also focused on the most vulnerable period for mother and baby—labor, delivery and the first 48 hours postpartum. The SMGL approach further integrates maternal and newborn health (MNH) services with HIV services (e.g., HIV counseling and testing and prevention of mother to child transmission of HIV-PMTCT services) and postpartum family planning. Linkages with other reproductive health services are strengthened.

Based on global best practices with evidence-based MNH and HIV interventions, and on implementation experiences in Uganda and Zambia, this model recommends that each health district incorporate the following:

- A sufficient number of public and private facilities with appropriate geographical positioning to provide for all pregnant women in the district—24 hours per day/7 days a week—clean and safe delivery services with essential newborn care and quality HIV testing, counseling and treatment (for woman, partner and baby as appropriate).
- At a minimum, five EmONC facilities (public and private), including at least one facility that can provide comprehensive emergency obstetrical and newborn care (CEmONC) for a population of 500,000 or per 20,000 births, accessible within two hours from a delivery site after the development of a severe obstetric or newborn complication, and for post-abortion care.
- A sufficient number of skilled birth attendants to provide, on a consistent basis, quality respectful delivery care, diagnosis and stabilization of complications, and if needed, timely facilitated referral for EmONC. Performance-based EmONC-trained personnel to provide required signal functions at basic emergency obstetrical and newborn care (BEmONC) and CEmONC designated facilities. WHO guidelines recommend one midwife per 120 deliveries/year; 1-2 doctors and six medical personnel (midwives, clinical officers and nurses) for a 1,000 births.
- Availability and maintenance of necessary infrastructure and equipment; reliable supplies of commodities and drugs to perform the seven/nine signal functions and provide newborn essential and special care, as well as HIV testing and treatment; and PMTCT services as appropriate to the level of the facility, on a continuous basis.
- A 24-hour/7 day per week, protocol-driven, integrated (public and private) communication/transportation referral system that ensures women with complications reach emergency services within two hours. This includes providing, where appropriate, short-term antenatal lodging for women who live greater than two hours travel time to an EmONC facility.
- A government-owned health management information system (HMIS) data-gathering system that accurately records every birth, obstetric and newborn complication and treatment provided, and birth outcomes at public and private facilities in the district. A timely, no-fault, medical death review performed in follow-up to every institutional maternal and neonatal death with cause of death information used for ongoing monitoring and quality improvement.

Prospective enumeration of maternal and newborn deaths in the community with verbal autopsies. Where appropriate, m-health approaches to facilitate the reporting process.

- Community outreach to counsel women, families, local leaders and community organizations on the importance of birth planning; four antenatal care (ANC) visits; HIV testing and treatment; pre- and postpartum homecare for mother/newborn and danger signs; and the value of facility delivery. Postpartum family practice methods also discussed.
- As feasible, financial demand-generation strategies and interventions to promote and facilitate women seeking, accessing and utilizing quality care, e.g. vouchers, user-fee reductions and conditional cash transfers.

The *Saving Mothers, Giving Life* model builds on:

- The leadership, health systems, policies/national and district plans and aspirations of partner governments
- Synergies derived from the investment and unique expertise of private and public organizations for the common purposes of preventing maternal and newborn deaths and creating an AIDS-free generation
- A foundation of relationships, infrastructure, partnerships, expertise and services supported through PEPFAR, USAID, HHS/CDC, Peace Corps and other USG agencies
- Other donor- and private sector-funded maternal, neonatal and child health efforts in countries, including those targeting HIV-infected and affected families and communities
- Local and global expertise in maternal and neonatal health, HIV/AIDS and evidence-based quality improvement processes

Saving Mothers, Giving Life Evaluation and Results

A critical element of SMGL's work during its 'proof of concept' period was robust monitoring and evaluation. CDC and USAID assessed the implementation of SMGL by conducting the following:

- Ethnographic studies of local childbirth practices
- Baseline and endline health facility assessments to measure capacity to deliver life-saving EmONC functions
- Baseline measurements of maternal mortality ratios in SMGL districts in Uganda and Zambia
- Endline measurement of maternal mortality ratios in Ugandan SMGL districts and in Zambian SMGL facilities
- Verbal autopsies to determine the cause of death in communities and maternal death reviews for facility-based deaths
- Routine monitoring of HMIS indicators
- Qualitative studies to measure patient and provider satisfaction with services
- Analysis of SMGL expenditures

In addition, an external implementation evaluation was conducted by Columbia University Mailman School of Public Health.

Results

Saving Mothers, Giving Life has delivered remarkable results, contributing to a rapid decline in the number of women who die in pregnancy and childbirth in Uganda and Zambia. A quantitative evaluation of the initiative's first year revealed a 30 percent decrease in the maternal mortality ratio in target districts of Uganda and a 35 percent reduction in target facilities in both Uganda and Zambia. (Visit www.savingmothersgivinglife.org for a comprehensive list of results and findings.)

SMGL interventions generated a range of positive results associated with improved maternal health outcomes, including:

- Uganda
 - 62% increase in deliveries taking place in a health facility
 - 200% increase in facilities offering BEmONC services
 - 18% reduction in obstetric case fatality rates with a 23% increase in cesarean sections
 - 17% reduction in institutional perinatal mortality rate
 - 28% increase in PMTCT treatment
 - 46% increase in facilities that did not experience stock-outs of oxytocin; a 32% increase in facilities that did not experience stock-outs of magnesium sulfate
- Zambia
 - 35% increase in deliveries taking place in a health facility
 - 100% increase in facilities offering BEmONC services
 - 35% decrease in obstetric case fatality rates with a 15% increase in cesarean sections
 - 14% decrease in the institutional perinatal mortality rate
 - 18% increase in PMTCT treatment
 - 26% increase in facilities that did not experience stock-outs of oxytocin; a 295% increase in facilities that did not experience stock-outs of magnesium sulfate

Saving Mothers, Giving Life FAQs

1. What enabled a 1-year initiative to achieve such dramatic results?

- SMGL followed and strengthened national MNH plans already in-place in both Uganda and Zambia.
- There was extensive engagement of the Ministry of Health (MOH), particularly at the district level.
- SMGL leveraged existing service delivery platforms (led by the MOH, nongovernmental organizations, USAID's maternal and child health division, PEPFAR and others) rather than creating parallel systems.
- The district-level systems approach prioritized inputs to both the public and private sectors that would contribute to improving the functioning of the entire system rather than just provide discrete benefits.
- The interagency-approach brought different resource streams together to support a shared goal of saving the lives of women and their newborns.
- Integration of MNH- and HIV-related services accelerated outcomes of interest for both the MCH and HIV/AIDS communities in the context of an increasing proportion of maternal deaths in sub-Saharan Africa (SSA) due to indirect causes, including AIDS-related mortality.
- SMGL's private-sector partners focused on the provision of the SMGL model by for-profit providers within SMGL districts thus mobilizing this network of providers.

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

- Yes. To significantly decrease maternal and perinatal 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 life-saving care closer to women, ensure expedited travel times to care and/or bring women closer to life-saving care, significant improvements in maternal and newborn health outcomes will result.

3. SMGL utilized a comprehensive approach to saving mothers lives. Are there 2-3 key interventions that could produce the same results at much less cost and intensity?

- The maternal mortality ratio (MMR) 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 SMGL 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.

- During SMGL scale-up, we do not recommend jettisoning life-saving elements of the SMGL approach simply to decrease cost. Rather, the commitment should be to provide in the most cost-efficient way the system-wide care that is needed to keep women and newborns alive.

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. SMGL builds on the existing public and private healthcare systems with support from USAID MCH and PEPFAR interventions and oversight.
- Over Phase 1 of the initiative, both countries have picked up an increasing number of inputs, e.g., provider salaries, ambulances and training.

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

- From the very beginning, SMGL focused on the needs of host country governments, building the program around existing national MNH plans, and sought to strengthen local partners and institutions to manage program activities. In order to be successful, SMGL 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 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. MOH officials will have a seat on SMGL’s Leadership Council, the governing body of the initiative.

6. Hasn’t USAID been implementing the SMGL model for over 20 years? What’s new?

- Historically, donors have focused on programming to address discrete causes of maternal mortality, a specific health system pillar or either the public or private sector rather than taking a more comprehensive systems approach. The SMGL model is built on an evidenced-based strategy: to dramatically decrease maternal deaths in low-resource settings, women must have access to respectful, normal delivery care from a skilled birth attendant (SBA) in a facility as close to their homes as is practical and access to quality emergency obstetric and newborn services within two hours of the onset of a complication.
- SMGL does not claim to have discovered any new ‘magic bullets,’ but rather is employing a new approach: bringing evidenced-based interventions together at the district level to address the three delays during the most dangerous time for women and babies—labor, delivery and the first 48 hours postpartum. This has required a systems approach to identify and open barriers and strengthen the capacity and sustainability of health care provision.
- Furthermore, SMGL employs innovative ways to address these delays. For example, in Uganda, we used geospatial technology to map travel times to clinics, utilized

motorcycle ambulances to transport mothers on even the most perilous roads, helped communities organize district transportation committees to oversee public and private transport for mothers and disbursed vouchers that cover the cost for travel and maternity services at private facilities.

- Until recently, MNH and HIV services were not provided at the same service delivery points. SMGL has integrated such services and has seen promising results in terms of both maternal mortality and PMTCT.
- The SMGL approach has also brought together the reach and resources of both the public and private healthcare sectors in SMGL districts, a collaborative interagency USG team, and other public and private global actors to work in concert.

7. What are lessons learned from the collaboration of multiple 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-sectorial interventions
 - Promoting research and innovation
 - Improving metrics, monitoring and evaluation
- The complexity of an all-USG approach should not be underestimated: it is labor intensive and actors must rise above historic agency squabbles. 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 SSA where indirect causes of maternal mortality are increasing.

8. Is a focus on 48 hours too narrow of a time frame to have a real impact?

- SMGL focuses on the critical period of labor, delivery and the first 48 hours postpartum because it is the most vulnerable period for mothers and newborns. Nearly 2 in 3 maternal deaths and 1 in 2 newborn deaths occur in this short timeframe. By focusing on this critical period SMGL was able to have significant impact.
- Such a focus does not mean SMGL interventions are only directed at the facility level during the intrapartum period. Maximizing birth outcomes requires action across the continuum:
 - At the community level encouraging birth planning and counseling on the importance of 4 ANC visits, teaching recognition of danger signs, promoting consideration of postpartum family planning options and reinforcing the need to be tested for HIV
 - Ensuring predictable transport options so women can access clean and safe normal delivery care and appropriate emergency care within two hours of the onset of a complication

- Providing timely, appropriate, respectful, quality delivery services once the facility is reached
- Instituting postpartum home visits within two days of discharge, if the hospital stay is less than 24 hours

9. How will *Saving Mothers, Giving Life* scale-up and scale-out differ from the proof-of-concept phase?

- **Streamlined M&E:** Monitoring for quality improvement will take precedence over evaluation. Resources will not be devoted to baseline maternal mortality enumeration in scale-up districts, but instead be spent on monitoring and real-time decision-making activities. Prospective enumeration of maternal deaths will continue in the eight original learning districts with the addition of newborn deaths. SMGL will work with national governments to strengthen the maternal death surveillance and response (MDS-R) approach in all new SMGL districts.
- **More rationalized implementation:** Rapid start-up necessitated using the Implementing Partners that were in place. In some cases, this resulted in inefficiencies and duplication. SMGL is working to streamline and improve implementation. How are the essential inputs best coordinated? How do the public and private healthcare sectors complement each other rather than compete?
- **Customer focus:** More attention will be paid to increasing client satisfaction and meeting expectations.
- **Additional resources:** New partners and donors will be recruited to scale up SMGL in Uganda and Zambia, and scale out to additional SSA countries.
- **Global impact:** The lessons learned from SMGL should contribute to a non-branded global movement to end preventable maternal and newborn deaths through health system strengthening and addressing the three delays.
- **Increased attention to newborns:** There will be a greater emphasis on newborn survival.

10. How will SMGL improve results for newborn survival?

- The programmatic emphasis for Phase 1 was on reducing maternal deaths.
- Working with country partners, SMGL will consider introduction of interventions such as:
 - Antenatal corticosteroids for premature labor
 - Kangaroo care for low-birth-weight babies
 - Chlorhexidine cord care to prevent sepsis
 - Postnatal care home visits within two days after birth to evaluate the ongoing health status of mothers and newborns and link them to care
 - Initial antibiotic dosing at the health center for presumed serious neonatal bacterial infection
 - Improving drilling and mentoring for improving neonatal resuscitation and essential newborn care

Saving Mothers, Giving Life Key Messages

Saving Mothers, Giving Life is a public-private partnership to dramatically reduce maternal and perinatal mortality in sub-Saharan Africa by increasing demand, facilitating access, and strengthening health systems at the district level, building on existing HIV/AIDS and maternal and child health platforms.

Saving Mothers, Giving Life is implementing a set of evidence-based interventions to ensure access to quality emergency obstetric and newborn care within two hours of the onset of a complication, and thus significantly enhance women's and their newborn's chances of surviving.

Saving Mothers, Giving Life has delivered real results, contributing to a rapid decline in the number of women who die in pregnancy and childbirth in Uganda and Zambia. An evaluation of the initiative's first year revealed a 30 percent decrease in the maternal mortality ratio in target districts of Uganda and a 35 percent reduction in target facilities in both Uganda and Zambia.

Saving Mothers, Giving Life is expanding to new districts in Uganda and Zambia – and to new high-burden nations in sub-Saharan Africa – with a long-term goal of catalyzing increased uptake and replication of this model to save more women's and newborn's lives. This will contribute to the global goal of ending preventable maternal and newborn deaths by 2035.

Saving Mothers, Giving Life has prioritized integration of maternal health and HIV services, understanding that HIV positive pregnant women have eight times higher risk of dying. The integrated service delivery approach has resulted in increases in women tested for HIV and placed on therapy and on the use of PMTCT services.

***Saving Mothers, Giving Life* is a public-private partnership to dramatically reduce maternal and perinatal mortality in sub-Saharan Africa by increasing demand, facilitating access, and strengthening health systems at the district level, building on existing HIV/AIDS and maternal and child health platforms.**

- SMGL is a five-year initiative to strengthen health services in countries facing high levels of maternal mortality and HIV, with a specific focus on helping mothers during labor, delivery and the first 48 hours postpartum – a particularly vulnerable period for maternal and newborn death.
- SMGL began with select districts in Uganda and Zambia, which have demonstrated the political will and commitment to reduce maternal mortality ratios that are among the highest in the world.
 - In Uganda, SMGL focuses on the districts of Kabarole, Kibaale, Kamwenge and Kyenjojo.
 - In Zambia, the initiative focuses on the Lundazi, Nyimba, Kalomo and Mansa districts.
- In close alignment with both governments' national health plans, SMGL has put in place life-saving interventions that are making high quality, safe childbirth services available and accessible to women and their newborns.
- The program builds on existing USAID maternal and child health programs – as well as HIV programs supported by PEPFAR.

- SMGL’s current partners include the Government of Norway, *Merck for Mothers*, the American ACOG, Every Mother Counts, Project C.U.R.E. and several U.S. government agencies, including USAID, the U.S. Departments of State and Defense, Health and Human Services, CDC and the Peace Corps.
 - USAID leads *Saving Mothers, Giving Life* Secretariat.
 - *Merck for Mothers* supports SMGL with complementary programming in Uganda and Zambia, all of which focuses on strengthening the local private health sector. It also supported Columbia University’s external evaluation of the SMGL partnership.
 - The Government of Norway supports efforts to enhance access to low-price maternal health commodities and plays a leading role in global strategy development.
 - Every Mother Counts supports efforts to strengthen emergency transportation and referral systems in Uganda. It also raises public awareness and donations for SMGL and advocates for increased support for maternal mortality reduction globally.
 - ACOG provides scientific, technical and clinical expertise.
 - Project C.U.R.E. provides customized donated medical supplies and equipment to SMGL facilities.
- During Phase 1, the initiative was monitored and evaluated by CDC to inform programmatic scale-up and expansion plans, including:
 - Enumeration of maternal and newborn outcomes
 - Health facility assessments
 - Health information system strengthening
 - Support for maternal death reviews and verbal autopsies
- An external evaluation by Columbia University’s Mailman School of Public Health assessed the partnership’s functioning and identified best practices and barriers to reducing maternal mortality. An expenditure study was also conducted by Futures group. Results are posted on www.savingmothersgivinglife.org.

***Saving Mothers, Giving Life* is implementing a set of evidence-based interventions to ensure access to quality emergency obstetric and newborn care within two hours of the onset of a complication, and thus significantly enhance women’s and their newborn’s chances of surviving.**

- SMGL interventions are intended to address the three delays model (delay 1: seeking care, delay 2: getting to care, delay 3: receiving respectful, quality care) as well as strengthening the health system more generally.
- Specific interventions include:
 - Equipping facilities to provide high quality EmONC services in a geographically strategic way, enabling women with complications to receive care within two hours.
 - Improving supply systems so facilities have the equipment, supplies, commodities and drugs needed to deliver high quality EmONC services.
 - Training and mentoring skilled birth attendants to provide quality, respectful delivery services, and stabilize, treat and refer emergency cases if necessary.
 - Mobilizing communities to generate demand for facility deliveries, antenatal and postpartum care while emphasizing birth planning, and encouraging HIV testing and treatment and uptake of family planning services.

- Strengthening linkages between communities and facilities through a 24/7 integrated communications and transportation system that helps pregnant women access childbirth facilities in a timely manner.
- Improving data collection systems to record pregnancy outcomes, including births, maternal and newborn complications, stillbirths, maternal and newborn deaths and strengthening host country health management information systems.

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- SMGL interventions also generated a range of positive results associated with improved maternal health outcomes, including:
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***Saving Mothers, Giving Life* is expanding to new districts in Uganda and Zambia – and to new high-burden nations in sub-Saharan Africa – with a long-term goal of catalyzing increased uptake and replication of this model to save more women's and newborn's lives. This will contribute to the global goal of ending preventable maternal and newborn deaths by 2035.**

- In 2014, the initiative is scaling up its efforts in Uganda and Zambia, expanding to additional districts in both countries.
 - New Uganda districts: Gulu, Dokolo, Lira, Nwoya, Pader, Apac
 - New Zambia districts: Chipata, Samfya, Choma, Kabwe
- SMGL's first-year progress generated a new \$3.1 million commitment from the Swedish International Development Agency (SIDA) to expand the initiative to Chipata, Zambia.
- SMGL set out with the ambitious goal to reduce maternal mortality ratios by up to 50% in its first year. Much of the initial capital investment, including infrastructure and essential medical supplies that occurred in year one will provide long-term benefits. These investments have

already yielded important gains in the intervention districts. These costs will be progressively assumed by the Governments of Uganda and Zambia over the five year implementation period.

SMGL has prioritized integration of maternal health and HIV services, understanding that HIV positive pregnant women have eight times higher risk of dying. The integrated service delivery approach has resulted in increases in women tested for HIV and place on therapy and on the use of PMTCT services.

- In several SSA countries the maternal mortality ratio is actually increasing due to indirect causes including HIV.
- The integrated service delivery approach has resulted in increases in women tested for HIV and placed on therapy, and on the use of PMTCT services.
- SMGL is promoting the use of integrated HIV- and MNH-related curricula for training providers.