

From Pledges to Progress: UK Advocates Working Together to Advance MDGs 4 and 5

Report of a collaborative event held on 6th May 2009,
at Church House, London, SW1P 3NZ

*“The real test of any health system is good maternal and neonatal health outcomes;
it is the primary test of the effectiveness of development as an intervention.”*

Ivan Lewis MP, Parliamentary Under-Secretary of State for International Development

1.0 Introduction

Ros Davies – Chief Executive Officer of Women and Children First introduced the event to mark the International Day of the Midwife. Women and Children First and the Royal College of Midwives hosted a half-day meeting on global maternal, newborn and child health (MNCH) on 6 May 2009. The event consisted of two panels addressing MNCH policy and practice. Speakers from a range of organisations including the then Parliamentary Under-Secretary of State for International Development, Ivan Lewis, and former UN Special Rapporteur on the Right to Health, Paul Hunt, alongside academics, NGO representatives and medical practitioners were invited to contribute.

The speakers provided an overview of progress made in the area of MNCH, identified the upcoming challenges and mapped the scope for future opportunities for collaboration.

This report highlights the key points made by each speaker and underlines the major debates raised during the two panels. Recommendations have been summarised at the beginning of this report.

2.0 Recommendations

The following recommendations have been developed from the presentations and panel discussions. These recommendations will be disseminated to DFID, The International Development Committee, the All-Party Parliamentary Group on Population, Development and Reproductive Health and the speakers and participants.

1. Financial Access to Health Care

- ensure that women and children do not pay for the current financial crisis, and that it is not used as a reason not to invest in the health services that could save their lives;
- follow through on commitments made to improve maternal, newborn and child health, ensuring that aid flows are adequate, predictable and long term, and urge other donor countries to meet their aid commitments and to scale up aid for health;
- align donor support around national health plans and target countries with the greatest maternal, newborn and child health needs, especially sub-Saharan Africa and South Asia;
- develop and use health financing mechanisms to ensure accountability, and hold governments in the North and South and multilateral agencies to account.

2. Use MDGs 4 and 5 to Measure the Health of the Nation

- ensure that progress made against MDGs 4 and 5, recognising the inextricable link between a mother and child's health, are at the core of UK development policy, and that MDGs 4 and 5 factor more strongly in support for national health plans;
- push for a multi-pronged approach aimed at ensuring a minimum package of health services and support programmes which take an integrated approach to MDGs 4, 5 and 6;
- push for progress made against MDG 5 to be used as a litmus test for the health of a nation's overall health system, against which governments in the North and South can be held to account.

3. Action by National Governments

- increase the proportion of the national budget allocated to health (up to 15 per cent for African countries, as set out in the Abuja Declaration);
- develop country strategies to recruit, train and retain enough skilled health personnel at primary, secondary and tertiary levels;
- scale up the provision of obstetric care to the recommended minimum of at least four facilities providing basic emergency obstetric care per 500,000 population, with at least one facility providing comprehensive care;
- strengthen the role of the midwife within the health system and build strong referral systems between antenatal care and other health services;
- Undertake more research into what improves maternal, newborn and child health and where, and improve data collection on maternal, newborn and child mortality and disseminate findings.

4. Involvement of Communities and Civil Society Groups

- ensure that health services reflect the needs of the communities they seek to serve and increase investment in community interventions such as women's groups;
- Increase the availability of basic maternal health supplies such as antibiotics, and adopt strategies to ensure these are available at community and primary care levels;
- support civil society – especially women – to hold governments in the North and South to account;
- support programmes which take a human rights-based approach – for example, by ensuring human rights form an essential part of health workers' training.

3.0 Panel 1: MNCH Policy and the Bigger Picture

Speaker 1: **Ivan Lewis MP – Parliamentary Under-Secretary of State for International Development – on DFID’s Health Strategy**

“The real test of any health system is good maternal and neonatal health outcomes; it is the primary test of the effectiveness of development as an intervention.”

Mr Lewis opened his presentation by highlighting the current opportunities from a global perspective – principally the election of US President Obama – as well as the challenges in terms of the global recession. He talked about the scandal of women losing their lives in childbirth and emphasised women’s role not just as mothers, but as community leaders and agents of change.

He then went on to describe UK government efforts to prevent maternal death, including:

- DFID’s commitment of £6 billion to strengthen health systems, with a view to delivering results on MNCH;
- the planned update of DFID’s maternal health strategy and the opportunity for improvement and transformation;
- the role that Sarah Brown has played in advocacy;
- Prime Minister Gordon Brown’s role in setting up the Taskforce on Innovative International Financing for Health Systems; and
- the UK’s support for the new Consensus for Maternal and Newborn Health – ‘every pregnancy wanted, every birth safe, every newborn healthy.’

Mr Lewis addressed the importance of preventing unwanted pregnancy and ensuring access to safe abortion as well as healthcare during pregnancy and birth. He highlighted the key role that a reformed UN system should play and emphasised that success depends on efforts being driven by countries in the South.

During the discussion, questions were raised about how organisational culture in developing countries can be changed, how the equality of women can be promoted, and how sexual and reproductive health and rights information and services can be scaled up. Queries on how the £6 billion for health will be allocated, and how we can ensure this money delivers real results for MDGs 4 and 5 were also raised. Responses from the Minister included:



- National champions are critical in ensuring results, as are informal leaders. Accountability is essential, and civil society – especially at the grassroots level – has an important role to play in holding governments to account. We need to build people’s awareness of their rights, especially women and young people. Parliamentarians have an important accountability role to play.
- Progress on MDGs 4 and 5 will depend on overall health system investment. Health systems strengthening is central to DFID’s work because it is the most sustainable way to bring about improvements in health.
- We cannot tackle MDGs 4 and 5 without clear strategies for reproductive health and gender equality, and we should work with other governments on these issues. Not everyone shares the UK government’s values, and tactics must reflect that. Governments that disagree should not be attacked, but work should focus on those who are willing to take these issues forward. We need to be sensitive, and work through informal networks and role models.

“We have the political will, and we have the evidence for what works. Now we need to raise the additional resources. If we do this, if we align donors, if we mobilise populations in developing countries, if we sort out the global architecture, and if NGOs and governments work together, we can reduce maternal and neonatal deaths by 2015.”

Ivan Lewis MP, Parliamentary Under-Secretary of State for International Development

Speaker 2: Paul Hunt – former UN Special Rapporteur on the Right to Health – on Human Rights and Ethics in Delivering MNCH

The key themes underpinning Paul Hunt’s presentation were governmental legal obligations and accountability in relation to the right to health. He began by giving a background to human rights, referencing the UN Charter of 1945 as the first time that the international community recognised the objective of human rights for all. Since then, human rights have been transformative, underpinning changes such as decolonisation, the US civil rights movement and the struggle for women’s equality. They can also be used in the context of MDGs 4 and 5.

Mr Hunt pointed out that all governments have signed up to at least one treaty that includes the right to health. This places a legal obligation on them to realise that right, he said – for example, by having a comprehensive health strategy, outreach programmes for poor and disadvantaged people, and accountability mechanisms. The right to health includes a legal obligation to provide sexual and reproductive health education and information, access to contraception, ante- and post-natal care etc.

These obligations are to be realised progressively – not overnight – and they are subject to the available resources, so more would be expected of the UK than, for example, Sierra Leone. But Sierra Leone still has an obligation to embark on the journey of realising the right to health. Furthermore, the UK has a legal human rights responsibility of international assistance and cooperation in health (for example, to assist a country like Sierra Leone).



Critically, like other human rights, the right to health requires that governments be held to account, including in relation to their conduct regarding MDGs 4 & 5. Accountability can come in many forms. A traditional form would be judicial accountability, but in the context of maternal mortality and MDG 5, governments could be held accountable by way of maternal death audits. While he focused primarily on maternal health, his comments could apply equally to newborn and child health.

“There is a need for greater accountability for the right to health on the part of donors and recipient countries. An independent ombudsman would be one way to ensure this. Maternal mortality audits could also play a critical role.”

Paul Hunt, former UN Special Rapporteur on the Right to Health

Speaker 3: Grace Mukasa – African Medical Research Foundation (AMREF) – on the Status of Women and Global Inequalities



Grace Mukasa’s presentation focused attention on the everyday realities of poor and excluded people. She based her key points on AMREF’s work with women from pastoralist communities in Kenya, and looked at how low social status, poverty and nomadic lifestyle impacted on access to maternal and newborn healthcare. She made the following overarching points:

It is important to recognise that access to healthcare is just one determinant of health; we also need to address the underlying determinants of poor health (sanitation, nutrition, clean water, gender etc).

The empowerment of women is critical. We must build their awareness of their rights and help them to form community groups where they can take control. We must also build their capacity to be autonomous decision-makers. This in turn will encourage them to demand their sexual and reproductive rights and rise above their low social, economic and political status.

We need to invest in trained community health workers. They play a pivotal role, as they are trusted by the community and help to link them with the healthcare systems. Indeed, in the absence of a strong healthcare system and in pastoral communities where the majority of women deliver at home, community health workers and midwives can play an important role in preventing maternal morbidity and mortality.

At the same time, community health workers should not take on the role of professionals. We need a dual strategy that provides for the long term and the short term.

We need to adapt health services to reflect the needs of the communities they seek to serve. Pastoral communities cannot rely entirely on a static healthcare system and, therefore, require innovations such as mobile health clinics and clinical outreaches.

“Money disappears in the bureaucracy, like investment in health workers – you hardly see any change on the ground. And sometimes commitments are forgotten, especially to vulnerable groups. The UK government should push for financing mechanisms that enable funds to go to the right places.”

Grace Mukasa, AMREF

Speaker 4: **Dr Alvaro Bermejo – The International HIV/AIDS Alliance and Action for Global Health – on HIV and AIDS and MNCH**

Dr Bermejo's presentation stressed the importance of working together on MDGs 4, 5 and 6. He looked at the close links between HIV prevalence and maternal and child mortality and stated that we need to stop thinking of these as separate issues and start designing interventions which recognise their interconnectedness.

For example, there is no doubt that HIV and AIDS contribute significantly to increased maternal mortality. Women living with HIV have an increased risk of prenatal and childbirth complications including miscarriage, anaemia, postpartum haemorrhage and puerperal sepsis, in addition to an increased risk of dying from indirect causes, such as malaria and pneumonia.

In addition, children whose mothers are HIV-positive will be much more likely to become ill and to die. We can prevent mother-to-child-transmission of HIV, and, alongside this, keeping HIV-positive women alive is the best thing we can do for their children.

But these links and how to manage them are still not well understood. More resources are urgently needed to examine these linkages and better understand how to manage them. Issues that require an integrated approach include Prevention of Mother-to-Child-Transmission (PMTCT), feeding support and antenatal care. We also need to rethink the way that HIV testing is done in antenatal settings, to ensure it brings benefits for both mother and baby.

As advocates, we should ensure greater recognition of MDG 6 at MDG 4 and 5 policy and advocacy meetings.



“There is evidence that health systems are inefficient if we spend less than \$15 per person. We need higher levels of funding. We must advocate for more money for the health MDGs, including ensuring that the UK supports the High Level Taskforce on Innovative International Financing for Health Systems.”

Dr Alvaro Bermejo,
International HIV/AIDS Alliance

Panel Discussion moderated by Gita Sahgal, Head of the Gender Unit at Amnesty International

How could the UK use the IMF and World Bank to disburse funds in more effective ways?

Paul Hunt noted that this point underscored the importance of accountability. The UK needs to devise better mechanisms to hold the World Bank and other institutions accountable and to do so in a constructive way. Dr Bermejo pointed out that the current economic climate presented an opportunity to highlight that the IMF and World Bank are sometimes part of the problem, and to push for reform. Grace Mukasa emphasised the importance of aid effectiveness.

What can be done to ensure health workers are trained in human rights?

Mr Hunt suggested that one way to do this is for medical colleges to insist that human rights training be a compulsory component of doctors' and midwives' education.

Will criminalisation of HIV transmission cause women to avoid going to health centres to deliver?

Dr Bermejo said that criminalisation was getting in the way of public health; it increases the vulnerability of women and impedes the urgent response that really needs to be provided. Mrs Mukasa agreed, and said "we need to look beyond criminalisation and look at the causes. Why do people do this? It doesn't help to brand people."



4.0 Panel 2: MNCH Challenges: Scaling up 4 Million More Health Workers

Chair: Linda Doull, Head of Health & Policy at Merlin

Speaker 1: Professor Anthony Costello – UCL Institute for Global Health, Institute of Child Health, University College London – on Community Responses to Improving Newborn and Child Health



Professor Costello began by stressing how central newborn health is to MDG 4, and explained that 54 per cent of deaths in children under five are in newborns. He then described the global picture in terms of newborn and maternal deaths, as follows:

- While 22 per cent of countries are on track to meet MDG 4, 41 per cent have made insufficient progress and 38 per cent have made none. In 11 countries the rates of mortality among children under five have actually increased.
- While it is estimated that there are four million newborn deaths each year, reliable statistics for newborn mortality are not available. This information gap should be addressed urgently.
- Between 1990 and 2005 maternal mortality decreased by just seven per cent across developing countries, and by only two per cent in sub-Saharan Africa. We need new approaches that reach the poorest women.

In some countries financial incentives have been offered to encourage women to deliver in a health centre or with skilled attendance, but in Nepal studies show that the uptake of financial incentives was largely confined to the wealthiest quintile. Yet simple interventions such as ensuring all mothers fed their babies colostrum (the first breast milk, which contains a high concentration of nutrients) after birth could reduce low-risk infant deaths by 23 per cent. Equally, an Institute of Child Health (ICH) initiative which trained traditional birth attendants (TBAs) in resuscitation for newborns led to reductions in newborn deaths.

While a trial by the ICH in Nepal found that direct health education had no impact on infant care or survival, an initiative of community mobilisation through women's groups led to a 30 per cent reduction in newborn mortality alongside a significant reduction in maternal mortality. There was also a small increase in women seeking delivery with skilled attendance, large changes in hygiene practices and antenatal care, with mothers more likely to seek care when babies became ill. These groups were facilitated by local women who were not health workers, and key components of the initiative included: providing clean home delivery kits; enabling women to debate problems using picture cards; helping to generate local funds for maternal and child health emergencies; and setting up stretcher schemes. Professor Costello pointed out that the relatively low cost (\$0.75 per head of population) met with World Bank cost-effectiveness criteria. The model is already being replicated in other parts of Nepal as well as in Bangladesh, India and Malawi.

“Simple community interventions – particularly women’s groups and antibiotics – can reduce mortality”.

Professor Anthony Costello,
UCL Institute of Child Health

Professor Costello also added that when the antibiotic Prontosil became available in the UK in 1936 it led to a sharp decrease in sepsis-related maternal deaths. Ideally, drugs such as Prontosil and Misoprostol (used to treat gastric ulcers, for early abortion, to treat missed

miscarriage, and to induce labour) would be provided within health facilities in the presence of a skilled attendant, but in settings where most women do not deliver in facilities these drugs could be outreached through community health workers and women volunteers at the village level.

Speaker 2: Frances Day-Stirk – Vice-President of the International Confederation of Midwives and Director of Learning, Research & Practice Development, Royal College of Midwives – on Midwives, Mothers and Mortality

Frances Day-Stirk began her presentation with the observation that so little progress has been made on MDG 5. It is well recognised, she said, that skilled personnel during childbirth is the single most important factor in preventing maternal deaths.

The International Confederation of Midwives (ICM) believes that every woman has the right to receive healthcare during pregnancy from a skilled person. ICM works globally, by helping midwives with support, advice, tools and resources, as well as

overseeing a code of ethics for midwives and setting out core competencies.

What are most needed are country strategies to increase the number of health workers and make universal access to skilled personnel during delivery a reality.

“Country strategies are needed to increase the number of health workers and make universal access to skilled personnel during childbirth a reality.”

Frances Day-Stirk, International
Confederation of Midwives



ICM is working with UNFPA in 11 African countries to scale up the number of birth attendants and achieve MDGs 4 and 5. Strategies include instituting Country Midwife Advisors (CMAs) who will guide and support the development of human resources for maternal health.

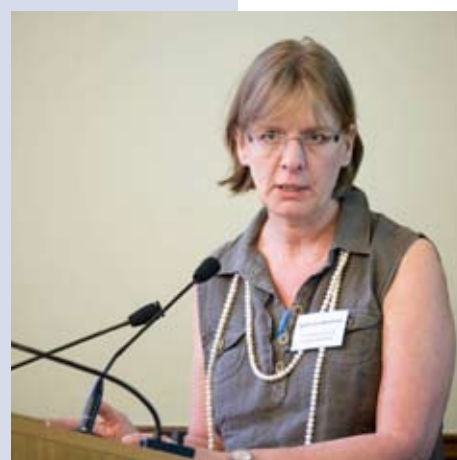
Three hundred and fifty thousand midwives are needed in community-, primary- and secondary-level health services to dramatically reduce maternal and newborn deaths. Strengthened infrastructure and referral systems to emergency obstetric care are also key. Alongside this, changes are needed to ensure that women can access healthcare services. All of this will require political will, commitment and investment.

Speaker 3: Dr Nynke van den Broek – Liverpool School of Tropical Medicine – on Emergency Care to Save Women’s Lives

Dr van den Broek began by calling for strategies to scale up skilled birth attendance and accessible, good-quality emergency obstetric care – both Basic Essential Obstetric Care (BEOC), which includes assisted delivery, manual removal of the placenta and administration of antibiotics, oxytocic drugs and anticonvulsants, and Comprehensive Essential Obstetric Care (CEOC), which also includes caesarean sections and blood transfusions.

The World Health Organization (WHO) recommends that a population of 500,000 should be served by a minimum of four BEOCs and one CEOC. However, in developing countries the minimum coverage target is not being met. The main reason, according to Dr van den Broek, is the insufficient number of midwives trained and employed. Not enough is being done to enable scale-up to the numbers required to prevent maternal deaths; there is a lack of enabling policy in developing countries, not enough workers are trained with the right knowledge and skills, and an ‘enabling environment’ within which midwives can successfully do their jobs is lacking.

The Liverpool School of Tropical Medicine has run competency-based training in the signal functions of EOC and newborn care, all of which can be performed by midwives. This is a simple and relatively cheap intervention but yields a number of important results in the healthcare setting, including increased knowledge and skills, behaviour change, increased enthusiasm and motivation to provide a better quality of care, and improved team work. It also builds midwives’ awareness of the need for evidence-based care and encourages examination of the supportive health system and policy at the central level.



“Strategies are needed to strengthen the supply side of healthcare for women: skilled birth attendance and emergency obstetric care must be scaled up.”

Dr Nynke van den Broek,
Liverpool School of Tropical Medicine

Speaker 4: Dr Stephen Greene – David Baum Fellow, Royal College of Paediatrics and Child Health International Board – on Scaling Up Paediatric Services to Reduce Neonatal and Infant Mortality

Dr Greene presented briefly on the Royal College's role in responding to neonatal and infant mortality. The college runs training and education activities, undertakes advocacy, acts as an international voice on child health and runs projects in the Middle East, Africa and India.

Since 2006 the college has had an international strategy aimed at building expertise and promoting training and post-graduate education which builds specialisation in newborn and child health. Long-standing partnerships have been established in a number of countries to ensure projects are sustainable, and there is a strong emphasis on impact and efficacy.

In 2009 the Royal College established and supported courses in India, Jordan, Iraq (Kurdistan), the West Bank, Malawi, Kenya and Tanzania, in subjects including paediatrics, paediatric resuscitation and primary care child health.



Panel Discussion moderated by CNN Security Correspondent Paula Newton

Key ways to make advocacy effective in order to deliver on MDGs 4 and 5:

- Professor Costello argued that because funding for MNCH is so low – as in India, for example – advocates must pressure governments to deliver more funding by measuring what they spend and demonstrating how little it actually is. Effective measurement techniques will also ensure that investments lead to improvements.
- Frances Day-Stirk added that scaling up is critical. We need to push governments to invest and hold them accountable for what they have committed to.
- Dr van den Broek suggested that the MNCH community start pushing for a multi-pronged approach. We need to fight for the availability of a minimum package of services instead of one magic solution, and ensure that people at country level are involved.
- Dr Greene argued for reduced fragmentation within the MNCH community and recommended we support programmes which take an integrated approach. We should evaluate these and undertake qualitative research so that we can understand what works where.

In settings where there is a total lack of personnel and equipment in many hospitals, how can maternal healthcare still be made to work?

- Professor Costello stressed that what can realistically be provided at present is still horribly insufficient. Access to obstetric care is the ideal but is not always possible. If the difference between life and death is getting antibiotics to a woman at the community level then we should and can do it.
- Mrs Day-Stirk noted that the introduction of midwives has had the effect of reducing maternal mortality extensively.
- Dr van den Broek repeated that we should stop debating what one thing can solve this problem, because solutions need to be context specific.



Beyond antibiotics and women's groups, how else can we improve outcomes in situations where women cannot access skilled care?

- Professor Costello suggested public health midwives who would be community orientated but linked to the rest of the health system and able to make prompt referrals. Midwives should not be seen as incidental but rather as an integral part of the wider health system.
- Mrs Day-Stirk agreed and emphasised the key role for community-level workers within health systems.
- Dr Greene talked about the problems of health professionals' time being diverted into multiple training courses, leaving no time for them to actually do their jobs; and brain drain away from the poorest and most-in-need areas. Health system development and health worker strategies must take this into account.

Are there any moves to build a regional midwife group for Africa?

Mrs Day-Stirk emphasised the importance of regional midwives' networks and said that there were a few midwife groups in the Africa region; Africa North and Africa South are represented at Board level at the ICM. But while the gap is slowly being tackled, there is no funding for this kind of project.

Where does access to family planning services fit into the MDGs?

Panellists pointed out that MDG 5b now explicitly addresses access to reproductive health and includes targets on access to family planning services and contraceptive prevalence.

What did the panel think of the 'Three Delays to Safe Delivery' Model?

The panel agreed that the Three Delays Model is important. Delay 1 concerns determining that the woman in childbirth needs urgent medical attention; delay 2 concerns transport to a medical facility; delay 3 concerns the woman receiving adequate medical attention when she arrives at the healthcare facility. Professor Costello added that there are really *four* delays to safe delivery, the first of which concerns the delay in recognising the problem, and that this – as well as determining that the woman in childbirth needs urgent medical attention – can be addressed through methods such as community mobilisation through women's groups.

5.0 Wrap Up and Conclusions

Professor Cathy Warwick, Secretary General of the Royal College of Midwives, summed up the proceedings and emphasised some of the key messages from the event. These underpin the recommendations listed at the beginning of this report.

Key messages:

- Inaction is not an option.
- Universal free access to health is critical.
- We have an opportunity now with the change of government in the USA.
- The UK must urge recipient governments to fulfil their commitments to health and must get other donors on board.
- The UK Government should support the development of professional-level workers and particularly midwives but also support the development of a cadre of community health workers/TBAs who do not need to work under the guidance of these professionals.
- The UK Government should ensure accountability at all levels of the system. This would include holding ministers to account and monitoring outcomes at local level to ensure that interventions are achieving objectives.
- The Taskforce on Innovative International Financing for Health Systems must find new solutions, and these must be implemented.
- Efforts have to be more consolidated – financially and organisationally – to get the most out of our money.
- Responses need to be country specific – there is no ‘one size fits all’ solution – and to target the most vulnerable groups.
- Monitoring and evaluation are important so that we can continually improve.

Recurring themes for advocates:

- We need to stand together and deliver bold, clear messages to the government and to the public on these issues.
- Short-, medium- and long-term solutions are all required.



We would like to thank UNFPA and Action for Global Health for supporting this event.



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