

A Call to Action for the G8

Additional resources needed for maternal, newborn and child health

A call for a doubling of resources: The welcome endorsement by the G8 of a global consensus¹ on maternal, newborn and child health at the LAquila Summit in 2009 committed all G8 Governments to take action to save the lives of vulnerable women and children. Under Canadian leadership, the G8 in 2010 must collectively support this commitment with new resources for Maternal, Newborn and Child Health (MNCH) including reproductive health. This commitment must include access to integrated and cost-effective interventions, which have been proved to save lives. The G8 must also put its leadership squarely behind the UN Secretary General and make an ambitious contribution to a concrete plan of action to accelerate progress towards the Millennium Development Goal (MDG) 4, which remains off-track, and MDG 5, which has made the least progress of all the goals.²

While funding trends for MNCH and reproductive health have been generally positive over the past decade, funding still remains woefully inadequate compared to the need. We have seen a welcome focus on MDGs 4 & 5 in the past 18 months, but that must be translated into broad based and dramatically increased investment in proven interventions.

The global Consensus on MNCH estimates that an additional \$30 billion³ is needed between 2009-2015 to accelerate progress on MDGs 4 & 5, with annual incremental costs ranging from \$2.5 billion in 2009 to \$5.5 billion in 2015. Analysis published in the PMNCH Consensus estimates that this investment would help to prevent up to 1 million deaths of women due to pregnancy and childbirth and save the lives of 4.5 million newborns and 6.5 million children.

The G8, together with other donors and national governments, can make a crucial difference. To help generate momentum in this pivotal year the G8 should commit at the Muskoka Summit to a doubling of total G8 bilateral aid for interventions that directly support MNCH. This would include a particular focus on care at the time of birth for both mother and baby, since this is the period of greatest risk, and the most neglected. Based on the most recently published figures, from 2007, total bilateral aid would increase to at least \$4 billion a year⁴ from 2010 through to 2015, frontloading as much of this increase as possible. The increased investment could save the lives each year of approximately 1 million additional children⁵ and between 200,000-330,000 women.⁶ A proportionate increase in multilateral aid is also needed. To help accelerate this progress, non-G8 donors should also commit to double their aid for maternal newborn and child health. This would mean overall resources in 2010, from OECD donors, i.e., both G8 and non-G8 donors, would double from \$4 billion⁷ to \$8 billion annually. In addition, governments of countries with high maternal, newborn and child health needs should also increase spending on health.

How should the money be spent? In the absence of a single global financial mechanism designed specifically to disburse funds to promote MDGs 4 & 5, a variety of bilateral and multilateral channels should be used—and indicators must be adopted and used—in order to specifically target additional resources to MNCH.

These include:

- **Bilateral support:** taking a lead from the Norwegian Government's \$1 billion programme on Maternal and Child Health
- **Multilateral financial mechanisms:** The International Finance Facility for Immunisation, World Bank, Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Alliance for Vaccines and Immunization (GAVI).
- **Multilateral support:** UN agency programs and funds.

¹ PMNCH <http://www.who.int/pmnch/en/>

² http://www.un.org/ga/search/view_doc.asp?symbol=A/64/665

³ Figures are totals for 49 aid-dependent countries (total population in 2009 is 1.4 billion; excludes India and China) for the 2009-2015 period, based on calculations done for the High Level Task Force on Innovative International Financing for Health Systems (HLTF), May 2009.

See http://www.internationalhealthpartnership.net/CMS_files/documents/working_group_1_-_report_EN.pdf

⁴ Greco, G. et al.(2008), *Countdown to 2015: assessment of donor assistance to maternal, newborn, and child health between 2003 and 2006*, Lancet 371 : 1268 – 1275

⁵ Based on the average cost per child life saved of US\$887 identified in Jennifer Bryce, Robert E Black, Neff Walker, Zulfiqar A Bhutta, Joy E Lawn, Richard W Steketee, "Can the world afford to save the lives of 6 million children each year?" Lancet 2005; 365: 2193–2200.

⁶ Jamison DT, et al; *Disease Control Priorities in Developing Countries* (2nd edition), 2006. Estimated \$3000 to \$5000 per maternal death averted

⁷ Greco, G. et al.(2008), *Ibid*.

At such a critical juncture in the countdown to 2015 the G8 also needs to ensure multilateral support from the Global Fund for AIDS, TB and Malaria (GFATM) is replenished. The G8 must also ensure that GAVI Alliance's projected financing gap to meet the demand by the world's poorest countries for life-saving vaccines is met. This currently stands at an estimated \$4.3 billion⁸ between 2010 and 2015. The Global Fund estimates that it will need \$20 billion between 2011 and 2013⁹ to meet demand for new and existing programs.

The G8 should adopt an agreed-upon set of indicators for tracking progress related to maternal, newborn and child health with the existing funding mechanisms, while leading a discussion on an appropriate funding mechanism for the health MDGs.

What should be funded? Additional money for MNCH should support nationally led health plans that seek to extend access to life-saving health information, commodities, services and facilities along a continuum of care from maternal to newborn to child health. These plans should support the strengthening and expansion of health systems. This would include removing barriers to access, with services for women and children being free at the point of use where countries choose, and recruiting, training and deploying additional skilled health workers to improve the health of women and children. A doubling of MNCH aid would be a significant contribution to the shortfall of 2.5 million health care professionals and 1 million community health workers needed to reach the health MDGs, including MDGs 4 and 5.¹⁰ Health workers are an example of the health systems strengthening investment needed for sustainable futures. In addition, plans should focus on strengthening community engagement as a key component of health system strengthening. Communities are able to hold health systems and governments accountable for the provision of quality health services and adequate investment in MNCH. There are no quick fixes: initiatives must be integrated into long-term comprehensive national health plans that include the recurrent cost financing needed to sustain these basic health services.

Achieving MDGs 4 & 5 will depend on our collective will to reduce inequities that deny life-saving care for women and children. Governments, donors and multilateral institutions should set targets for reducing disparities in the coverage of proven interventions between rich and poor, plus targets for reducing mortality rates across income and other social groups. Closing this gap requires concerted action to tackle underlying causes of global and national inequity. By addressing gender discrimination, cultural prejudice and financial barriers through comprehensive approaches that engage the community in partnership with the health system and government, we can break down barriers and address the multiple forms of discrimination and prejudice that prevent women and children from accessing and utilizing quality health services.

How should the G8 be held to account? G8 accountability for investment in maternal, newborn and child health should be an integral and permanent component, measured in terms of support that contributes directly to achieving MDGs 4 and 5. We welcome G8 investment in water and sanitation, programs to combat maternal and child under-nutrition and food insecurity, education of women and girls and other such steps that address the indirect or underlying causes of mortality. However, only funding within the health sector that contributes to improve maternal, newborn and child health should be counted under this Muskoka initiative.

The following principles should be incorporated into the matrix:

- All development commitments should also be results-based, with specific and measurable objectives;
- Commitments should be time-bound with clear start and end dates;
- Commitments should be explicit about whether funding is additional or inclusive of previous commitments;
- Commitments should be clear about how much each donor and partner country is contributing.

It is time for the G8 to ensure that every pregnancy is wanted, every birth is safe, and every newborn and child is healthy.

For more information, contact: The G8 Task Team of the Partnership for Maternal, Newborn & Child Health. Tel: + 41 22 791 2595; www.pmnch.org

⁸ http://www.gavialliance.org/resources/Financing_Country_Demand_March_2010.pdf

⁹ http://www.theglobalfund.org/en/pressreleases/?pr=pr_100324

¹⁰ HLTF, 2009, *Constraints to Scale Up Health Related MDGs: Costing and Financial Gap Analysis*. Background to the Working Group I report to the Taskforce on Innovative International Financing for Health Systems, Final Draft as of 23 September, Table 1C, p.22