Report on Wilton Park Conference 950

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MATERNAL, NEWBORN AND CHILD SURVIVAL: MEETING MILLENNIUM DEVELOPMENT GOALS 4 & 5

Wednesday 10 – Sunday 14 December 2008

The conference brought together senior political figures, including the Secretary-General of the Commonwealth, Health Ministers or Deputy-Ministers from Mozambique, Namibia and Sierra Leone, donors, UN and international agencies, non-governmental organisations, as well as academics and independent specialists.[1]

Propositions for Action

The Wilton Park conference reached 8 concrete propositions for action.

- Our collective efforts should cohere around credible and costed plans at the national level, operating across the continuum of care and reaching down to the community level. These should be based on strong systems and effective delivery mechanisms.

[1] On the Millennium Development Goals, see: http://www.un.org/millenniumgoals/bkgd.shtml

- These plans should link to the wider social, economic and environmental determinants of high mortality, including under-nutrition, unsafe water and sanitation, maternal education, family planning, and governance.

- We should publicise success: examples of countries and communities that have cut mortality and the reasons for this.

- We need more resources. No low income country which has committed itself to a credible national plan for maternal, newborn and child survival should fail to implement this strategy for lack of funds. We must consider more seriously the impact of financial barriers to health care and other services. As a minimum, all countries should provide a basic package of maternal, newborn and child health and related services, as well as family planning. This should be provided to all, free at the point of use. Donors should work with low income countries to address the financial costings of this policy. Increasing the number of trained healthcare professionals is priority area for the allocation of additional resources. 54 of the countries with the worst records on maternal, newborn and child mortality have less than the agreed minimum standard of 2.5 health workers per 1,000 members of the population.

- Equity and rights should be at the centre of all our efforts to tackle maternal, newborn and child mortality. It is the poorest mothers and children in the poorest communities who are at greatest risk.

- We should engage the public and help to create a popular movement around maternal, newborn and child survival. Clear and compelling messages are needed to galvanise action.

- We should create platforms for champions, at the local, national and global levels.

- We must challenge existing indicators of success in development. Whether

the child and maternal survival prospects of the poorest communities are improving is a really powerful indicator of whether development is working.

Key themes throughout the 4 days of the conference.

i. The centrality of politics.

There are proven technical interventions that have been shown to prevent the vast majority of maternal, newborn and child deaths. These have been set out, for example, in *The Lancet* series.[1] But these interventions are often not accessible to those who need them. The reasons for this are usually political: the weakness or lack of accountability and responsiveness of government institutions, inequality, and entrenched discrimination against particular groups. The standard response to the problem of maternal and child mortality – indeed to most development problems – is to call for more political will. But the real question is how to create and sustain that political will. What sort of political strategies are required to secure the policy change and the resource mobilisation and prioritisation necessary?

ii. The importance of equity:

It is the poorest and most marginalised mothers, newborns and children that are at greatest risk of dying. At one level, these inequalities are increasingly acknowledged in the literature. But there is not yet a convincing policy or programmatic response to the needs of mothers and children in these communities.

iii. The need for sustainability:

A better resourced, more energetic donor effort could certainly help to boost coverage rates for key interventions in particular countries, but how credible is the existing conceptual and operational framework for developing effective national and

[1] See: http://www.thelancetglobalhealthnetwork.com/archives/237http://www.thelancetglobalhealthnetwork.com/archives/237

district-level systems, capable of delivering the interventions needed, as well as being sustainable over time? The question of building local and sustainable capacity was a key element in our deliberations.

The Scale of the Problem

1. Globally, 9.2 million children die before the age of five each year. Nearly 3.7 million of these children die within their first 28 days, with 2.8 million babies living less than a week. Nearly all child deaths – 98% – occur in developing countries. Sub-Saharan Africa accounts for around 4.5 million of all child deaths, while around 3 million are in South Asia. The latest available figures show the average child mortality rate (child deaths per 1,000 live births) is 148 per 1,000 in sub-Saharan Africa and 78 per 1,000 in South Asia. That compares with 6 per 1,000 in the UK.[2]

2. The persistence of high levels of child mortality can be explained at three separate but related levels. Firstly, there are a set of basic diseases or medical conditions - including pneumonia, measles, diarrhoea, malaria, HIV and AIDS, and neonatal conditions – that are the direct cause of most child deaths. The direct causes of maternal mortality mainly relate to complications during pregnancy and labour, including post-partum haemorrhage, infections, eclampsia and prolonged or obstructed labour, as well as complications of abortion.

3. Despite the fact that there are proven interventions and policy responses that could prevent or treat these diseases and medical conditions, these continue to be inaccessible to many mothers and their children in the world's poorest countries and communities. To understand why, we need to consider a set of secondary causes: factors that influence which children are most exposed to infection and whether the outcome of that infection is recuperation or death. The key secondary factors that shape the survival prospects of children and mothers are: the capacity, quality and accessibility of health systems, under-nutrition, the availability of clean water and safe sanitation, female literacy and access to family planning.

[2] UNICEF, *The State of the World's Children, 2009*, UNICEF, 2008

4. Underlying the immediate causes of maternal and child mortality and the secondary factors that increase a mother and child's risk of early death are a set of deeper, structural causes. These are largely about poverty, inequality and discrimination. However, there are also other significant underlying causes of child and maternal mortality, such as poor governance and violent conflict. A disproportionate number of those mothers and children who die unnecessarily are dying in poorly governed states, and eight of the ten countries with the highest under-five mortality rates have recently experienced violent conflict.

Lessons from the Past

5. What can be learned from the first Child Survival and Development revolution in the 1980s, particularly from UNICEF's experience under the leadership of Jim Grant?[3] The 1980s and early 1990s was a period in which levels of child mortality fell very significantly (although there was less progress on maternal mortality). Four particular lessons from this period were highlighted: the importance of a clear vision and leaders who can articulate it; the need for a plan and goals - with a doable agenda broken down into manageable chunks, particularly at the country level; the need for social mobilisation – (for example, in Colombia, secondary school students were required by the government to engage practically with the child survival movement); and the requirement for effective monitoring, (for example, Multiple Indicator Cluster Surveys (MICS), which came from the child survival and development revolution, are now being used in 95 countries).

Access to health services, health care financing and the right to health

6. The weakness of existing health systems and services at the national and community level is a major barrier to improving maternal, newborn and child survival rates. There was a strong focus on the question of user fees. There is now considerable evidence that charging people to attend a health centre or for basic treatments acts as a significant disincentive to the utilisation of health services, with very serious implications for morbidity and mortality. For example, a 2005 study

[3] See: R. Jolly (ed.), Jim Grant: UNICEF Visionary, UNICEF, Florence, n.d.

published in the *British Medical Journal* found that the elimination of user fees could prevent approximately 233 000 deaths annually in children aged under 5 in 20 African countries.[4] More recent research has reinforced the findings of this study. Evidence from Uganda, Burundi, Rwanda and DRC has demonstrated that the removal of user fees has led to significant increases in the use of vital health services, including the birth of children in hospital, caesarean section surgeries, and child outpatient visits. An *Equitap* study of 14 Asian countries also found that, *"The only poor countries where the poor are effectively reached are those where policies do not explicitly target the poor, either through user fee exemptions or specially-targeted programmes".* There is now growing support from some key donors (DFID, the EU, WHO, the World Bank) for the removal of user fees in health. But this demand is also increasingly driven by developing country governments themselves.

7. In many developing countries, the number of health workers per head of population falls short of the WHO target of 2.3 health workers per 1000 people. Indeed 54 of the 68 countries with the worst rates of maternal and child mortality fail to meet this WHO target. In some countries, the figures are much worse. Sierra Leone, for example, has only 5 paediatricians, 7 obstetricians and gynaecologists, 8 general surgeons, and a major shortfall in midwives. Within countries, there also tend to be wide variations between income groups. In the poorest and most remote parts of developing countries - the places where they are needed most - there are often no trained and properly equipped health workers available. Health professionals living in rural areas will often seek out better career opportunities in the cities and some of the best trained workers will leave their countries to find work abroad. A proportion of health workers are also being lured away from the primary health care system into better funded 'vertical' disease programmes. There was a widespread consensus that governments needed to invest considerably more resources into the development, training, retention and equipment of the health workforce, particularly at the community level.

8. In the context of the discussion on health, the conference considered the question of the right to health and inequalities in health. Governments have existing legal and

[4] James C et al BMJ 2005;331:747-749

political obligations in relation to the health and well-being of mothers and children. These are set out in international human rights agreements. Making greater progress on maternal, newborn and child survival issues will depend upon governments being held to account more effectively for these obligations, and a rights-based approach creates opportunities for combating those forms of political, legal or social discrimination that are the underlying causes of high mortality.

Pushing Nutrition up the Agenda

9. The deaths of 3.5 million children each year (more than one third of all the children under five who die) can be attributed to the effects of under-nutrition.[5] Poor nutrition is also a significant factor in maternal mortality. In the case of child mortality, the damage can start when a child is still in the womb, an indirect consequence of the poor nutritional intake of the mother. Globally 18 million babies are born with low birth weight each year.[6] A lack of certain micronutrients can also damage the health of the mother and her child. For example, iron deficiency affects around 42% of pregnant woman,[7]and their children are at greater risk of low birth weight, prematurity, cognitive impairment and newborn death.[8]

10. Under-nutrition weakens a child's immune system, making them more susceptible to disease and less able to fight off infection. A child is almost ten times more likely to die from key diseases if they are severely underweight than if they are of average weight for their age, and two and a half times more likely to die if they are even moderately underweight.[9] A particularly critical period for cognitive and physical development is from the first few weeks in the womb until the second year of life. If a

[5] R Black et al, Maternal and Child Undernutrition: Global and regional exposures and health consequences, Paper 1, Lancet, Maternal and Child Undernutrition, Lancet, 2008, p5

[6] Save the Children US, State of the World's Mothers 2006, Saving the Lives of Mothers and Newborns, Save the Children, 2006

[7] E McLean, M Cogswell, I Egli, D Wojdyla and B de Benoist 'Worldwide prevalence of anemia in preschool aged children, pregnant women and non-pregnant women of reproductive age,' in K Kraemer, and M Zimmerman (eds), *Nutritional Anemia*, Sight and Life Press, 2007

[8] G Gleason and N Scrimshaw,'An overview of the functional significance of iron deficiency' in K Kraemer, and M Zimmerman (eds), *Nutritional Anemia*, Sight and Life Press, 2007

[9] R Black et al, Maternal and Child Undernutrition: Global and regional exposures and health consequences, Paper 1, Lancet, Maternal and Child Undernutrition, Lancet, 2008, p9

child is chronically malnourished, or stunted, during this time, the effects are irreversible. No amount of subsequent intervention will make up for the damage done. There was wide agreement that exclusive breastfeeding is a critically important intervention for reducing maternal, newborn and child mortality, and that governments and companies should uphold to the full their obligations under the International Code of Marketing of Breast-Milk Substitutes.[10]

11. There are a number of reasons why nutrition still fails to command sufficient political attention. There is a perception that economic growth will fix the problem of under-nutrition. But the evidence suggests that even if developing countries were to experience more equitable and above average economic growth rates, this would be inadequate to reduce malnutrition fast enough to reach the Millennium Development Goals (MDG) target. There is a lack of leadership and no clear institutional home for the issue. The nutrition community's messaging is overly complex. Nutrition is seen as only a problem in emergencies. Finally, the data on nutrition is often weak and inconsistent.

12. A number of specific proposals on how these problems could be overcome and how nutrition could be pushed higher up the political agenda were made. First, it was suggested that a government's record on nutrition should become a proxy for its performance on governance. Second, there were lessons to be learned from the success of cross-cutting movements around HIV/AIDS, gender and climate change. Third, a simple, unified and powerful message needs to be sent out that poor nutrition is killing mothers and their children. Fourth, a two-way dialogue is needed between the development and humanitarian communities to flesh out a new architecture for dealing with nutrition issues at the international level. Fifth, accurate and regularly collected data is necessary to track and compare progress, identify failures, correct strategies and secure funding.

13. The discussion on nutrition also considered the implications of the global rise in food prices. While prices have fallen somewhat in the last few months, they are still

[10] See: http://www.who.int/nutrition/publications/code_english.pdf and http://www.unicef.org/nutrition/index_24805.html

significantly higher than they were three years ago, and several underlying drivers are likely to keep prices high and push them up further in the years to come. As of December 2008, it was estimated that over 900 million people were hungry and at risk of various forms of under-nutrition. Most poor households are net food buyers, with female-headed households squeezed hardest by increases in the price of staple foods. A multiplicity of dangerous and risky behaviours surface as families attempt to cope with volatile prices - from selling assets and taking loans, removing children from school, and engaging in harmful labour. Households will also decrease consumption of nutrient-dense foods and their overall amount of food intake. These actions have the greatest negative impact on growing infants and children and pregnant and lactating mothers. The micronutrient deficiencies and reduction in dietary energy that ensue lead to increased susceptibility to infections (particularly diarrhoea which then further increases nutrient loss and reduces appetite), slowed cognitive development and growth, impaired school performance, reduced work productivity, thinness, low-birth weights and increased stunting.

Vicious Cycles: HIV/AIDS and MDGs 4&5

14. The conference looked at the relationship between HIV/AIDS and maternal, newborn and child mortality is a key factor. Because the HIV status of mothers and children is often not known or acknowledged, it is difficult to be precise about the exact impact. However, the evidence available does suggest that HIV/AIDS can considerably worsen maternal and child mortality rates. In South Africa, for example, where the best data is available from census reports, very large peaks of maternal mortality stand out in area with high prevalence of HIV and large troughs become visible where antiretroviral (ARV) coverage is high. Similarly, research evidence from Zimbabwe and Malawi indicates that mortality rates are eight times higher among HIV positive women than those who are HIV negative. In Uganda, maternal mortality rates triple amongst HIV positive women.

15. The causes of increased risk of death in pregnancy for HIV positive women are well understood. Suppressed immunity causes high risk of prenatal complications such as anaemia, post-partum haemorrhage and puerperal sepsis. Indirectly,

pregnant HIV positive women experience increased susceptibility to opportunistic infections such as pneumonia, tuberculosis and malaria. [11]

16. The impact of HIV/AIDS on child mortality is also well documented. A child is 3 times more likely to die in his/her first 5 years if his/her mother is HIV positive and 10 times more likely to die if his/her mother dies. Without intervention, one-third of HIV positive children will die before there first birthday and one half will not see their second birthday.[12] Yet today only 10% of HIV positive children receive ARV treatment.

17. However, it appears that neither HIV/AIDS organisations nor those working on maternal and child health have sufficiently taken into account these connections. The Prevention of Mother to Child Transmission (PMTCT) is still not receiving the resources and support that is required. ARV coverage has increased since 2004, but only from 10% to 33% coverage for pregnant women. The impact of HIV/AIDS on maternal and child mortality reinforces the urgency for securing and strengthening a continuum of care which includes access to family planning, antenatal care, improved testing facilities and uptakes, ARV coverage and paediatric care.

Virtuous Circle: Education and MDGs 4 and 5

18. There was broad agreement that maternal education is a critically important factor in improving maternal and child health outcomes. The research evidence shows clearly that educated mothers are more likely to seek antenatal care than mothers without education. The number of children without any antenatal care decreases by 51% when the child's mother has received primary education and decreases by 85% when she has received secondary education. Moving from a mother with a primary education to a mother with secondary education, there is a decrease of 40 deaths per 1000 births.

[11] James McIntyre 2003 Mothers Infected with HIV - *Perinatal HIV Research Unit, University of the Witwatersrand, Johannesburg, South Africa*

[12] Newell, Marie-Louise, et al., 'Mortality of Infected and Uninfected Infants Born to HIV-infected Mothers in Africa: A pooled analysis', The Lancet, vol. 364, no. 9441, 2–8 October 2004, pp. 1236– 1243.

19. While school enrolment and completion rates are on the rise, large disparities and inequalities exist in education, within countries and between them. There is a global divide where nearly every child in OECD countries is in education by the age of 7 compared to only about 40 per cent of their peers in Sub-Saharan Africa. Attendance at school is no guarantee of educational attainment. The widespread prevalence of anaemia, vitamin A and iodine deficiency impede seriously a child's ability to learn, enter, remain in and complete school.

20. The focus on education, as an intervention for improving maternal and child health, should not be allowed to obscure deeper structural barriers to better health. While inappropriate caring practices do contribute to malnutrition in some instances, households' inadequate purchasing power and insufficient income should also be acknowledged as major obstacles, even when families are aware of best practice for good nutrition. Conditional cash transfer programmes such as Opportunidades[13] in Mexico and Bolsa Familia[14] in Brazil are demonstrating the positive impacts of redistributive social justice on both education and child health. Furthermore, the time and resources available to a carer will heavily influence care practices, not just their knowledge, attitude and practice. Finally, even with knowledge, time and resources, the amount of decision-making power a woman has in the household will ultimately determine how she is able to act on her knowledge and distribute her time and resources. In other words, strategies to improve nutrition as well as basic education and health outcomes must not only be joined up but must also run in tandem with policies which promote poverty reduction and women's empowerment.

Clean Water and Safe Sanitation

21. There was wide agreement that lack of access to clean water and safe sanitation facilities, alongside poor hygiene practices, is a major contributory cause of maternal, newborn and child mortality in the world's poorest countries. The facts here are very clear and sobering, and yet basic and low cost interventions to improve

[13] See: http://www.oportunidades.gob.mx/

[14] See: http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/LACEXT/BRAZILEXTN/0,,contentMDK:21447054~pagePK:141137~piPK:141127~theSitePK:322341,00.html

access to water and sanitation are still receiving less priority than curative approaches to health. Nearly 2 million children die each year because of a lack of clean water and a safe way of disposing of human waste. Many of these deaths relate to diarrhoea, which spreads rapidly in unhygienic environments. Poor children are at much greater risk, because they tend to have more limited access to clean water than their better-off peers. There is no prospect of reaching MDGs 4 and 5 without a more concerted effort to tackle this issue.

Maternal and Newborn Health and Nutrition in Emergencies

22. Emergencies can worsen dramatically newborn and child health through the direct impact of violence, conflict or natural disaster and the indirect deterioration in livelihoods and the surrounding environment. Often protracted conflict will also have a residual effect; long after the peace treaties are signed, heightened levels of child mortality will persist.[15]

23. Even in very challenging and insecure environments, however, clearly identified and proven measures can be taken to reduce the loss of children's lives in emergencies. However, while drug subsidies are often introduced, access to health services in all too many emergencies is still neither automatic nor free. While malnutrition, measles and other vaccine preventable diseases represent the main causes of child mortality in emergencies, malaria is one of the biggest under-5 killers in conflict-affected regions of Sub-Saharan Africa. Malaria Rapid Diagnostic Tests (RDT) have the potential to improve the quality of management of malaria infections in areas when the main alternative form of diagnosis, high quality microscopy, is not readily available.[16] Malaria can be effectively treated with Artemisinin-based combination therapy (ACT), but these are generally not freely available in emergencies. There should be greater focus on free access to skilled labour and delivery attendance, emergency obstetric care and family planning services remain a priority in all emergency response efforts.

[15] As in the case of the DRC, even after conflict ended, those who had been affected by conflict for at least 3 years, experienced higher levels of mortality even one year after the violence had stopped.

[16] WHO - http://www.wpro.who.int/sites/rdt/whatis/malaria_rdt.htm

The Economics of Maternal and Child Survival

24. The economics of maternal and child survival involve a number of factors. Growth in national income does correlate with reductions in child mortality. However, to a major extent, the association reflects other factors correlated with income. including mother's education, mother's work status, access to safe water, medical assistance in pregnancy etc. The inclusiveness of growth does matter for mortality rates. Countries at comparable levels of national income vary considerably in terms of their performance on maternal and child mortality. Not surprisingly national statistics disguise massive inequalities, which adversely affect maternal and child health, and differentials in mortality rates within countries

The Politics of Change

25. On the current trajectory, the world will miss the MDG4 target by approximately 2 million children's lives. A real step change is governments are to meet agreed targets. This requires an analysis that goes deeper than the call for more donor money (though additional resources are certainly required) and considers the power relationships and structures that need to be changed if dramatic reductions in mortality are to be secured.

26. At the heart of this is an understanding of the incentive systems that dictate the "decisions of governing elites, other powerful interest groups and change agents in civil society, the private sector and the government bureaucracy."[17] How do we convince national governments to see "good health as good politics" and establish MNCH as a prominent issue on campaign platforms? How do we monitor and track where resources that are put in at the top are filtered through to the bottom?

27. There was broad agreement that civil society groups have an important role to play in moving maternal, newborn and child health higher up the development agenda. Firstly, they can act as watchdogs, where governments are failing to

17 Landell-Mills, Pierre, Gareth Williams and Alex Duncan, 'Tackling the Political Barriers to Development: The New Political Economy Perspective'. Policy Practice Brief 1, The Policy Practice, January 2007, p2.

honour their commitments for maternal, newborn and child health. Secondly, they can support capacity building for local civil society and information dissemination.

Partnerships

28. Several partnership initiatives have been created in the last few years around maternal, newborn and child health and survival. There was discussion about their respective roles and about how these various initiatives might be better coordinated.

29. **The Partnership for Maternal, Newborn and Child Health** is a global health partnership launched in September 2005 and joins the maternal, newborn and child health (MNCH) communities into an alliance of almost 260 members which include developing country governments, donors, UN agencies, health care professional associations, academic institutions and NGOs. The Partnership aims to work together to get at least 60 of the countries with the worst rates of maternal and child mortality on track to meet the MDGs 4 and 5 in the next five years. In 2009, the Partnership aims to foster greater political and financial support for MNCH globally at the G20 and G8 meetings and to influence the outcome of the High-Level Task Force on Innovative Financing for Health Systems. It also plans to identify gaps in the existing proposal for an MNCH core package of interventions and prioritise implementation research. A main element of this will include the development of costed strategies for commodity supplies, human resources and demand creation.[18]

30. **The Countdown to 2015: Maternal, Newborn and Child Survival initiative** is a collaborative effort to monitor coverage of priority interventions necessary to reduce newborn, child and maternal deaths. The Countdown focuses on the 68 countries which account for 97 per cent of maternal, newborn and child mortality and 22 interventions which are vital for preventing these deaths. The Countdown produced its first report in 2005, its second in 2008 and will continue to report regularly up until 2015. Tracking progress in coverage of critical interventions, inequities in coverage, donor assistance, and progress in health policy and

[18] http://www.who.int/pmnch/en/

strengthening of health systems, the Countdown helps to hold governments, partners and donors to account for the commitments they have made.

31. The Countdown effort has brought to light some critical issues for maternal, newborn and child health.[19] For instance, the findings have shown that interventions that can be routinely scheduled, such as immunization, vitamin A supplements and antenatal care visits have higher coverage rates than those needing functional health systems and 24-hour availability (malaria and diarrhoeal treatment, pneumonia care-seeking and antibiotics). These patterns of coverage have changed very little since the 1990s. The Countdown has also introduced a new "coverage gap" measure which analyses the difference between full and actual coverage for 4 parts of the continuum of care. This is vital as the gap reflects how well health systems are doing in delivering multiple essential interventions and the effects of adding new interventions to what is already being delivered.

32. The **International Health Partnership (IHP)** initiative and related initiatives (IHP+), which was launched in 2007, seeks to address concerns about the coherence of existing global initiatives around health. It promotes 'country compacts' that commit development partners to provide sustained and predictable funding and increase harmonisation and alignment being a host country's own strategy for health. Not unlike the Partnership and the Countdown, the IHP+ also aims to generate and disseminate knowledge, guidance and tools in specific technical areas related to strengthening health systems and services, and to promote mutual accountability between donors and developing country governments.[20]

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[19] http://www.countdown2015mnch.org/g8/

[20] http://www.internationalhealthpartnership.net/