Stronger national plans for maternal, newborn and child health

WHO/P.Williams

Dr Francisco Songane

Francisco F. Songane trained as a medical doctor and obstetrician/gynaecologist at the University of Eduardo Mondlane in his native country, Mozambique, and at St. James University Hospital in Leeds, England. He has a Master of Public Health from Boston University and Master of Science in financial economics from the University of London, United Kingdom. In Mozambique, he was a district medical director and teacher, as well as director of the country's second-largest hospital. He was the health minister of Mozambique from 2000–2004 and helped to launch a national health-sector strategy – a single national plan for health. He has served as an executive committee member and board member of the GAVI Alliance and was a member of Task Force 4 of the UN Millennium Project (2002–04). Songane, recognized both nationally and internationally for innovation and leadership, was appointed director of the Partnership for Maternal, Newborn & Child Health in 2006.

The Partnership for Maternal, Newborn & Child Health, launched in 2005, is a global initiative of 170 member bodies dedicated to ensuring that all women, neonates and children remain healthy and thrive. To do this, the partnership advocates proven, cost-effective interventions that evidence has shown can save at least 7 million of the more than 10 million children who die before their fifth birthday and over 500 000 women who die in pregnancy. For improvements to be made, its leadership is urging countries and donors to work together better and avoid duplication of interventions and single-disease approaches. Instead, it calls for integrating maternal, newborn and child health into nationwide health plans. Partnership director Dr Francisco Songane explains.

Q: The 2005 World Health Report *was devoted to maternal, newborn and child health. Your Partnership merged previous campaigns to revitalize these subjects. What impact has the report had on maternal, newborn and child health?*

A: This report was instrumental in bringing together maternal, newborn and child health, with regard to programming, resource mobilization and assessing progress made in recent years. The message – that the (health of the) mother, newborn and child are intricately linked – was quite strong. Since then, there has been more discussion about integration and less about the mother being separate from the child and neonates. Since its launch in 2005, the Partnership for Maternal, Newborn & Child Health has made the "continuum of care" concept its core approach.

Q: Is this new awareness reflected with ongoing work, aid, development and government projects?

A: Unfortunately, there is a disconnect between what is being done and said. People often say: "We have to think of the mother together with the newborn and the child." But in practice, institutions, some donor countries, foundations and funds want to select a particular aspect, such as child health, immunization or traditional birth attendants, and forget about the rest. On the ground they do things differently from what they say publicly. Another aspect is that global decisions often don't accurately reflect country interests. For example, they address an initiative for ARVs (antiretrovirals) or immunization and select some countries for interventions, but don't do what the countries planned for in development strategies.

Q: Can an integrated approach resolve this?

A: Some governments try to do this but it's difficult for countries highly dependent (on donor support). In many African countries, around 60% of health resources are external. Even though countries have integrated plans, they do not always control all the money. They negotiate with the donor, but often have to accept a distortion of their own programme to get the resources. Some governments are strong, some are not. Donors must ask governments what they want and understand these needs have been discussed and agreed with different health sector players. This need for change of behaviour is one of the issues we are addressing in the Global Business Plan for Millennium Development Goals (MDGs) 4 (on child health) and 5 (on maternal health), for which the Partnership provides the platform.

Q: The African Regional Health Report 2006 *recounts how many campaigns failed to improve maternal, newborn and child health in African countries and how the situation has sometimes worsened in the last three decades. Why has progress been difficult?*

A: Yes, there are problems, but there has been some progress in child health and there are signs of positive change in maternal health in some countries. Neglected health systems are the main cause of the lack of progress. Other causes are political turmoil, war, and the lack of political commitment and a health strategy for each country. A key reason is donors often influenced a country health programme's terms to satisfy their own targets, which may have little to do with country needs.

We will mark 20 years of the Safe Motherhood Initiative in October, but maternal health in Africa has stagnated, and experienced reversals in many countries, because the campaign's resources were linked to specific ideas. For example, donors focused a lot on traditional birth attendants, saying: "You can get as much money as you like if you want to train traditional birth attendants or family planning, but not if you want to build a small maternity ward or small operating theatre in a district hospital offering Caesarean section." Good maternity care needs the whole range of services, but that was regarded as expensive and complex. The 2005 *World Health Report* estimated an additional US$ 9 billion per year is needed to help the 75 high-burden countries set basic maternal, newborn and child health services. You see the huge discrepancy when you compare the risk of women dying in childbirth in Africa, which is one in 16, to women in developed countries, which is one in 3 000. Is the life of a woman in Europe or North America more valuable than a woman's in Africa? These women are not dying from disease, they are pregnant and healthy. It is the noblest moment of their lives, something that should bring happiness to their families. Failure to provide comprehensive maternal care is a denial of their rights.

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Q: What are good examples of developing countries or districts improving maternal, newborn and child health?

A: There are several. Take Sri Lanka, Malaysia, Thailand and Kerala state in India: those are developing countries, and Kerala is not amongst the richest Indian states, and yet they are doing extremely well. Before the introduction of campaigns, these countries worked on maternal, newborn and child health in an integrated manner from the 1960s and 1970s and have reduced maternal and child mortality levels substantially. They didn't have the huge resources to address AIDS that we have today, yet they did it. They addressed the issues because they properly used effective interventions that solve the problems. Some campaigns wanted to prescribe a particular intervention, but in many cases this was not needed. In contrast, these countries invested in midwives and small maternity units offering skilled care supported by available emergency obstetric care. They were poor countries but used their own resources. In Latin America, Bolivia is addressing high levels of maternal mortality among indigenous women by addressing social issues. In Africa, [the United Republic of] Tanzania is making remarkable progress in child health. Cuba is the leading example in terms of health care in developing countries, not just for maternal and child care, but all aspects. Cuba rivals some developed countries.

Q: Single-disease, or vertical programmes, cause health system imbalances in developing countries, but still – on their own terms – they work. What is being done to address this? How can you convince donor and recipient governments to provide a range of essential health care services in developing countries?

A: Vertical programmes are good, but you cannot have them in a vacuum. They must be in the context of reinforcing health systems. Campaign after campaign has failed because they have not addressed the right issues. Take the HIV programme, which has brought most of the resources to Africa. In Rwanda, for example, 70% of external aid for health programmes in 2005 was devoted to HIV/AIDS, and 30% for the rest. Donors influenced this, but they didn't produce many results because they didn't address the whole sector.

> "You see the huge discrepancy when you compare the risk of women dying in childbirth in Africa, which is one in 16, to women in developed countries, which is one in 3000. Is the life of a woman in Europe or North America more valuable than a woman's in Africa?"

You need a comprehensive approach. For example, the Global Fund [to Fight AIDS, Tuberculosis and Malaria]. A McKinsey report published in 2005 (*Global Health Partnerships: Assessing Country Consequences*), described the consequences of the vertical approach of programmes with conditions that do not allow countries to make proper decisions nor let them spend money elsewhere in the health sector other than HIV/AIDS, tuberculosis and malaria. That was a lesson learned and now the situation is changing. Now the Global Fund says countries will decide how the money it provides will be used, with more of a focus on health systems in general. I commend the Global Fund for taking courageous steps to address the three diseases so to contribute to health systems.

Q: How can countries work better with donors?

A: Every vertical programme requires a specific plan in each country that results in multiple plans, depending on the donors. Our Partnership urges each country to have one health plan prepared in consultation with all concerned parties. For example, Mozambique had a problem with multiple programmes, with UN agencies and bilateral donors carving up the country. There was no coordination. It was confusion. In 2000, the government agreed with donors to have one plan. We established a coordinating mechanism across the health sector that worked well and is cited as a model. Every partner should buy into one plan. If you as a donor cannot put your money into a common pool of resources, you can put it into one activity that is still part of the overall plan. Control and monitoring are the same across the whole country. If we all accept this is as the way to go, we could build health systems without fragmentation.

Q: How can we deal with governments supporting corrupt bureaucracies?

A: If you take the health sector and establish a system, achieve harmonization and coordination, you must ensure all the players are coordinated, not overlapping and duplicating. Whatever

they do is known by everyone and, therefore, transparent. Within such a framework there is a platform to point out and address issues. The civil society should use its comparative advantage to demand change.

Q: You advocate that donors should help countries reinforce health systems, but shouldn't you advocate for more funds for maternal, newborn and child health?

A: When we advocate for resources for maternal, newborn and child health we do this in an integrated approach. We don't call for specific country plans for maternal, newborn and child health. We want these elements to be reflected in properly budgeted plans and ensure money flows to fund those activities within the context of the whole sector. Maternal, newborn and child health is an indicator for overall health system performance, as it affects the most disadvantaged and poor. In district health centres in many developing countries, 60% of activities deal with children and women.

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Q: Next year WHO marks the 30th anniversary of the Declaration of Alma Ata for universal health care and launch of primary health care. Why did primary health care fail to fulfil promises in many countries?

A: Primary health care worked in countries that provided comprehensive health care for mothers, neonates and children, such as Sri Lanka. Some countries, however, offered family planning but did not invest in a delivery room. They trained midwives and nurses for a few months but provided no more training to gain better skills and address what was afflicting women and children. It was this selective approach to primary health care that killed it. It would have worked with comprehensive support. Primary health care is about health systems. It includes referral from the health centre to district level and then to the provincial hospital. People say primary health care was for the periphery. But it's not second-class care. That's a misconception. But there are exciting new opportunities under way. The (18-20 October) Women Deliver conference, will focus political will on efforts to improve the health of women, mothers and newborn babies (http://www.womendeliver.org/). The 30th anniversary of Alma Ata next year, I trust, will advocate strenuously for strengthening health systems as a foundation for improving the lives of mothers, neonates and children. The idea of having one country plan is maturing, and it is a core message in the Global Business Plan for MDGs 4 and 5 which will be launched soon. I hope by the end of the year we will have a more coordinated approach to maternal, newborn and child health. ■