



women and children first (UK)

Mapping UK Advocacy for  
Millennium Development Goals 4 & 5



# Mapping UK Advocacy for Millennium Development Goals 4 & 5

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Women and Children First carried out this mapping exercise in March 2008; its objective was to produce a user-friendly document which would inform UK advocates for MDGs 4 and 5 what their colleagues were engaged in and help identify priorities for co-ordinated action.

A questionnaire was circulated to 60 organisations (91 people in all) asking respondents to share:

- Information on the advocacy work their organisation has done or is doing to accelerate progress towards MDGs 4 and 5
- What their organisation sees as priorities for UK advocacy work on MDGs 4 and 5 in terms of:
  - a) Issues to be prioritised
  - b) Target audiences
- What their organisation perceives as gaps in UK-based advocacy for MDGs 4 and 5
- Advocacy materials their organisation has produced which are relevant for advocacy on MDGs 4 and 5.

This booklet contains a summary of the priority issues, key target audiences, and the perceived gaps in UK advocacy for MDGs 4 and 5 from the 18 replies received. These summaries are followed by each organisation's own description of the relevant advocacy work they are engaged in and contact details.

The resources and weblinks which were provided are contained in the CD which accompanies this booklet and, in many cases, additional materials can be sourced from the organisations' websites. Selected key messages gathered during the mapping exercise are reproduced on the cards which also accompany this booklet.

## Issues to be prioritised

The extensive list set out below indicates that UK advocates have identified a wide variety of issues which need to be addressed, spanning key messages, finance, political will, health-system strengthening, civil-society involvement, the role of traditional birth attendants (TBAs), the importance of the continuum of care and access to comprehensive reproductive healthcare, and the need for an evidence base for the cost-effectiveness of interventions.

The priorities are:

- **Raising awareness** that maternal deaths are largely preventable
- **Gaining political will**; increasing support from the developed countries (the North) to the developing countries (the South), particularly in terms of capacity-building and finding innovative ways to fill human-resource gaps
- **Financing**; awareness and understanding of the **strengths and weaknesses of vertical and horizontal funding** – need to strengthen health systems alongside targeting specific diseases; government awareness of the **cost-effectiveness** of targeting the major causes of maternal, newborn and child mortality; investment in **operations research** to show impact of resources invested
- **Continuum of care**
- Focus on **reproductive health**; importance of **family planning**; need to address the decline in global donor support for family planning
- **Health-system strengthening**
- Inclusion and scaling up of **primary healthcare** as an essential part of a fully functioning health system

- **Human resources: lack of skilled attendance** in many countries; need for more and better trained and utilised health workers (task shifting); lack of trained midwives in health facilities serving remote areas owing to low pay; **training and status of midwives**; providing appropriate books and other material for health workers
- Strengthening **links between TBAs and health centres** so TBAs can refer high-risk pregnancies; training TBAs where health services are inaccessible; need for an adequate, constant and reliable supply of health **commodities**
- **Burden of maternal mortality disproportionately borne by the poor**; financial barriers are a major factor; current strategies aimed at the poor tend to reach the non-poor
- **DFID** to advocate on all aspects of maternal mortality, including the need for safe abortion services; ensuring that key interventions (those cited in the Lancet child-survival series) are a priority for DFID working with countries to develop country compacts
- **Liberalise abortion laws**; restrictive abortion legislation (e.g. Nicaragua)
- **Implement the Maputo Plan of Action** to ensure universal access to comprehensive sexual and reproductive health services in Africa
- Getting international **humanitarian response in emergencies** to address sexual and reproductive health and rights (SRHR) needs as a matter of routine; the need to better address SRHR and maternal health needs in humanitarian emergencies
- **Civil-society involvement**; how the capacity of **non-state health providers** can be used to best complement national (and global) health objectives,
- **Barriers indigenous women face** in accessing maternal and child-health services (e.g. distance from health facilities, costs of accessing services – high transport costs); lack of culturally appropriate maternal health services for indigenous women (e.g. ignoring traditional birthing practices); lack of health information and communication in local languages and dialects.



## Advocacy targets

The following were identified as key targets for UK advocacy:

- DFID
- The Treasury
- The Prime Minister and the Chancellor of the Exchequer
- Parliamentarians – British and European
- International Development Committee
- All Party Parliamentary Groups
- UK Permanent representative to the EU
- UN system and other bridging partnerships/mechanisms
- International Health Partnership
- G8 governments
- International Donors (EC, World Bank, UNICEF) with leverage on national governments through budget support mechanisms
- Media
- UK public – to put pressure on Parliamentarians
- Professional associations and health professionals involved in maternal and child health; nurses, midwives, medical assistants
- Students, mothers: to raise awareness of the plight of mothers and children in other parts of the world
- Academic institutions to encourage strengthening of the research base for evidence-based practice
- Corporate Sector/Corporate Social Responsibility activities.

Also mentioned were:

- Global leaders
- National governments in high-mortality countries
- Governments of developing countries including those with large populations of indigenous people
- Health ministries
- PEPFAR
- CSOs.



## Perceived Gaps in UK Advocacy for MDGs 4 and 5

The responses to the questionnaire, and further discussion during a consultation meeting in early April 2008, demonstrated agreement on the need for a stronger UK-based advocacy movement for MDGs 4 and 5. Advocates agreed that a lack of leadership and co-ordination, and low levels of communication and collaboration resulted in organisations working in silos, and hindered a common voice on policy asks and targets. The absence of a (yearly) forum on maternal mortality was a cause for concern, and the desirability of building a campaign aimed at raising awareness and implementing effective lobbying activities was discussed. It was agreed that UK advocacy for maternal, newborn and child health would benefit from strong leadership and a strategy built on consensus with an adequate framework for action and agreed messages. The need for a database of all UK organisations addressing MDGs 4 and 5 was also identified.

Specific points on gaps perceived were:

- UK public not aware that a major problem exists; lack of public awareness on key messaging around maternal and child mortality; analysis of similar issues in UK
- Recognition of breadth of audiences
- Lack of consistent messaging on priorities
- The 'easy wins' for the MDGs have come from looking at the statistics regarding newborn and child health whereas maternal health, being the more difficult aspect to tackle, has been neglected
- Lack of funds for health-systems strengthening and support for introducing effective public health systems into the country (prevention rather than cure)
- Health equity not sufficiently acknowledged
- Need a broad base of health advocates to ensure multisectoral response that addresses gender, legal reform, girls' education etc
- Voices of the poor; voices of children
- Child-health advocacy needs to link to wider development sector
- Need for an adequate midwifery voice
- Sharing scaling-up of programmes that have worked
- Focusing on and including reproductive and sexual health within the context of MDG 5 needs greater attention
- The cost-benefit arguments for family planning
- Link between availability of family planning and safe abortion services reducing mortality is not well understood
- Only insiders know about the Gag rule and its effects
- Very little done to promote the Maputo Plan of Action
- Nothing on addressing the problems of registering generic commodities in developing countries
- Very little on ensuring value for money: lots of work calling for more resources but more needed on ensuring that health policy in developing countries creates an environment where use of scarce resources can be optimised
- Very little on the role of the non-state sector
- Lack of backing of community-based primary healthcare as a significant tool to make significant headway on maternal and child mortality rates.

## UK advocacy for MDGs 4 and 5

Information from these organisations is set out on the following pages:

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World Vision _____	18
White Ribbon Alliance _____	19

## BirthLink

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BirthLink is a UK-based charity supporting maternal and neonatal healthcare in developing countries, in response to MDGs 4 and 5. We have completed projects in Armenia, Nagorno Karabakh, Vietnam, Russia and Nigeria providing workshops and ‘hands-on’ clinical training to midwives, nurses and doctors.

The programmes we provide cover topics for the newborn and up to six weeks of age. In addition, we are targeting neonatal departments to address the needs of the sick and low-birth-weight baby, to support ‘low-tech’ interventions. Topics include resuscitation at birth, essential newborn care, hygiene and infection control, thermal control, nutrition and respiratory management. Where appropriate, this is extended to include additional needs for the management of the sick baby.

Our workshops provide education to midwives and doctors for the care of women through pregnancy. Topics include antenatal, intrapartum and postnatal care of the mother, and obstetric emergencies.

## Cara Consulting

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- Three-country (Zambia, Nigeria and Malawi) analysis of paediatric access to antiretroviral therapy

- Barriers to accessing health for children in seven countries (advocating for services to be made free at the point of access)
- Advocating for HIV programmes to be fully integrated into national maternal and child-health systems
- Advocating for the continuum-of-care approach towards maternal and child health
- Advocating for increasing the number of women delivered by a skilled attendant and encouraging traditional birth attendants to act as gatekeepers, monitors and in postnatal health and HIV follow up (including encouraging the uptake of nevirapine and septrin for HIV-affected infants)
- Advocating for alignment of global funds and partnerships (Global AIDS Vaccine Initiative/Global Fund for AIDS, TB and Malaria) with national systems and an allocation of 50% of these funds to go towards health-systems strengthening
- Advocated for the GAVI CSO pot of resources (and now for it to really reach local NGOs)
- Advocating for community monitoring system (helping to develop one in Nigeria)
- Supporting the integration of EPI into health systems in Nigeria
- Cara submitted an NGO consultation document on maternal health to WHO prior to the Women Deliver meeting and a report to the IDC UK Parliament prior to their inquiry on maternal health.
- Cara's Director was the Special Adviser for the UK International Development Committee maternal health inquiry
- Advocating for social development (including gender and poverty work) and multisectoral approaches to health and development
- Advocating for more involvement of health-professional agencies such as the International College of Midwives and the International College of Nurses in health-policy formation and that health workers are also included in health-policy determination
- Maintain a focus on equity and participation (following Alma Ata principles)
- Advocate for the Right to Health
- Advocate for all maternal-health services to be free at the point of delivery
- Advocate for STI services to be linked to maternal-health services and free at the point of access
- Advocating for a renewed system of health prioritisation (other than the DALY).

## **FIGO (International Federation of Gynaecology & Obstetrics)**

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FIGO's undertaking of the Safe Motherhood and Newborn Health project in ten countries is directed in large part towards achieving progress in both MDGs 4 and 5. FIGO members participate in a number of partnerships including the Partnership for Maternal, Newborn and Child Health (PMNCH) and the Countdown to 2015 as

well as consulting on initiatives with the International Confederation of Midwives (ICM) and the International Paediatric Association (IPA). All of these groups exercise advocacy for a combined voice of health and medical expertise amongst health professionals. An example of this is the recent conference held in Cape Town, South Africa whereby the health professionals had an audience of international parliamentarians to whom to present on state developments and progress towards improving maternal and child health.

FIGO's advocacy work towards the achievement of MDG 5 is in tandem with our work for MDG 4. Currently, an advocacy strategy is being formulated between FIGO and members of the Royal College of Obstetricians and Gynaecologists (RCOG) in preparation for the G8 Summit in July. It is hoped that issues directly related to MDG 5 will be compelling to the political leaders attending due to advocacy by health professionals. FIGO is also developing joint statements with ICM and IPA regarding a number of maternal-health issues including active management of the third stage of labour and breastfeeding and HIV.

## Health Unlimited

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- Pilot project called Action Research Into Advocacy (ARAI) in Cambodia which examined the experience of the three main indigenous groups in Ratanakiri in accessing modern maternal healthcare. The results of this report were used as the basis for a series of stakeholder advocacy workshops with indigenous communities, health centre staff and government

officials (November 2005 - March 2006) which enabled these groups to discuss the results of the research, prioritise key issues, learn about advocacy and develop an advocacy action plan. A working group of seven indigenous women and health centre staff was also established to take forward the action plan. In February 2007 there was a meeting of representatives of relevant government, UN and NGO agencies at the national and provincial level as well as district level and the villages. At this meeting indigenous women presented their concerns and these were discussed by participants.

- In Huanta Province in Ayacucho, Peru, Health Unlimited worked in partnership with the local-level Ministry of Health, TBAs and Quechua women to introduce culturally appropriate birthing facilities in the province, leading to an increase in the proportion of health-centre deliveries and decrease in reported maternal deaths. Health Unlimited and the local-level MoH used this evidence to advocate with the national MoH, contributing to the development of a national MoH norm recommending vertical deliveries. It also led to culturally appropriate birthing facilities being established in four health centres in Huanta Province that were outside the initial project area.
- In Cambodia, Health Unlimited piloted the setting up of health posts to provide basic health services for remote communities in two provinces. Each health post is located close to remote communities in order to provide them with basic health services (antenatal care, basic care for common illnesses, and community health activities and education), and is linked to a government health centre, with staff meeting regularly. The success of this approach was used to lobby the MoH for the expansion of the use of health posts to provide services in remote communities to other provinces with a substantial proportion of their population living a distance from the nearest health centre.

- As part of its Irirwa project in Rwanda (giving a voice to rural women and youth), Health Unlimited is developing the capacity of community-based groups to contribute to the development of district health plans and health aspects of Rwanda's Economic Development and Poverty Reduction Strategy.

## Impact

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Impact is a global research initiative for the evaluation of safe motherhood intervention strategies. While our focus is on MDG 5, Impact research is of direct relevance to organisations involved in advocacy work on MDG 4 as maternal and newborn health directly relates to child health, hence the bridging of MDG 4 and 5 undertaken by the WHO Partnership for Maternal, Newborn and Child Health (PMNCH).

Impact's outputs include tools and methods for safe-motherhood programme evaluation and an evidence base on which maternal-health strategies work best.

Impact has developed a range of tools to measure maternal and perinatal mortality, quality of maternal healthcare, economic outcomes, and health systems factors (Impact toolkit). Alongside factsheets and policy briefs, one example of Impact evidence suitable for advocacy purposes is a Free D resource document on enhanced strategies to reduce financial barriers to maternity care. A brief overview follows:

Why FreeD? The two-way relationship between poverty and maternal mortality is widely accepted. However, few studies isolate barriers specifically to the poor. Impact studies in the focus countries – Burkina Faso, Ghana, Indonesia, Nicaragua and Senegal – have demonstrated how the poor have more difficulty accessing delivery care than richer women. The poor face multiple and overlapping disadvantages and women often face additional gender barriers and burdens as caregivers. The repercussions of financial barriers to uptake of care have been found by Impact to be wide-reaching and long-term:

- Women who are poor are more at risk of very severe complications and may not know how they can access pro-poor-measures when they do exist.
- Indirect and unofficial costs are often highly significant, and many women have difficulty in accessing consultations and treatments.
- Low status for women and limited decision-making powers can interact negatively with these issues of poverty, impoverishment and costs.

The implications of these findings are that mechanisms for financing healthcare must not place the burden on women in poor households, which will only contribute to further impoverishment of the family unit and household. Women's work, status, and poverty (both before and after delivery) must be considered alongside health-system factors.

**Strategies for addressing barriers.** The experience of policies to reduce financial barriers, as reflected in the literature and through the Impact case studies, demonstrates the wide range of potential context-specific strategies. The range of experiences include: fee exemption, waivers, formalising informal payments, conditional cash transfers, vouchers, loans, community health insurance, and social health insurance. These

different approaches to reducing financial barriers have much in common. All, if effective, have the potential to raise utilisation of services by the poor, reduce delays in seeking care and reduce household debt. Developing support for policies to protect the poor is a universal challenge: it is rarely feasible that those paying into a scheme can finance fully the costs of those in poverty and additional subsidy is required. Ensuring sustainability is a financial but also a political challenge which must be addressed proactively in specific contexts.

**In summary**, Immpact findings strengthen the existing evidence that financial barriers are important although this is alongside other barriers, particularly the non-availability of midwives in remote areas, lack of use of health centres and questionable quality of EmOC (Emergency Obstetric Care). An enhanced financing strategy could be used to both help mitigate the financial barriers and reduce other barriers. Immpact is committed to working with its partner countries to help create the capacity to use the evidence it has gathered to influence policy and the design and evaluation of strategies.

Immpact has also worked to strengthen global capacity on measurement aspects of maternal mortality as well as in-country capacity on maternal health research; some of the collaborating organisations and agencies include:

- PMNCH
- WHO
- HMN
- Countdown to 2015
- Institute for Health Metrics and Evaluation
- GREFSaD
- UNFPA
- 

## **Interact Worldwide/ Action for Global Health**

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Interact Worldwide, the International HIV/AIDS Alliance and TB Alert comprise the UK partners of Action for Global Health, a European-based advocacy movement. The network is co-ordinated in Brussels and present in five other European countries: the United Kingdom, Italy, Spain, France and Germany.

The core business of Action for Global Health is generating awareness, momentum and commitment, both political and financial, from European donors to help developing countries achieve the health Millennium Development Goals (MDGs 4, 5 & 6).

Action for Global Health advocates on the cross-cutting issues which underpin the achievement of the health MDGs. These have been identified as: work to strengthen health systems; mobilise and better co-ordinate finance for health; highlight and mainstream gender and health; and increase awareness for and investment in research and development for health.

Within the Action for Global Health partnership, advocacy happens on two levels. An over-arching cross-European advocacy strategy, which is currently focused on Aid Effectiveness, sets the strategic direction for advocacy in Europe. Additional country-level advocacy then occurs within this strategic context but is flexible to national priorities and calls from civil society.

MDG 5 is a priority for Interact Worldwide and we have utilised our role within Action for Global Health UK to incentivise greater UK action on policy and advocacy on maternal health. We became a member of the Partnership for Maternal Newborn and Child Health in 2007 and are involved in its Advocacy Working Group.

Advocacy around MDG 5 as well as the other health MDGs focuses squarely on advocating the strengthening of health systems, hand-in-hand with ensuring more and better co-ordinated aid is available to support national governments in realising their national health plans.

Interact has played a strong leadership role in the UK Network on SRHR. Our Policy and Advocacy Manager for Action for Global Health served as Deputy Chair of the Network and Chair of the Maternal Health working group which was initiated as the UK forum for advocacy on MDG 5. The Chair co-ordinated the Working Group's submission of evidence to the International Development Select Committee inquiry into Maternal Health.

To date Interact and Action for Global Health have been involved in the following advocacy activities in connection with MDGs 4 & 5:

- Development and dissemination of a series of factsheets on the Millennium Development Goals, this includes specific factsheets on MDGs 4 & 5. Factsheets have been disseminated in the UK to representatives attending all three political party conferences in 2007, as well as at national and international conferences.
- Publication of a policy report in 2007 which builds a business case for financing the health MDGs and reports on the serious lack on progress against MDGs 4 & 5.
- Action for Global Health organised a conference in September 2007 on the subject of 'financing for global health'. At this event, international speakers highlighted

the lack of progress being made, particularly in relation to MDG 4 (especially in sub-Saharan Africa). Senior representatives from DFID, the Global Fund, the UN and WHO spoke at the conference and all acknowledged the need to get behind the advocacy priorities in Action for Global Health's first policy report.

- A report from the conference was published in February 2008; it acts as a further resource in highlighting the lack of progress against MDGs 4 & 5 and sets out potential advocacy goals for civil society under the cross-cutting issues Action for Global Health works on as detailed above. In relation to MDGs 4 & 5 these include: continued, co-ordinated work on the International Health Partnership; creation of a gender checklist for health-policy processes to include gender debates on the workforce for health-service delivery; advocating for a restructured and well-resourced UN architecture on women's development and health; and planning for Round 8 of the Global Fund to improve the gender sensitivity and SRH-HIV integration content of proposals.
- Following the Action for Global Health conference in September, the UK-based partners galvanised support from British civil society by organising a series of follow-up meetings to agree common advocacy themes (as set out in the conference report), a co-ordination mechanism for ongoing collaboration and communication; and to agree advocacy priorities. This culminated in a meeting this month, where Action for Global Health presented an electronic communication platform to facilitate coordinated action on the health MDGs. Civil-society partners all agreed that a further committee structure would be unhelpful and burdensome, hence the idea of using existing structures established by Action for Global Health. These include list-serves and resource areas on all the health MDGs.
- Interact has championed MNCH issues within Action for Global Health, ensuring that advocacy priorities have

taken these issues into account. For example, AFGH's advocacy strategy for 2008 includes specific reference to gender and health.

- The UK partners of AFGH are leading work on the International Health Partnership, including maintaining a watching brief, proactive communication with DFID and WHO, organising civil-society meetings, drafting consultation documents and attending IHP events and meetings.
- Action for Global Health will publish its second policy report in early summer 2008. The subject of this report is 'aid effectiveness' and the report will make strong use of case studies to illustrate its case. These case studies make specific reference to MDGs 4 & 5.
- Interact co-ordinated Action for Global Health's involvement in the Women Deliver conference. This involved partnership with our German, Spanish and Italian colleagues, forging new alliances and supporting the work of the EURONGOs network<sup>1</sup> and promoting our advocacy priorities.

## **International Planned Parenthood Federation (IPPF)**

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- Produced MDGs briefing pack (2005)
- Asked IPPF Member Associations to contact their governments requesting them to highlight SRH in their World Summit speech

- Asked MPs to raise questions in chamber
- Conducted MDG mapping (2006) and monitored the IAEG meetings/reports
- Produced backgrounders on targets and indicators
- Advocated with governments and other CSOs for the new RH target
- Referenced the MDGs at countless meetings and in numerous reports
- World Bank HNP strategy.

## **Malaria Consortium**

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Our advocacy work mainly focuses on malaria which accounts for one in five of childhood deaths in Africa. As a result, our advocacy work has direct relevance to the achievement of MDG 4. On the ground Malaria Consortium delivers interventions aimed at vulnerable and most affected groups, namely pregnant women and children under five.

Pregnant women are the main adult group at risk of malaria and are four times more likely to suffer malaria than other adults; and pregnancy reduces a woman's immunity to malaria making her more likely to become affected. Our advocacy work therefore has significant relevance in the context of reducing maternal mortality.

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<sup>1</sup> www.eurongos.org

## Marie Stopes International (MSI)

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### In-country advocacy

A number of MSI partners have strong advocacy programmes in South and South-East Asia and in Latin America, and several of our African partners are using the Civil Society Challenge Fund (DFID) in addition to other means to develop their advocacy capacity. In-country advocacy often consists of promoting a 'rights-based approach' to healthcare and empowering communities to voice their health needs to local health authorities.

Work is also planned to encourage Country Co-ordinating Mechanisms to support integrated services.

### EU/EC Advocacy

Our Brussels office provides a secretariat to the European Parliament Working Group on Sexual and Reproductive Health and Rights (SRHR). This facilitates the co-ordination of Members of the European Parliament willing to champion women's health issues.

### UK Advocacy

Following recent success in getting the International Development Select Committee to engage with maternal health, attention is now turning to:

- Systematic efforts to sensitise the British print media to SRHR and maternal health issues
- Providing information to DFID on engaging the non-state sector
- Urging DFID to ensure that the EU-Africa Strategy supports Maputo Plan of Action implementation

- Attempting to get DFID CHASE interested in maternal health and SRHR.

### International Advocacy

Trying to rally interest in bloc-registration of health commodities in Africa.

## Nomado (No Mothers Are Dying)

### Gloria Esegbona

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Public engagement through media materials, participatory multidisciplinary action. Policy engagement.

## Royal College of Midwives

### Janet Fyle

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The RCM is a WHO-collaborating centre for midwifery. It has engaged in a number of initiatives, for example teaching the trainers to ensure that women receive care from skilled attendants.

The RCM is developing twinning projects with poor countries to support midwives with equipment, and sponsoring them to attend study days especially the International Confederation of Midwives (ICM).

## Reproductive Health Matters

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Maternal morbidity and mortality is an ongoing priority for the publication.

## SafeHands for Mothers

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While our advocacy work has not been focused specifically on MDG 4, child mortality is indirectly addressed as our advocacy work on maternal health and safer delivery has an impact on neonatal health.

SafeHands was commissioned by the International Federation of Gynaecologists and Obstetricians (FIGO) to produce the advocacy film *Fistula Pilgrims* in 2002. Set in Ethiopia, this film tells the story of a girl pregnant at 11, who gave birth to a stillborn child at age 12 and was left with obstetric fistula as a result of prolonged and obstructed labour. This film has been shown to international and national audiences and can be viewed on SafeHands' website.

A second advocacy film, *Diary Update*, is also available on the SafeHands website and highlights the importance of emergency transportation in saving the lives of women and newborns in the event of obstetric complications.

A training film aimed at Health Extension Workers (HEWs) in Ethiopia will soon be adapted into a shortened version for use at community level, advocating to community audiences the importance of good antenatal care and nutrition for pregnant women, the importance of birth preparedness in the event of problems, and advocating possible solutions such as community funds.

A new film on child marriage is currently in progress, which will highlight the link between early-age marriage and childbirth and the risk of pregnancy-related deaths and injuries. Set in the rural Amhara region of Ethiopia where child marriage, though illegal, is still practised, the film will be shown on national television and also within community programmes.

An important innovation, which allows these advocacy films to be shown in villages with no electricity, is a portable, solar-powered DVD player. SafeHands has developed this in partnership with a company in Wales and is able to supply this product to other interested organisations. SafeHands would like to encourage other organisations advocating to prevent maternal deaths to use or adapt its films, and is willing to discuss making copies of its films available to other organisations.

SafeHands is following up with UK media (Sky, Channel 4) to interest them in stories on maternal deaths, and is keen to co-ordinate this with Women and Children First and other organisations.

## Save the Children UK

### Alice Schmidt

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Save the Children UK, as an international development organisation, advocates on local, national, regional and global levels. Improving child health, and thus working towards the achievement of MDG 4, is at the core of our health work. Furthermore, with its recently launched global campaign on child survival the organisation as a whole has made a 3-5 year commitment to helping to accelerate the progress towards MDG 4.

Recognising the strong links between child and maternal health, Save the Children UK has always addressed MDGs 4 and 5 in a joint manner. Therefore, the organisation advocates on local, national, regional and global levels on maternal mortality and morbidity issues.

## **TALC** **(Teaching Aids at Low Cost)**

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TALC is a major distributor of books, CDs, and small items such as Mid Upper Arm Circumference tapes.

More than most organisations TALC has advocated the need to emphasise the part that nurses, midwives and medical assistants must play if the MDGs are to be reached. They are the health workers most in touch with the poor, either directly or through community health workers often responsible to them.

TALC is concerned that studying from books plays a small part in their training due to the absence of up-to-date, appropriate books in the schools. This shortcoming may mean that they do not know how to refer to books when trained to extend their knowledge and solve problems.

TALC has a programme to overcome this shortage where donors can be found.

For the majority of national health workers purchasing of books is difficult. They are not retailed locally and they do not have the foreign exchange to purchase them. TALC has evolved a partial answer to this for those with access to a PC, through free CDs loaded with a mass of up-to-date information targeted at a range of health workers. Currently one a year is produced; they have proved popular and over 10,000 of a recent one was distributed. As well as TALC's own free CDs TALC has identified around 25 other free CDs and DVDs, which are distributed free to anyone purchasing a book.

Examples of materials are a coloured MUAC tape, a two-ended spoon for home preparation of rehydration fluid, and the ThermoSpot to place on newborns to identify to health workers and the mothers when hypothermia occurs.

TALC distributes a selection of important low-cost books such as the *Life Saving Skills Manual* prepared by the RCOG, *Textbook of Postpartum Haemorrhage* by C.B. Lynch, the Marie Stopes *Safe Motherhood in developing countries*, *Nursing and Midwifery* by Hubbard and the text on family planning from Johns Hopkins. TALC is also the only source of a Fundal Height Measure and Chart and of the TALC baby model to show the need for head flexion in delivery.

## **Women and Children First (UK)**

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<sup>2</sup> Women & Children First's phone number will change in mid-July 2008. Check the website for up-to-date contact details.

We are leading on an initiative to harness UK expertise in advocacy for MDGs 4 and 5 with a view to increasing and better co-ordinating UK advocates. To this end we held a workshop in March 2008 which is being followed up by a consultative process to:

- Produce a user-friendly UK advocates mapping document
- Develop an up-to-date toolkit tailored for Advocacy on MDGs 4 & 5 and the continuum of care
- Establish a mechanism through which UK advocates for MDGs 4 & 5 can work more closely together and achieve greater coherence in messaging and activity.

A follow-up meeting in April 2008 indicated keen interest in better co-ordinated and accelerated UK advocacy and for Women and Children First to lead on the co-ordinating role.

Internationally, we support our partners in Bangladesh, India and Malawi with their local advocacy initiatives, geared primarily at lobbying for improved maternal and newborn health services. We are about to engage in a 5-year programme to scale up work on maternal and newborn health in Bangladesh and India, one component of which will be working with local partners on district, national and international policy and advocacy. Through this programme we will develop messages based on in-country programmatic experience and research findings and amplify these into the UK and wider national policy arena through, for example, regional meetings in Africa and Asia, member meetings of the Partnership for Maternal, Newborn and Child Health, and UN meetings.

Women and Children First is a member of the UK Network for Sexual and Reproductive Health and Rights and is represented on its Steering Committee as well as belonging to its maternal health working group. Through the maternal health working group we have contributed

to presenting written evidence to the International Development Select Committee 2007 Inquiry into maternal health. We are also members of the Partnership for Maternal, Newborn and Child Health and the White Ribbon Alliance and support their UK-based initiatives.

## **World Vision**

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World Vision is a global federation that has programmes in over 100 countries. WV is a child-focused organisation looking to improve the wellbeing of children in areas where it works. World Vision's health strategy is community-focused and looks to build capacity at grassroots level to facilitate access to primary healthcare. WV staff work with community and all other key stakeholders responsible for the provision of services to ensure that the voice of the community is heard and they are able to advocate for their right to health.

At a national level, WV works in coalition with other NGOs to lobby governments to make appropriate policy decisions in the area of health – sufficient general budget allocation and a National Health Plan that targets the needs of the population, paying particular attention to rural areas and the needs of vulnerable groups such as mothers and children.

On the international stage, WV has a position paper for the G8 that will lobby to increase funding for health-system strengthening. It is planning a child-health campaign for the latter half of 2008 – this will be based on a gap analysis, taking into account other existing action and

NGO campaigns on health (details of specific tasks will be available later this year).

Actively involved in the processes of coalitions looking to impact MDG 4:

- Global Movement for Children (WV chairs this coalition)
- Partnership for Maternal, Newborn and Child Health (World Vision is part of civil-society representation on the country support working group, which works closely with the advocacy arm of the PMNCH – Deliver Now for Women and Children)
- International Health Partnership (responding both in coalition and individually to the recent consultations on civil-society engagement and the development of country compacts)

## White Ribbon Alliance

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The White Ribbon Alliance (WRA) is a global, multisectoral coalition, with members in 91 countries. It works from the grassroots in families and communities through membership groups at district and national level. The Alliance does two things simultaneously; firstly carrying out a “social watch” on governments, seeing whether or not they are doing what they’ve promised – holding them to account – and working with governments, in particular with Ministries of Health, to improve policies, deliver appropriate services and improve women’s access to those services. The WRA focuses on MDG 5, but every mother’s life saved dramatically improves the chances of the survival of the child.

WRA’s Promise to Mothers campaign focuses on big international events – examples include Women Deliver, IMF/World Bank meetings, the World Economic Forum and the UN’s 2008 MDG Summit. The Young People’s Convoy to Cape Town – a North/South young people interactive project – is using music to communicate and share experiences. At country level WRA focus is on changing policies; working, for example, with Ministries of Finance, persuading governments to prioritise women and maternal health.

The Alliance has an expanding presence in the UK through two UK-based board members, and a UK office which has recently been established to function as the media and communications arm of the global secretariat. Sarah Brown has become Patron, and with her support, the WRA is reaching out to a wide and strong network of global leaders, for example, leaders of the G8 countries.





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