BRIEFING

A global action plan for maternal, newborn and child survival

Decision time

In September 2010 the world's leaders meet in New York for the Millennium Development Goals (MDG) Review Summit. For the MDGs, 2010 is an absolutely decisive year. The deadline to achieve them is just five years away – five years which will see the goals either rescued from failure, with lasting benefits for millions of the world's poorest children and their families, or jeopardised by inaction, setting back the fight against poverty by a generation.

The summit must agree a concrete plan of action to achieve all eight of the goals. Save the Children is particularly calling for action to address maternal, newborn and child mortality. The commitments to cut child mortality by two-thirds (MDG 4) and maternal mortality by three-quarters (MDG 5) between 1990 and 2015 are way off track.

Four in every ten deaths of children aged under five result from complications or infections during or immediately after birth or in the first month of life.[1] Achieving MDGs 4 and 5 must be a single priority – we cannot achieve one goal without the other. Equally, an exclusive focus on newborn survival, as part of an effort to tackle maternal mortality, will ignore the majority of child deaths. This is especially the case in sub-Saharan Africa, where 75% of child deaths occur *after* the first month, in contrast to South Asia, where over half of all deaths are of newborns.[2]

MDGs 4 and 5 also deserve urgent and concerted political attention at the summit because they are a powerful indicator of wider social and economic progress. Providing more and better healthcare on its own will not achieve these goals, despite the pressing need for effective, accessible and equitable health systems in low-income countries. Achieving MDGs 4 and 5 will depend to a considerable extent on progress on the other MDGs. Malnutrition contributes to at least 3 million child deaths each year,[3] and we will not improve child survival without a much more determined effort to tackle malnutrition. We also know that women's education is a powerful predictor of both maternal and child health, as is access to clean water and sanitation. In sum, any successful effort to improve child and maternal survival must tackle not just the direct causes of high mortality but the wider issues that drive it.

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Current efforts are failing
The current approach to MDGs 4 and 5 is falling short on three fronts:

- **Lack of focus**
  Existing government and donor efforts to improve child and maternal survival are poorly coordinated and piecemeal. Most low-income countries' health systems underspend on preventing and treating the chief causes of child, newborn and maternal death, and lack clear policies. Health spending is often disease-focused and skewed towards high-cost treatment for the better-off sections of the population. Donor aid is more fragmented in health than in other sectors, with single-issue initiatives and projects often diverting resources from the development of comprehensive health systems. The wider factors behind maternal, newborn and child survival – nutrition and clean water and sanitation in particular – are especially neglected, as they tend to fall between different areas of response.

- **Lack of funding**
  Current funding is not only inefficient, it's also insufficient. Only six African Union member countries were allocating 15% of their budgets to health in 2006 – despite all 53 members promising to do so in 2001.[4] The global Consensus on Maternal, Newborn and Child Health estimates that **an additional $30 billion is needed between 2009 and 2015** to accelerate progress on MDGs 4 and 5 in 49 of the poorest and most off-track countries.[5] Moreover, just 1.5% of aid for health focuses on malnutrition, despite this contributing to around one-third of all child deaths.[6]

- **Lack of accountability**
  There is a major accountability gap on MDGs 4 and 5, with government and donor failures to honour pledges often passing unremarked within the UN system and at the national level. Where there's popular demand for action, and strong political leadership, as in Bangladesh, Liberia, Malawi and Tanzania, even the poorest countries can make dramatic strides. However, this is currently the exception rather than the rule. At the global level, the absence of an effective champion for MDGs 4 and 5 within the UN system has stymied effective global action.

A global action plan
To achieve MDGs 4 and 5, the world's leaders need to agree on a global action plan for maternal, newborn and child survival at the September UN MDG Review meeting. This action plan should help countries to implement their existing obligations under international human rights law, including the relevant provisions of the UN Convention on the Rights of the Child. The plan should focus on the 68 low- and middle-income countries that account for 97% of all child and maternal deaths, and should include the following five priorities:

1. Linking to – and supporting – credible national plans
National plans should focus on proven, cost-effective action:

- antenatal care
- skilled support at childbirth
- early postnatal care
- vitamin A supplements
- community case management of diarrhoea, pneumonia and malaria
- universal access to immunisation and vaccines.

The plans must strike a balance between 'quick wins' from now to 2015, some of which can be achieved through initiatives on specific diseases, and the need for these efforts to help establish functioning, universal health systems that cover the whole range of care in maternal, newborn and child health, provide accountable standards of coverage and access, and ensure community engagement. This will require:

- proper attention by governments to a national policy framework
- sound planning and budgeting
- a massive scale-up in the recruitment of health professionals, community health workers, nutrition and related professionals
- investment in community-level services and consultation with civil society.

The WHO has estimated that an additional 4.3 million health workers need to be recruited across developing countries as a whole to meet the health-related MDGs.[7] These extra workers should be in place by no later than 2012.

2. Mobilising more resources

National plans can only be devised, implemented and sustained if there is a substantial scaling-up of technical and financial support. Current levels of investment, both by developing country governments and donors, are not enough. Donors should provide coordinated technical support to help countries develop their plans, and make a collective pledge that no country with a credible plan in place and a commitment to implement it will fail through a lack of resources.

Donors should bridge the financing gap for national plans to 2015 by making multi-year commitments that are consistent with International Health Partnership principles.[8] An **additional $30 billion is needed between 2009 and 2015** to accelerate progress on MDGs 4 and 5, with annual incremental costs ranging from $2.5 billion in 2009 to $5.5 billion in 2015. According to the Consensus, **this investment would help to prevent up to 1 million deaths of women due to pregnancy and childbirth, and save the lives of 4.5 million newborns and 6.5 million children**.

All donors should also work with the International Monetary Fund in-country, and through the board in Washington DC, to ensure that there is sufficient flexibility in fiscal rules to allow a substantial scaling-up of recurrent spending. As part of the global action plan, developing countries should reaffirm their commitment to MDGs 4 and 5 by meeting a spending threshold: for low-income countries. The Abuja commitment to spend 15% of domestic resources on health is a good indicator that others might adopt, though the effectiveness of this spending and the equity of its distribution are also crucial.

3. Focusing on equity

There are vast and shameful inequalities in rates of maternal, newborn and child mortality between countries and within them. In the countries furthest off track, MDGs 4 and 5 cannot be met without much greater attention to the structural disadvantages faced by the poorest people, including rural communities and women and girls. This includes discrimination on the grounds of ethnicity, caste, gender or HIV status. National plans need to tackle the issues that restrict access to maternal, newborn and child health.

Progress on equity also requires a focus on rights. In many countries, the relative powerlessness of women and girls means they cannot access services without the consent of their husbands, fathers or male relatives. Securing women's and girls' rights, and enhancing their status, power and opportunities, is absolutely key to progress on newborn, child and maternal survival.

It is also essential to increase awareness of important health practices and care, as well as geographical, socio-cultural and financial barriers to accessing services. National governments and donors should commit to addressing barriers and to ensuring basic reproductive, health and nutrition services are available and accessible.

While there are different views about the most appropriate ways to finance healthcare, in 2009 the G8 explicitly supported the global consensus that maternal and child healthcare should be "free at the point of use where countries chose to provide it".[9] Donors and national governments should agree, as part of a global action plan, to set targets for reducing disparities in the provision of effective healthcare and in mortality rates between better-off and worse-off social groups.

4. Tackling the underlying causes, especially malnutrition

MDGs 4 and 5 can only be met if the wider causes of mortality are tackled. More than 30% of all child mortality is linked to maternal and child malnutrition, and this is also a significant factor in maternal mortality. Developing countries and donors should prioritise funding for proven approaches such as breastfeeding, complementary feeding, micronutrient supplementation, child and maternity benefits and treatment of severe acute malnutrition. Plans should ensure a coherent approach to nutrition across government departments such as health and agriculture. National plans must also

recognise the crucial role that improved water, sanitation, hygiene and maternal education play in improving maternal, newborn and child survival.

5. Ensuring accountability

A robust accountability system is essential to ensure that the global action plan commitments by governments and donors are met in full. Plans should be nationally owned and led, and the policy analysis and choices should be based on an inclusive process of consultation. At the national level, plans should be formally endorsed by donors, as part of the financing agreement. A joint government–donor group, including civil society representatives, might be convened in each country, chaired by the head of government/state or deputy, to meet regularly in order to drive implementation. A short annual report should also be published for each priority country, detailing progress against the plan commitments. These could be synthesised at the global level into an annual report that is reviewed at a high-level group meeting convened by the UN Secretary-General's office.

The global action plan should include a small amount of challenge funding administered by the UN Secretary-General's office to spur the creation of national-level civil society coalitions advocating for progress on MDGs 4 and 5. These coalitions will work to make the current toll on children and mothers politically unacceptable, and help to maintain popular pressure on governments and donors to deliver on their pledges to the world's poorest mothers and children.

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[1] Countdown to 2015, *Tracking Progress in Maternal, Newborn and Child Survival: The 2008 report*, Countdown to 2015, 2008

[2] UNICEF, *State of the World's Children 2009*, UNICEF, 2009

[3] The Lancet, *Maternal and Child Undernutrition* series, 2008 http://www.thelancet.com/series/maternal-and-child-undernutrition accessed 27 May 2010

[4] WHO, *World Health Statistics*, WHO, 2009; African Union, *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*, African Union, 2001

[5] Figures are totals for 49 aid-dependent countries (total population in 2009 is 1.4 billion; excludes India and China) for the 2009–2015 period, based on calculations done for the High Level Taskforce on Innovative International Financing for Health Systems (HLTF), May 2009. See http://www.internationalhealthpartnership.net//CMS_files/documents/working_group_1_-_report_EN.pdf accessed 27 May 2010

[6] J Kates et al, *Donor Funding for Health in Low- and Middle-Income Countries 2001–2007*, Kaiser Family Foundation, 2007

[7] World Health Organization, *World Health Report 2006 – Working together for health*, World Health Organization, 2006; cited in Save the Children, *Women on the Front Lines of Health Care: State of the world's mothers 2010*, Save the Children, 2010

[8] IHP+ is a group of partners who share a common interest in improving health services and health outcomes by putting the Paris and Accra principles on aid effectiveness into practice. It was launched in September 2007. IHP+ is open to all developing and developed country governments, and agencies and civil society organisations involved in improving health, who are willing to sign up to the commitments of the IHP+ Global Compact. Currently IHP+ has 46 members. For more info: http://www.internationalhealthpartnership.net/en/about

[9] G8 Communiqué. L'Aquila, Italy, 2009