Meeting of Development Partners:
Maternal and Newborn Health
with a focus on
country implementation
Stockholm, Sweden
21-22 June 2006
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**BACKGROUND**

The Stockholm meeting on 21–22 June 2006, organized by WHO’s Department of Making Pregnancy Safer (MPS) and the Swedish International Development Cooperation Agency (SIDA), aimed at exploring better ways of coordinating Partner’s efforts and support to Member countries to implement evidence-based, cost-effective interventions and accelerate progress in achieving the Millennium Development Goals 4, 5 and 6 related to maternal and newborn health and survival.

Participants included: six high-level national representatives from Angola, India, Malawi, Mali, the Philippines and Sudan; representatives from bilateral agencies in Australia, Canada, Finland, France, Germany, Japan, the Netherlands, Norway, Sweden, the United Kingdom Department for International Development (DFID) and the United States Agency for International Development (USAID); and representatives from the World Bank, the African Development Bank, United Nations Population Fund (UNFPA), the Partnership on Maternal, Newborn and Child Health (PMNCH) and WHO regional offices in the African, European, South-East Asia and the Western Pacific regions. Staff from UNICEF and the Asian Development Bank had expressed their interest to participate but were unable to attend due to unavoidable circumstances.

**PROCEEDINGS**

The meeting acknowledged the slow progress in improving MNH thus far and emphasized the need for accelerated action, especially in sub-Saharan Africa and South-East Asia with the least progress in reducing maternal and neonatal morbidity and mortality. Of particular importance is the low proportion of deliveries attended by skilled attendants and lack of access to emergency care services in countries with the highest maternal mortality ratios and neonatal mortality. The strong link between poverty and maternal deaths was noted with a call for an end to policies that condone poor health options for poor people. The increasing contribution of HIV and malaria to maternal and newborn morbidity and mortality was also well recognized. A commitment to working towards sectoral approach, which includes country ownership, multidonor funding, implementation of the Paris Agenda, and harmonization and alignment was emphasized.
Dr Anders Molin of SIDA welcomed participants to Stockholm and jump-started the meeting by highlighting four key areas in the SIDA policy framework on maternal and newborn health. Dr Molin underscored maternal and newborn health issues in relation to sexual and reproductive rights, poverty, micro-economic growth and abortion and family planning, particularly for youth. He highlighted the International Conference on Population and Development (ICPD) plan of action as a good tool for countries to ensure that mothers and their newborns are guaranteed their human right to health.

Dr Monir Islam from the Department of Making Pregnancy Safer (MPS) highlighted the global situation and the Department’s efforts in promoting safe motherhood, perinatal and newborn health. He emphasized the urgent need for action, in particular in countries in sub-Saharan Africa and South-East Asia where the burden of mortality is highest, but where limited progress has been made in reducing maternal and neonatal mortality over the past decade. As maternal deaths are more common among poor women, he called for greater attention to the rich–poor divide and for an end to policies that condone inadequate health options for poor people. He highlighted the main determinants for achieving universal coverage:

- recognition of the problem, involvement of individual, family and communities in decision-making and providing support;
- access to skilled care for every birth and referral system to deal with life-threatening complications in a timely and adequate manner; and
- responsiveness of the system in providing timely quality care.

Dr Islam cited recent global health statistics that indicate that the proportion of deliveries attended by skilled attendants in a country is directly related to the maternal mortality ratio, and that maternal and health and survival is linked to newborn mortality and survival. He also emphasized that countries with the highest numbers of maternal deaths also have a high burden of neonatal deaths.

Dr Islam outlined a way forward by indicating the great need to promote evidence-based best practices in maternal and newborn health at the country level. This includes skilled care for every birth and requires the training and support of health professionals with midwifery skills so they are able to provide adequate care during pregnancy and childbirth, including comprehensive obstetric first aid and newborn care. Additionally, improved health system responses to timely
manage maternal and newborn complications are essential. This will only be possible with effective coordination between key players to ensure a conducive policy environment, the availability of skilled human resources, transport, management and supervision, timely and sustained equipment, supplies and life-saving drugs.

Central to Dr Islam’s message was the improvement of health system response and quality of services to ensure that the right people are in the right place at the right time. Moreover, policies and activities for skill acquisition and skill retention, employment and deployment, planning, costing, management and supervision, supplies and logistics, transport, demand creation, and monitoring progress are all essential elements of a comprehensive, effective and evidence-based strategy to improve maternal and newborn health.

Malaria and HIV in pregnancies are additional factors having a devastating impact on maternal and newborn health and survival. Dr Islam discussed the impact of HIV and malaria on maternal and newborn survival, as well as the enormous need for an integrated safe motherhood approach.

Moderator Dr Mahmoud Fathalla then introduced country representatives and requested they present the magnitude of the maternal and newborn health problem in their countries, the status of current programmes and their expectations for collaboration from UN agencies and donors.

COUNTRY PRESENTATIONS

The magnitude of the problem, current situation and support needs

Dr Hirondina Esperanca de Armando from Angola stressed the urgent need to rebuild human resource capacity and to establish a functional referral system for all pregnant women. The burden of HIV and malaria form key obstacles in achieving the African Roadmap for improving maternal and newborn survival. The Government is working hard to offer a universal package of maternal and newborn interventions that integrates preventive and curative care. Special emphasis is given to increase coverage in communities with difficulty accessing health services.

In India, the Government is taking action to develop the patients’ welfare community. Dr Himanshu Bhushan elaborated on the accredited social health activities programme (ASHA) that was launched in 2005 to improve coverage of basic care for rural pregnant women and to ensure that they receive timely access to adequate health services. As this initiative requires massive investments in the development of manpower, the Government is looking for further assistance from donors to facilitate the establishment of centres of excellence for master trainers, to personalize health facilities in the In-
Malian public health service and to develop quality tools for monitoring deliveries and newborn health.

Malawi has a high maternal mortality ratio of 984 maternal deaths per 100,000 live births (DHS 2004). The Government is working hard to support the implementation of safe motherhood projects across the country. A nationwide assessment on emergency obstetric care found that only 2 out of 94 districts provide basic EmOC functions. Dr Wesley Sangala informed participants that the Government is developing training materials to improve the competencies of Skilled Birth Attendants (SBAs), including for EmOC functions. Efforts are also being made to improve access to and uptake of family planning services. Malawi is in great need of further support for the development and implementation of its national Roadmap for reducing maternal and newborn deaths through increased financial commitments and concerted action to reach coverage.

In Mali, the maternal mortality ratio is 582 per 100,000 live births. Apart from a lack of access to standard childbirth care the key areas of concern are access to and availability of emergency obstetric care, including management of postpartum haemorrhage (PPH) and sepsis. There is also a great need to create blood banks in selected health facilities and to renew health facility equipment in order to improve the quality of care for the mother and newborn. Building the technical capacity of health personnel, resource mobilization for strengthening the health infrastructure, advocacy to create awareness and utilization of improved services were cited by Dr Salif Samaké as key activities for partners to join hands.

In the Philippines, a high proportion of deliveries (70%) continue to take place in the home. This translates to a great number of women who do not have access to essential obstetric health services. The Government recently developed a reproductive health framework for women’s health and safe motherhood that promotes counselling and quality health service delivery for maternal health and family planning. The framework, which is to be integrated into a broader service package, includes information on contraceptives, institutionalized community-based delivery options and interventions for the prevention and control of HIV and malaria in pregnancy. Dr Yolanda E. Oliveros emphasized that the country has made a strategic shift from a risk approach to an integrated community approach to health service delivery—from home delivery to the training of skilled birth attendants.

In the Sudan, the maternal mortality ratio is currently 509 per 100,000 births. According to Dr Mohammed Ali Yahia Alabbasi, there are 7000 pregnancy-related deaths per year with the highest death rates in the Darfur region. The rate of female genital mutilation (FGM) in women of reproductive age is extremely high. Additionally, although federal ministers have signed pledges for stronger health commitments to mothers and newborns, health services, including care during pregnancy and childbirth, are still very poor by international standards. The overall coverage of women receiving postpartum care is only 13%. There is an urgent need to strengthen the health system, including outreach services, and to increase a rapid community response to promote best standards of care. Intensified efforts in medical and midwifery training are needed to dramatically improve the access and quality of services for maternal and newborn health.
**WHO Regional Offices: Responding to the needs of countries**

**WHO Regional Office for Africa** (AFRO) described the region’s maternal mortality ratio in countries in sub-Saharan Africa as among the highest in the world. Maternal mortality has increased from 870 maternal deaths per 100,000 live births in 1990 to 940 per 100,000 live births in 2001. Every 3 minutes, one woman dies due to causes related to pregnancy, childbirth and the postnatal period. An additional 1.12 million newborns die every year in Africa. The main recommendations of WHO Regional Office are to:

- support skilled attendance during pregnancy, childbirth and the postnatal period at all levels of the health care delivery system;
- improve provision of and access to quality MNH care including family planning services;
- strengthen the referral system and district health planning and management of MNH care;
- advocate for increased commitment and resources for MNH;
- promote the household to hospital continuum of care; and
- empower communities and foster partnerships.

**WHO Regional Office for South-East Asia** (SEARO) highlighted skilled care through the continuum of care approach. Member States have adopted the regional resolution SEA/RC58/R2, which puts greater focus on human resources for MNH, quality of MNH services and equity issues – reaching the unattainable population groups – poor, marginalized sections, adolescents and children. SEARO currently responds to country needs by addressing strategic issues, i.e. long-term plan on human resources for MNH to provide technical assistance to priority countries on skilled birth attendants (country with proportion of births assisted by SBA less than 50%): Bangladesh, Bhutan, India, Nepal and Timor-Leste. This also includes a more efficient response to country technical support requests by providing necessary information, networking with partners, resource mobilization and advocacy.

Tajikistan. The WHO Regional Office is working with countries to change policies and to support the adaptation of evidence-based practices. The Region underscored that it is clear the countries cannot depend on donor support only and there needs to be a common programme at the country level through UN reform programmes that include the division of labour and a plan forward on how to mobilize resources and maximize benefits for countries.

**WHO Regional Office for Europe** (EURO) highlighted skilled care through the continuum of care approach. Member States have adopted the regional resolution SEA/RC58/R2, which puts greater focus on human resources for MNH, quality of MNH services and equity issues – reaching the unattainable population groups – poor, marginalized sections, adolescents and children. SEARO currently responds to country needs by addressing strategic issues, i.e. long-term plan on human resources for MNH to provide technical assistance to priority countries on skilled birth attendants (country with proportion of births assisted by SBA less than 50%): Bangladesh, Bhutan, India, Nepal and Timor-Leste. This also includes a more efficient response to country technical support requests by providing necessary information, networking with partners, resource mobilization and advocacy.
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WHO Regional Office for the Western Pacific (WPRO) drew attention to the major challenges in the region; in particular, in Cambodia, the Lao People’s Democratic Republic and Papua New Guinea, where the situation in maternal and newborn health is grave due to high fertility, low contraception, unwanted pregnancies and lack of skilled attendants and emergency care. Reasons for the low capacity for skilled attendants are the low utilization rate, lack of resources (financial, human), governments have other “competing” priorities and health workers are not motivated. The Regional Office has continued to work on building initiatives that harness political commitment and create advocacy for MNCH/MPS, capacity building, manuals and guidelines, and a MNCH framework. The RO also conducted ongoing trainings, workshops and meetings focused on building bridges and further expanding the network of partners working on maternal and newborn health throughout the region.

**PARTNER AGENCIES**

**Responding to the needs of countries**

**United Nations Population Fund** (UNFPA) presentation focused on building regional capacities and responding to the needs of countries. The presenter highlighted three key pillars and priority areas for UNFPA’s work in countries, namely

- family planning to ensure all women have access to contraception and the prevention of unwanted and potentially dangerous pregnancies;
- skilled attendance at birth to ensure all pregnant women have access to skilled attendants; and
- emergency obstetric care to ensure all pregnant women with complications to access essential services.

To achieve these goals, UNFPA focuses on the creation of an enabling environment for human resource development and deployment. Through the Reproductive Health Commodity Security initiative, UNFPA is also expanding activities to strengthen health sys-
Promotion of gender and sexual and reproductive rights is an overarching principle in all activities.

UNFPA indicated that many of the maternal health inequities are a result of gender bias and that reproductive health should be the right of the poor and excluded. UNFPA priorities include rearranging the framework for scaling-up access to effective health interventions so they will reach vulnerable groups of women. Emphasis is also put on the establishment of services for emergency obstetric care (facility-based approach) and the improvement of the technical quality of the procedures. Transforming the role of a skilled birth attendant is key in national reproductive health programmes, as is the need for systematic process of planning that includes a needs assessment. National reproductive health security initiatives and human resources, in particular for midwives, will be central in strengthening family planning and addressing unsafe abortion. In the Africa region, UNFPA is implementing the Roadmap to accelerate the reduction of maternal and newborn mortality, initiated by WHO/AFRO and now endorsed and implemented by a wide range of partners. Countries highlighted were Colombia, India, Morocco, Mozambique, Nicaragua and the Niger.

The African Development Bank (ADB) has several key priority areas of intervention including:

- public health and health promotion;
- the provision of public goods and services;
- promotion of reproductive health;
- the prevention and control of communicable diseases, including HIV/AIDS and STDs;
- preparation for and response to disasters; and
- promotion of research.

Dr Tshinko B Ilunga indicated that only low-income countries have access to concession loans and grants. ADB supports the development of health systems that promote maternal and newborn health policies and strategies including hardware, clinics and health centres. The Bank also supports health care financing initiatives and promotes the creation of environments conducive to the health and education of girls. The Tanzania project was cited as a key initiative that is driving forward this strategic plan to accelerate progress in the reduction of maternal and newborn deaths. ADB will continue to give more support to the formulation of health policies and strategies, introduction of reforms, health care delivery (including hardware), health care financing, girls education, safe drinking water, food security, roads and communications systems, physical environmental safety and income generation.

The World Bank (WB) remains extremely committed to reproductive health, but in many countries the health sector is unable to engage finance ministers to commit sufficient resources to maternal and newborn health initiatives. Lending for human development is expected to decline for the Africa region as finance ministers have asked for more resources to be devoted to infrastructure development, with less funding for health. Stronger advocacy at the ministerial level is required if health commitments are to in-
crease. Dr Khama Rogo proposed adopting strategies that cross the boundaries beyond maternal, newborn and child programmes by establishing synergies between MNCH programmes and education, transport, water, environment, gender and poverty reduction programmes. Also emphasized was the need to establish links between MNCH programmes and core health systems development processes through comprehensive investment plans for scaling-up effective interventions including: better training of health professionals, increased human resources supply factors and policy investments, transport and infrastructure, and use of appropriate technologies: for example partogram, Misoprostol and the Kangaroo approach. Other suggestions were to remove barriers between facilities and communities, enhance family/community actions, build partnerships and to move towards the integration of interventions and service delivery.

The Partnership for Maternal, Newborn and Child Health (PMNCH) presented its current strategy and how it works to harmonize the inputs of partners at the country level. The Partnership follows the three–ones approach that promotes one coordination mechanism, one country plan and one monitoring and evaluation mechanism for maternal, newborn and child health programmes in countries. Dr Songane underlined that PMNCH promotes the Continuum-of-Care (CoC) approach by bringing together maternal, newborn and child care and has two dimensions: First, it means that care is provided as a continuum throughout the life cycle from pre-pregnancy through pregnancy, childbirth into the crucial early days and years of life. Secondly, the approach underscores that care has to be provided in a seamless continuum that spans the home, the community, the health centre and the hospital. Working with its partners, PMNCH develops consensus on essential packages of effective interventions for CoC, facilitates integration of MNCH into national plans, budgets, poverty reduction strategies and health sector reforms, supports existing country coordination mechanisms and promotes integration within the context of health systems strengthening.

Dr Songane underscored that donors can play a critical role in supporting the CoC approach, and in highlighting the centrality of maternal, newborn and child health in health systems development efforts. Towards the achievement of MDG 4 and 5, PMNCH advocates to raise the profile of MNCH, assists countries to narrow the equity gap and build demand, increases allocation and disbursements for MNCH, promotes accountability by tracking commitments and flow of funds, and creates a movement to drive the agenda forward. He underlined that partners can increase consistency in their decisions and operations, exert more flexibility in approaches to adhere to a joint country plan and allow for country ownership, while assisting to mobilize additional resources.
Australia (AUSAID) began the session by underlining key initiatives in the new White Paper 10-year plan launched in April 2006. It has four key thematic areas namely:

- accelerating economic growth
- fostering functioning and effective states
- investing in people
- promoting regional stability.

These areas are the central premise through which the government will contribute towards improving maternal and newborn health. There is a focus on countries in southern and south-east Asia and the Pacific region (Indonesia and the Mekong countries). In particular, Philippe Allen indicated that Australia will be supporting broader health sector reforms – which include national and district level decentralization and the creation of social safety-nets to improve access by the poor to MNH services. Investment will also be made to improve MNH services, promote outreach to rural and remote areas, train health workers training, curb the incidence of HIV/AIDS and STIs, and initiate service agreements linked to performance targets to reduce maternal anaemia and malaria. AUSAID will look to MNH priority countries to use funds to:

- build supply and demand for MNH services, including through community schemes (“desa siaga” village readiness), IEC material targeting community leaders, gender training of midwives and capacity building of health agencies in analysis and planning.

The United Kingdom (DFID) highlighted the disparity between developed and developing countries giving an example that a woman in Sierra Leone is 200 times more likely to die from pregnancy or child-birth than a woman in the UK (life time risk). DFID briefed participants on its maternal health strategy and emphasized advocacy to raise the profile of maternal and newborn health (Nepal and Malawi were sited as examples). Ms Fran McConville noted that its is of utmost importance to scale-up evidence-based interventions for maternal and newborn health, address wider social and economic barriers to progress, develop women’s health, address poverty and development, improve access to contraception, respect sexual and reproductive rights (ICPD, CEDAW), and create an overall improvement in health system response.

The United States (USAID) highlighted its efforts to promote country programming in partnership with governments, multilateral and bilateral agencies and NGOs. This includes comprehensive or focused MNH programming, and the expansion of proven inter-
ventions. Investments are directed to improve skilled care at delivery and focused ANC linked with malaria, and PMTCT in Africa. Mrs Lily Kak underlined that support is provided to quality improvement processes in LAC and Africa, and initiatives for fistula repair in Asia and Africa. Safe Birth Africa, aimed at prevention of postpartum haemorrhage, was highlighted as a special initiative. Key objectives are to scale up AMTSL, global PPH working group, partnership with FIGO, ICM, and 16 country level professional associations. International and regional advocacy workshops were held in Bangkok, Entebbe and Goa. USAID also provides technical assistance in advocacy, policy and guidelines development, training and scaling-up of access (10–15 countries). Partnerships were central to the USAID approach, including with PMNCH, White Ribbon Alliance and MotherNewBorNet. There is currently a five-component framework to guide the nature of assistance: Rebuilding, Developing, Transforming, Sustaining and Reforming. However, it was noted that the implementation of new reforms under discussion may affect the nature of programmes and funding levels.

Canada (CIDA) responds to health sector challenges by working with countries to improve health outcomes and by stepping up efforts to prevent and control poverty-linked disease and burden of illness. Ms Geetanjalee Khosla outlined CIDA’s guiding principles, which call for greater support for sustainable development and poverty reduction at the country level in order to meet the Millennium Development Goal targets, the promotion of human rights principles and governance, alignment with the Paris Principles and support for gender equality as a cross-cutting theme across all sectors. Canada’s current support in bilateral programming focuses on countries where health and HIV/AIDS have been identified as a priority in national development programming frameworks and include:

- **Nigeria**: improving reproductive security through increasing availability of contraceptives and safe motherhood kits;
- **Bolivia**: vaccination programme to provide mother and child access to quality health care services and immunization;
- **Haiti**: technical assistance, support to family planning and provision of EmOC to reduce maternal mortality;
- **Afghanistan**: improving access to social and productive services and infrastructure for rural communities;
- **the Balkans**: strengthening public health functions, including epidemiological analysis.
The Netherlands underscored the importance of disseminating operations and research findings to delegations responsible for health financing and decision-making through embassies, in-country support to a limited number of sectors, and working towards sectoral approach, which includes country ownership, mult donor funding, implementation of the Paris Agenda, and harmonization and alignment. Dr Elly Leemhuis-de Regt highlighted the government’s efforts in providing reproductive health support in 12 of their 36 partner countries (Mozambique, Zambia, the United Republic of Tanzania, Ethiopia, Yemen, Burkina Faso, Mali, Ghana, Nicaragua, Suriname, Bangladesh and Viet Nam). The government also continues to support multilateral organizations such as WHO, UNFPA and UNICEF to implement the ICPD/ Cairo agenda, including on maternal health, abortion and adolescent health.

Norway (NORAD) highlighted recent research study findings as significant in harmonizing efforts for advocacy at the country and global level. Ms Helga Fogstad outlined lessons learnt to guide the development of NORAD’s current programmes. Funding is provided for education, anti-corruption, energy, the environment and women’s rights and gender equality. She underscored that support at the country level includes joint planning and sector planning with the UN system and NGOs, with a focus on human resources for health (Malawi and Mozambique).

Japan drew attention to health system strengthening and home care for maternal and child health as key areas of its technical cooperation and country operations on MNH. Dr Hitoshi Murakami canvassed two major projects that are currently in the follow-up phase in Indonesia and Honduras. In the Lao People’s Democratic Republic a large-scale project is being implemented and two new projects are in formulation in Cambodia and Madagascar. Equipment, facility and supplies have been provided (since 2002) to Georgia, Senegal, Cape Verde, Nicaragua, Suriname, India, Kenya, Bolivia, Indonesia and Uzbekistan. The Government will be strengthening investments in management functions and will focus its efforts on deprived areas/population. The ICPD objectives remain a guiding principle and the government will facilitate south–south collaboration in its technical assistance to countries.

France’s priority is maternal and newborn health interventions, including the prevention of unwanted pregnancies, infertility, women’s rights and gender equity, and treatment and rehabilitation of obstetric fistula. The Government, through the Ministry of Foreign Affairs and with support from members in Parlia-
Group One was tasked with identifying key constraints on funding for health that were underscored during the breakout session as inadequate and not deemed a priority. The Group canvassed several solutions to better increase funding mechanisms and thus strengthen health systems. Stronger health systems were underlined as an essential entry point in creating more efficient national strategies for maternal, newborn and child health, and need to be integrated into national plans. Additionally, stronger health mechanisms must be integrated at the provincial and district level and focus on the division of labour among partners on the ground.

Group One underscored that critical actions must be taken at the global level, including review of the existing mandates of various multilateral agencies, including the World Bank and the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFTAM). At the global level, multilateral agencies should be held accountable in defining standards in the global division of labour and to be more transparent on issues such as coordination. This should feed into the medium-term strategic plan of WHO at the regional level and on coordination issues at the country level. Group One suggested that each country set up a venue for coordination of current stakeholders in country, to ensure that both the Ministry of Health and Min-
istry of Finance are at the table. This process should then feed into Roadmapping exercises at the national level. Roadmaps (national plans) should be centred on health system strengthening as an entry point for MNCH interventions. All partners are greatly needed during this process to better support Roadmap planning, implementation and measuring progress. Group One also highlighted that efforts should be made to ensure that national plans feed into district level planning and budgetary allocations.

Key issues

- Funding for health remains inadequate/not a priority: How do we correct this?
- Health systems strengthening is an essential entry point – Roadmaps/national strategies for

Critical Action

Global level

- Review of existing mandates for different multilateral agencies, including WB and GFTAM
- Global division of labour should be defined
- Clarity around country coordination among multilaterals

This should feed into medium term strategic plan of the WHO

Regional level

- Coordination at country level: Each country to set venue for coordination of current stakeholders in country; ensure that both MoH and MoF are at the table

This should feed into Roadmapping exercises

National level

- Roadmaps (national plans) should be centred in health systems, strengthening as an entry point for MNCH interventions
- Donors are needed here to support Roadmap planning

Efforts should be made to ensure the national plan feeds into district level planning and budgetary allocations
**Group Two**

**Group Two** outlined MNCH in the context of SWAP and budget support to highlight more effective methods to ensure sufficient resource allocation to MNH. Group Two suggested MNH issues should be included in national resource allocation mechanisms and part of national development plan. It was emphasized that MNH issues must be captured in essential health packages, programme of work and the annual work plan. This greatly depends on strong leadership and advocacy for MNH on all levels and the Ministry of Health, Ministry of Finance, planning and local governments must be convinced and vested in the issue.

Additionally, there is a greater need to have people at the table with the right knowledge and skills to ensure effective negotiation – technical personnel – and to engage all key stakeholders in the process of resource allocation. There should also be more emphasis placed on the need to align national health budgeting tools with Ministry of Finance budgeting tools. Moreover, existing World Bank Institute (WBI) packages need to be utilized more effectively and used for the purpose of boosting existing resources in disease-based initiatives (HIV, Malaria and TB) and to effectively mobilize for MNH activities. The Group also underscored that more commitment should be placed on how to monitor gaps in funding and how to provide broader functioning SWAPs platforms for effective planning and negotiation. Other donors who are not part of the SWAPs should consider being part of the process as long as they fund activities within the agreed programme of work. Capacity building for advocacy at all levels (with various experts and practitioners) and the need for stronger data on MNH for advocacy purposes (in country) were also cited as a very relevant part of the resource allocation process.

Also highlighted were national health accounts, which may serve as useful tools for advocacy, and advocacy for MNH should be a commitment coming from all partners, including donors. Other advocacy issues include capacity building to create awareness of the importance of health and development issues and to reinforce the leadership role of the Health Ministry in intersectoral cooperation. The Ministry of Finance should also be encouraged towards a paradigm shift in defining “growth” to include all aspects of growth and not just “economic growth”. There also needs to be better communication for both the direct and indirect benefits of health investments and WHO has the important task of pooling together evidence to support MNH interventions and strategies. The evidence exists – so there is no need to generate new evidence.

Ministers of health need to be in the leadership role and engage in health planning with other Ministers, Permanent Secretaries and Directors of medical services with the backing from pressure groups, such as professional associations and parliamentarians. Additionally, there should be more emphasis placed to identify key reproductive health actors in order to determine what needs to be done to ensure that monies are spent more wisely. Achieving better coordination in-country and globally, and promoting solid structures for donor coordination at the country level to guarantee funds are used adequately are essential.
In the context of SWAP and budget support; ensuring sufficient resource allocation to MNH:

- Key is to ensure that MNH issues are included in national development plan and resource allocation mechanisms.

MNH issues must be captured in:
- essential health package
- programme of work (POW)
- annual work plan.

Depends on strong leadership and advocacy for MNH at all levels
- MoH and MoF must be convinced and make investment plan.

- Need to have people at the table with right knowledge and skills to ensure effective negotiation – technical personnel.
- Engage all key stakeholders in process of resource allocation.
- Need to align national health budgeting tools with MoF budgeting tools.
- Existing World Bank Institute (WBI) packages may be utilized more effectively and used for the purpose.
- Existing resources in disease-based initiatives (HIV, malaria and TB) need to be mobilized for MNH activities and we need to explore how to do this effectively.
- Monitor gaps in funding.
- Good and functioning SWAP platforms are necessary for effective planning and negotiation.

Current approaches and resource allocation in countries are very project oriented, leading to fragmented efforts and chaotic donor architecture, and working partners need to be transparent and avoid hidden agendas. The World Bank can play an effective role in resource coordination at the country level but technical input seems to be lacking. Therefore, there should be a memorandum of understanding at the country level to ensure that donors and partners adhere to better standards in regards to transparency, accountability and the question of how to perform according to comparative advantage at country levels.
Leadership and Championship

- Ministers of Health need to be in the leadership role and engage MoF in planning for health.
- Ministers, Permanent Secretaries and Directors of medical services with backing from pressure groups such as professional associations, parliamentarians
- Need to identify who key RH actors are to determine what needs to be done to ensure that monies are spent more wisely

Achieving better coordination, in-country and globally

- Good structures for donor coordination exist at country level
- Partners must support coordination processes in country
- UN country teams being established can be coordination body
- Alternatively, Task Force can be formed
- All UN agencies should come together to work on national plan (e.g. Malawi, Roadmap)
- Current approaches and resource allocation to countries are very project-oriented leading to fragmented efforts and chaotic donor architecture
- Partners need to be transparent and avoid hidden agendas

Advocacy

- Capacity-building for advocacy at all levels (various experts and planners, etc.)
- Need good data on MNH for advocacy purposes (in country)
- National Health Accounts may serve as useful tools for advocacy
- Advocacy for MNH should be from all partners, including donors

Other advocacy issues

- Capacity-building to create awareness of the importance of health and development issues and to reinforce leadership role of health ministry in intersectoral cooperation.
- MoF: Paradigm shift in defining “growth” to include all aspects and not just “economic growth”.
- Need to be better at communicating both the direct and indirect benefits of health investments.
- WHO has the important role of pooling together evidence to support MNH interventions and strategies. The evidence exists – no need to generate new evidence.

Other donors who are not part of the SWAPs should be considered as being part of the process as long as they fund activities within the agreed programme of work.
DISCUSSIONS

How the Department of Making Pregnancy Safer (MPS) supports countries

Responsibilities of MPS

WHO needs to provide timely support to countries to build consensus and develop national evidence-based policies, strategies and plans on maternal and newborn health and survival. Participants underlined that countries with few donors are more successful, in the case of Eritrea, for example. WHO/MPS can build the bridge for the continuous presence and contact with Ministries of Health and other relevant ministries. MPS must also provide continuous support, including training, to countries in building technical, managerial and monitoring capacities for timely implementation of national maternal and newborn strategies and plans that are then translated and promoted to ensure effective district level strategies, implementation and monitoring.

WHO also has an enormous normative role, developing evidence-based clinical, technical and managerial tools and guidelines, and can be greatly involved not only in dissemination of these guidelines and tools but also in building national and district capacity for their utilization for changing practices and improving quality. From some donors’ perspectives, MPS needs to ensure that countries have the right capacity at the table when various issues are discussed: e.g. macroeconomic and financial issues or health systems strengthening. Also needed is to ensure that appropriate skills and competencies are represented in specific processes at the country level, especially in relation to health systems strengthening.

In regards to knowledge management, MPS can contribute to this role as well as share lessons from countries. Additionally, one key aspect of health systems strengthening as a knowledge management tool is human resource development. Suggestions were made that WHO MPS could play a central role in developing country-specific strategies and plan to strengthen human resources. Along with others, MPS needs to embark on advocacy for increased and sustained investment in maternal and newborn health

- The World Bank can play an effective role in resource coordination at country level but technical input seems to be lacking
- Need a memorandum of understanding at country level to ensure that donors and partners adhere
- Need better accountability
- Question is how to perform according to comparative advantage at country levels
at global, regional and country level. Also underlined was the need to further spotlight major health dilemmas and new emerging issues, such as malaria and HIV in pregnancies and FGM, which remains a major concern, especially in EMRO.

SUMMARY

Dr Mahmoud Fatthala summed up the meeting’s conclusions with the central theme: Towards a shared vision of the partners. He underscored three major areas that surfaced from discussions and were principle needs for countries, donors and UN agency partners and governments: 1) key policies and interventions in countries; 2) accelerated support to countries to implement these policies and interventions; and 3) the way forward.

1. Key policies and interventions in countries

1.1 Consensus and endorsement

Key policies and interventions in countries underscored building consensus among all players to promote a coordinated system-wide maternal and newborn health plan that was effectively endorsed by governments in their national plans. Dr Fatthala highlighted the crucial importance of universal access to skilled attendance at birth, addressing the dyad of the mother and her newborn. Additionally, the concept of continuity of care in pregnancy, childbirth, newborn, infant and child health from home care to the community to the facility, including referral care, must be an integrated approach at the local, national and regional level.

- The crucial importance of universal access to skilled care at every birth addressing the dyad of mothers and newborns.
- Concept of continuity of care: Pregnancy, childbirth, newborn, infant, child and adolescent health from home care to facility care, including referral care.

1.2 Policies and interventions highlighted and emphasized as areas countries need to address

There is also a great need to address inequity and to focus on the poor and disadvantaged. This includes building synergies with other sectors – transport and communication, water and sanitation, infrastructure development, education – and with health system development. Family planning must be a part of this planning process, as well as the integration of HIV/AIDS, malaria and nutrition programmes in pregnancy, childbirth and post-delivery care services. This includes scaling up evidence-based interventions and knowledge networking of successful interventions.
Dr Fatthala emphasized that new pilot projects and vertical programmes that do not address the health system issue are not needed and that we need to scale up what we already have through a multisectoral approach.

- The need to address inequity and to focus on the poor and disadvantaged.
- Need for synergies with other sectors – transport and communication, water and sanitation, infrastructure development, education. Also, synergies with health system development.
- Need for incorporation of family planning as part of the strategy.
- Integration of HIV/AIDS, malaria and nutrition in pregnancy, childbirth and post-delivery care services.
- Scaling up evidence-based interventions.
- Expansion of proven interventions.

1.3 A policy and an intervention countries do not need

Instead of investing in pilot projects, countries and partners need to invest in scaling up existing and proven interventions. The time for more pilot projects needs to come to an end. Vertical programmes draw not only funding but also other resources, particularly scarce human resources, at the expense of other vital programmes. Countries need to invest in district health management, improving overall health system response.

- No new pilot projects – we need to scale up what we already have.
- Vertical programmes: not addressing health system issue.

2. Accelerated support to countries to implement these policies and interventions

2.1 Endorsement

Accelerated support to countries to implement these policies and interventions can be achieved if there is proper endorsement from all partners to put countries in the driving seat. Dr Fatthala stressed that we must work to provide coordinated support according to comparative advantages and that the roles of each partner or agency must centre on building partnerships as part of the strategy of making pregnancy safer. The initiative for accelerated support has to come from the countries. We need to support what the country wants. Maternal and newborn health is about investment and it is important for maternal and newborn health advocates to have a place at the table when resources are allocated.

- All efforts should be country support, putting countries in the driving seat.
- Provide coordinated support according to comparative advantages and roles of each partners or agencies.
- Building partnerships as part of the strategy of making pregnancy safer.
2.2 Areas highlighted and emphasized
Maternal and newborn health may be slipping down in health sector support and partners need to show commitment by making public sector investments. Countries must take the initiative for accelerated support as the need is to support what countries want. Investment is important for maternal and newborn health, and it is imperative that maternal and newborn health advocates are involved when resources are allocated. WHO must provide all the support needed to policy-makers and programme managers to make the case for increasing country budgets for maternal and newborn health programmes. WHO needs to build its country offices' technical capacities for providing timely support. The initiative has to come from the country.

- Maternal and newborn health may be declining in health sector support. The need to show commitment must be evidenced by making public sector investment.
- WHO needs to increase country budgets for maternal and newborn health programmes.
- WHO needs to build its country offices' technical capacities for providing timely support.

2.3 Concern expressed
A lot needs to be done in providing support for countries to achieve their MDGs. Development partners, including UN agencies and the World Bank, need to harmonize and coordinate their support to countries to maximize utilization of scarce resources and minimize duplications. Coordination of support is still a challenge, particularly at the country level, and what is critical for countries is to have long-term strategies and predictable funding.

- Coordination of support is still a challenge, particularly at the country level.
- It is critical that counties have long-term strategies and predictable funding.

3. The way forward
Dr Fatthala concluded by chronicling the way forward in three key messages: 1) The need to reposition maternal and neonatal health as a human rights issue – and one that carries an obligation by all policy-makers and planners. Maternal and newborn health is a development, poverty reduction and gender issue. 2) Providing solutions by building the bridge for all key players to talk more about maternal and newborn health solutions rather than about problems. 3) Pave the way to bringing hope – it is possible. We must strive to advocate a message of hope and to be optimistic so that progress can continue to be made in countries with low-resource settings.

- The need to reposition maternal and neonatal health
  - as a human rights issue that carries an obligation by policy-makers
  - as a development issue
  - as a poverty reduction issue
Making Pregnancy Safer

- as a gender issue.
- The dialogue should be more about solutions than about problems.
- Advocate a message of hope and positive optimism. Progress has been made but more can be achieved in countries with low-resource settings. Together it is possible.

FURTHER DISCUSSION AND COMMITMENT

WHO ADG Joy Phumaphi concluded the meeting by briefing participants on the next steps. She advised that WHO will organize a meeting of UNICEF, UNFPA and World Bank participants to discuss and decide on a broader framework of roles and responsibilities for UN partners in supporting countries. These discussions are expected to outline a Stockholm Accord, which will be presented to the wider audience in September 2006.

Dr Monir Islam thanked all the participants for their commitment to improve maternal and newborn health and survival, and for their active and very frank participation, discussion and inputs.
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