Update on Results achieved by the Department for International Development between 2011 and 2015.

1. Introduction

The DFID Results Framework (DRF)[1] covered the period 2011-2015 reporting on the results commitments in the coalition government's 2011 publication "UK aid: Changing lives, delivering results[2]". 24 indicators measuring outputs and intermediate outcomes, mainly directly linked to DFID programmes and projects were included within this framework. These covered DFID's work in areas such as health, education, water, sanitation and hygiene, nutrition, humanitarian and climate-change.

The DRF results indicators were last published in DFID's annual report for 2015/16[3] and in results sector pages alongside the annual report[4]. The annual report indicated that complete information for certain indicators would be available in 2017. This report uses the latest available information to set out final estimates of what was achieved in the DRF for the indicators on maternal lives saved, newborn lives saved and malaria specific deaths. These indicators and related targets are set out in Table 1 below.

Table 1

Indicator	**Target**
Number of maternal lives saved through DFID support	50,000
Number of newborn lives saved through DFID support	250,000
Number of malaria specific deaths per 100,000 per year	Help halve malaria deaths in 10 high burden countries

The indicators for maternal lives saved and newborn lives saved are linked to achievements made by DFID programmes. In contrast, the malaria indicator is an internationally agreed measure of global progress that cannot be linked to DFID programmes and project achievements, although DFID programmes that tackle malaria make a contribution.

The annual report for 2015/16 also indicated that further information would become available for the DRF indicator for family planning (additional users). While the additional user indicator was part of the DRF, it is also part of DFID's Single Departmental Plan (SDP) and DFID has continued to report beyond the 2015/16 annual report publication on this indicator. Most recently DFID published that it had

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/360906/DFID-external-results-Sep_2014.pdf
[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/67584/BAR-MAR-summary-document-web.pdf
[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/538878/annual-report-accounts-201516a.pdf
[4] https://www.gov.uk/government/publications/dfid-results-framework-results-2011-to-2015-by-sector

supported 12.5m additional users between July 2012 and March 2018[5]. The next update on the additional user indicator (due in summer 2019), will provide additional information on this indicator for the DRF period 2011-2015 as well.

2. Context

2.1 Maternal & Newborn Health

Improving maternal and newborn health has been a high priority for DFID. Between 2011 and 2015 DFID has funded maternal and newborn health programmes bilaterally in many low income and lower-middle income countries. DFID has also funded several centrally managed programmes and funded several multilateral institutions to improve maternal and newborn health. Many programmes support an integrated package of services for maternal and newborn health. Programmes also support initiatives to create the demand for services. In addition, DFID fund the procurement of health commodities and equipment for global deployment. DFID works through government facilities and the private sector (profit and not-for-profit organizations). Results achieved by these programmes over the period 2011 - 2015 were tracked using the following indicators:

- **Maternal lives saved:** This is defined as the number of women's lives saved while pregnant, or within 42 days of childbirth or end of pregnancy, with DFID support.
- **Newborn lives saved**: This is defined as the number of lives saved within 28 days of birth, with DFID support.

2.2 Malaria

DFID contributes to the global effort in malaria through bilateral programming and funding to multilateral institutions including the Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Health Organisation (WHO). DFID also funds research on the development of new drugs and diagnostics. Global progress on malaria over the period 2010 – 2015 was tracked using the following indicator:

- **Number of malaria specific deaths per 100,000 per year:** This is defined as the number of malaria attributable deaths per 100,000 at risk worldwide. This is not attributable solely to DFID support.

[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/725012/Family-Planning1.pdf

3. Results and disaggregations

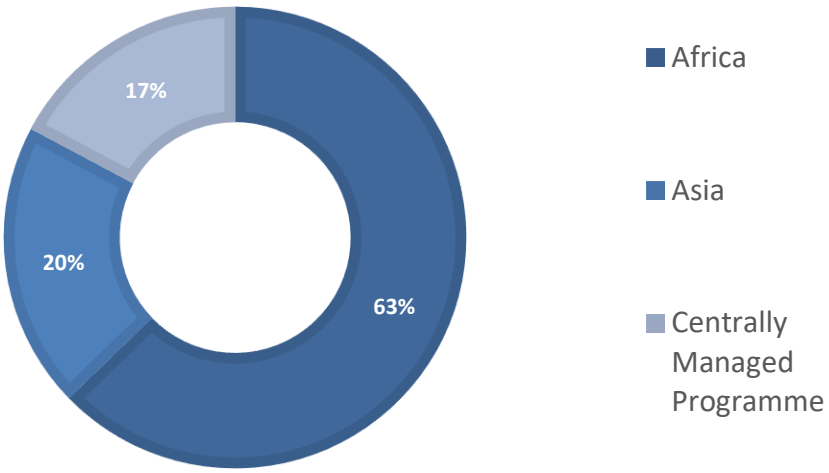
3.1 Number of Maternal Lives Saved

Between 2011 and 2015, DFID contributed to saving an estimated 80,100 maternal lives. This figure has already been published in the 2018 Independent Commission for Aid Impact (ICAI) maternal health review[6] [7]. This estimate is approximately 23,000 lower than the estimate published in DFID's annual report in 2015/16, which covered the period 2011 to 2014. There are 2 main reasons for the reduction in results: First, the incorporation of more up to date information from DFID programmes in Bangladesh and Ethiopia reduced estimates from bilateral country programmes. Second, the final estimate of 80,100 only includes results estimates from 1 centrally managed programme. Previously in the 2015/16 annual report, estimates from 2 such programmes had been included. One of the programmes has now been excluded from final estimates as there is a risk that results may be overclaimed in some countries. On the basis of these estimates, *DFID exceeded its target to save 50,000 maternal lives.*

3.1.1 Maternal lives saved by region

Between 2011 and 2015, DFID country office programming contributed to saving approximately 50,000 and 16,000 maternal lives in Africa and Asia respectively (see Figure 1). In addition, DFID's centrally managed programme Preventing Maternal Deaths through Unwanted Pregnancy PMDUP[8] contributed to saving a further estimated 13,800 maternal lives which cannot be attributed to a specific region.

Figure 1: Maternal lives saved results, by region.

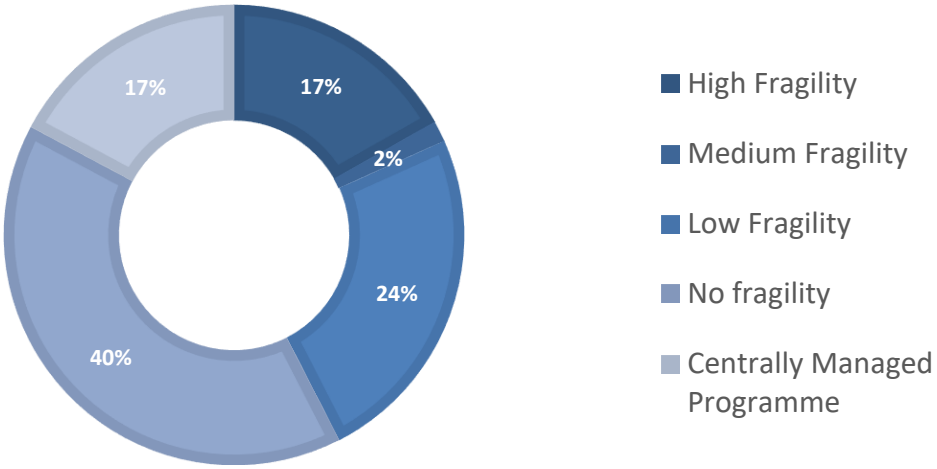


[6] 80,100 is after rounding some of the underlying data.
[7] See Assessing DFID's results in improving maternal health: An Impact Review, Oct 2018.: https://icai.independent.gov.uk/wp-content/uploads/ICAI-review-Assessing-DFIDs-results-in-improving-Maternal-Health-.pdf
[8] https://devtracker.dfid.gov.uk/projects/GB-1-201518 (programme renamed Preventing Maternal Deaths)

3.1.2 Maternal lives saved by country fragility level

Between 2011 and 2015, DFID contributed to saving an estimated 34,000 (approx.) maternal lives in fragile states, including 13,500 maternal lives in highly fragile states (see Figure 2). States are considered fragile by DFID if they are: fragile states defined on objective data on state stability from United Nations and the World Bank and; neighbouring countries of fragile states and/or part of the three designated regions: Middle East, North Sahara and South Sahara. DFID produces an internal listing of fragile states which is used to monitor the UK commitment to focus resources in fragile states[9].

Figure 2: Maternal lives saved by, country fragility level



3.2 Number of Newborn Lives Saved

Between 2011 and 2015, DFID contributed to saving an estimated 226,000[10] newborn lives. This is 39,000 higher than the estimate published in DFID's annual report in 2015/16. The estimate in the 2015/16 report covered the period 2011 to 2014. The main reason for the increase is availability of further information from DFID's bilateral programmes for the period between April 2014 and March 2015. On the basis of these estimates, *DFID was approximately 10% below its target to save 250,000 newborn lives.*

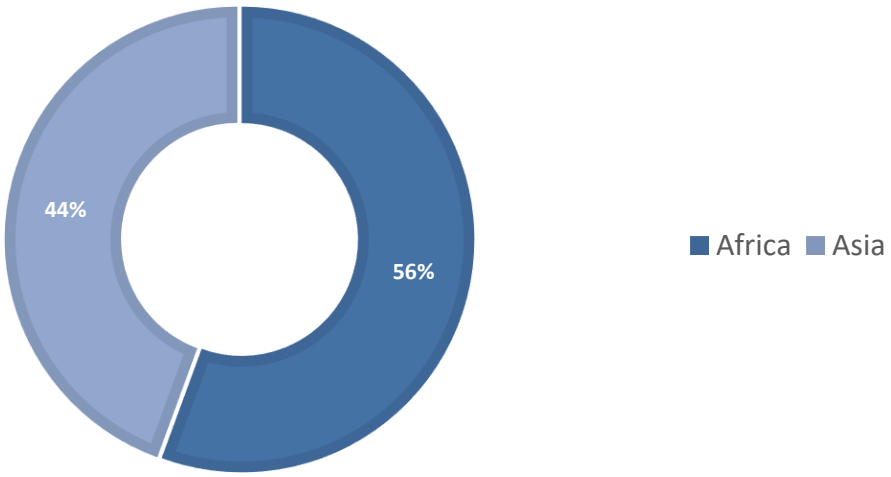
[9] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722389/Methodology-Note-Fragile-and-conflict-affected-states-and-regions.pdf

[10] 226,000 after rounding some of the underlying data.

3.2.1 Newborn lives saved, by region

Between 2011 and 2015, DFID country office programming contributed to saving approximately 125,000 and 100,000 newborn lives in Africa and Asia respectively (see Figure 3).

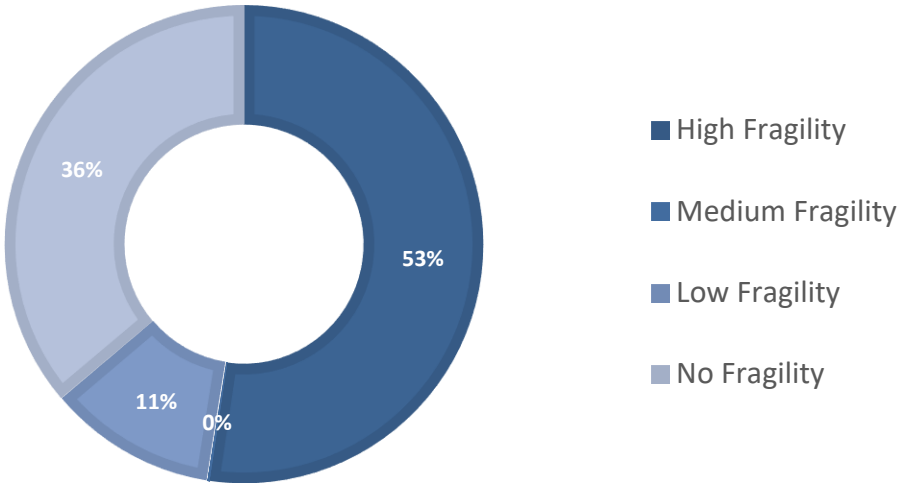
Figure 3: Newborn lives saved by, region



3.2.2 Newborn lives saved by country fragility level

Between 2011 and 2015, DFID contributed to saving an estimated 144,000 (approx.) newborn lives in fragile states, including an estimated 118,000 newborn lives in highly fragile states (see figure 4).

Figure 4: Newborn lives saved by country fragility level

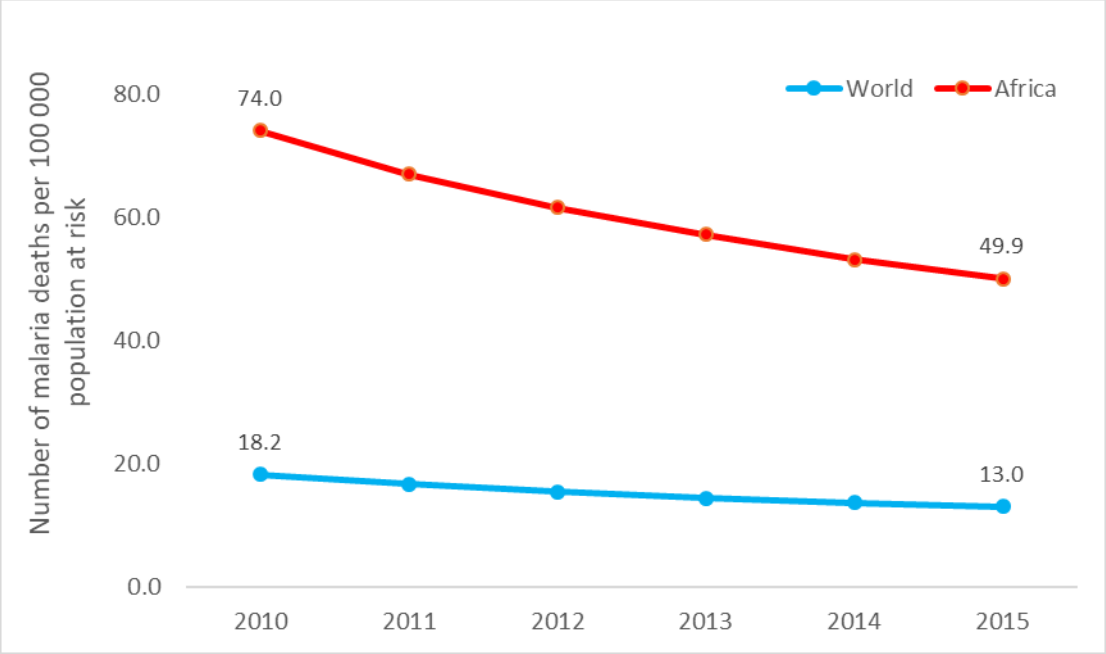


3.3 Number of Malaria Specific deaths

The World Health Organisation (WHO)[11] estimate that in 2015, there were 13 malaria related deaths per 100,000 at risk of contracting malaria worldwide, down from 18 in 2010 (a 29% reduction). The majority of these deaths occurred in Africa. In Africa there were an estimated 50 malaria attributable deaths per 100,000 at risk in 2015 down from 74 in 2010 (a 33% reduction). The global and Africa trends in malaria mortality rate between 2010 and 2015 are shown in Figure 5.

Between 2010[12] and 2015, The World Health Organization (WHO) estimates that malaria deaths were halved in two high-burden countries. The malaria deaths are estimated using the methodology agreed by the WHO's Evidence Review Group on malaria burden estimation methods and published in their World Malaria Report 2018[13]. This is lower than the estimate of five high-burden countries published in DFID's annual report in 2015/16. The estimate in the 2015/16 report covered the period 2010 to 2014 and used a different methodology[14] as there was no internationally agreed methodology at the time. The *global target to halve malaria deaths in 10 high burden countries has not been met.*

Figure 5: Trends in malaria mortality rate (deaths per 100 000 population at risk), globally and in the WHO African Region, 2010–2015.



[11] http://www.who.int/malaria/publications/world-malaria-report-2018/en/
[12] Baseline year for most indicators in the DRF was 2010.
[13] http://www.who.int/malaria/publications/world-malaria-report-2018/en/
[14] This methodology used national data sources to make estimates of the number malaria deaths by country. As this data is not consistently available annually and there is now a globally agreed methodology, this has not been replicated for comparison.

4. Methodology

4.1 Maternal & Newborn lives saved

DFID's results on maternal lives saved were obtained by modelling undertaken by partners at John Hopkins University using the Lives Saved Tool (LIST). LIST used information from DFID's health-related programmes and drew on the latest available evidence on the effectiveness of interventions and publicly available data to estimate lives saved. The DFID methodology note for estimating the maternal lives saved results are published on DFID website pages. [15] [16] A summary of the methodology is published in the BMC public health journal on 7th Nov 2017 [17].

The final estimate of 80,100 maternal lives saved aggregates results from DFID's bilateral country programmes and one centrally managed programme called Preventing Maternal Deaths through Unwanted Pregnancy (PMDUP). Maternal lives saved estimates include the effect of relevant maternal health interventions including family planning interventions. An adjustment was made to results estimates achieved by bilateral country programmes and PMDUP to ensure that there was no double-counting. Previously, DFID also included results estimates from another multi-country programme with the United Nations Population Fund (UNFPA) that supplied family planning commodities to low and lower middle-income countries (after adjusting for double counting). However, for this final estimate, results have not been included from the programme. This is because, a subsequent review of the methodology underlying the results suggested that there is a risk that results may be overclaimed in some countries. The data required to adjust for potential overclaims, is not available, hence results have been excluded.

The final estimate of 226,000 newborn lives saved aggregates results from DFID's bilateral country programmes only and no other programming, as it was not methodologically possible to robustly adjust estimates for double counting from multilateral and centrally managed programmes[18]. Newborn lives saved estimates have also excluded the effect of family planning interventions. This is because within the LIST model, family planning averts deaths due to reduction in pregnancies. Therefore, a modelling decision was taken to exclude the newborn lives saved via pregnancy prevention, on the basis that a life never conceived should not be counted as a life saved.

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[15] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/361492/maternal.pdf

[16] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/525563/Est-mat-newborn-lives-saved-technote-23may2016.pdf

[17] https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-017-4748-z

[18] In the 2015/16 DFID Annual Report, it was published that 187,000 newborn lives had been saved between 2011 and 2014. This included results from bilateral country programmes and one centrally managed programme. However, as it was not possible to accurately estimate the overlap in results achieved by this centrally managed programme and bilateral country programmes, this programme has been excluded from the final estimate to avoid any risks for over-claims

Many steps have been taken to ensure a cautious approach to final estimates, such as adjusting down to avoid double counting where PMDUP worked in the same country as a DFID country office programme. DFID at the time ran several other centrally managed programmes that targeted maternal and newborn health, but apart from PMDUP no other such programme was included in the final estimates. This is because it was not possible to adjust for double counting estimates of lives saved from these programmes. Rather than over-estimate any results, it was decided to exclude these investments. For similar reasons, DFID did not include results estimates from core funding to multilateral organisations that deliver programming on maternal health (for example, WHO, and the World Bank). Many programmes which benefit women and their babies, but in an indirect way, were not analysed as it was not methodologically possible to do so (for example, education, technical assistance and some training programmes). This further reduces the scope for over-estimation.

4.2 Number of Malaria specific deaths

The number of malaria specific deaths per 100,000 per year is based on the WHO methodology for estimating malaria deaths and the population at risk. The estimates are made using methods from three categories, full details of which are included in the World Malaria Report 2018.[19]

In the WHO methodology, in countries accounting for 90% of malaria deaths globally, estimates of malaria deaths in persons aged over 5 years are based on modelled estimates of proportion of deaths in children aged under 5 years due to malaria. These estimated deaths are then used to further estimate malaria deaths among persons aged over 5 years.

The proportion of the population at high, low or no risk of malaria was provided to the WHO by National Malaria Programmes (NMPs). This was applied to UN population estimates, to compute the number of people at risk of malaria.

5. Data Sources

5.1 Maternal & Newborn lives saved

Broadly, the default data sources in LIST are as follows:

- **Population data and trends**: UN Population Division
- **Causes of death structures**: drawn from work done by the World Health Organization (WHO), UNICEF; Child Health Epidemiology Reference Group (CHERG)
- **Intervention coverage data for maternal & newborn health**: Primarily Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Survey (MICS).

[19] World Malaria Report 2018, Annex 1 – Data sources and methods.

LIST allows input of user-centred data. Therefore, where possible DFID programme data on beneficiaries reached by different maternal & newborn health interventions was used in estimations. This was taken from programme logframes, annual reviews and partner reports. When it was not possible to use programme data, attribution calculations were necessary to estimate results and this was done using financial spend data. For this, DFID's spend data was drawn from approved business cases and government spend data was collected from ministries of health.

5.2 Number of Malaria specific deaths:

The number of Malaria Specific deaths per 100,000 per year was calculated using the WHO estimates in the World Malaria Report 2018 of total malaria deaths and the population at risk in 41 high-burden countries.

6. Data Quality

6.1 Maternal & Newborn Lives Saved

The accuracy of the estimated results depends on the quality of the underlying data. In many cases DFID used data collected by others (e.g. country governments, international organisations) and therefore had limited control over the quality of the data inputted into the results estimates. Sensitivity analyses were also conducted by the Johns Hopkins partner. These analyses showed that the final estimates do not change substantially when key assumptions/input data are altered. To maintain further statistical integrity, where possible, modelling assumptions were checked and qualitatively assessed by DFID programme staff to ensure they were reasonable.

6.2 Number of Malaria specific deaths

As the trends in malaria mortality are mainly determined by trends in all under-5 mortality, in some countries this leads to a declining trend in deaths despite malaria cases increasing.

The WHO recognises that there are limitations with the methods used to estimate malaria deaths. It has noted that several countries have reported more confirmed malaria cases from the public health sector alone than the whole population estimates generated by the methodology. This means that in many of the very high burden countries, it is likely that the methodology underestimates malaria deaths. WHO's Evidence Review Group on malaria burden estimation methods continues to review and refine the methodology.