WHO CARES FOR BABY?

Divisions between maternal and child health services in the developing world, first reported 20 years ago, left services for newborns overlooked.

Today, neonatal mortality is still unacceptably high. **Hannah Brown** reports on initiatives trying to bridge the gap

There are few better examples of the wasteful and damaging results of uncoordinated health efforts than in Cambodia. Hundreds of well meaning non-governmental organisations have taken up residence in various parts of the country's 20 provinces since the brutal civil war of the 1970s and 1980s gave way to peace. But although this massive influx of resources is welcome, the confusing array of organisations, programmes, and priorities has proved unable to meet Cambodia's needs—particularly when it comes to improving maternal and child health.

Many actors mean many approaches. This has created an incomprehensible patchwork of programmes that have a bewildering range of effects on the population's health. Unequipped for such a complex managerial challenge, the resource poor government has little capacity to get the non-governmental organisations to coordinate or put in place national programmes that can capitalise on the influx of resources. Instead, disparate independent aid offerings are often

the only services many of the country's 14 million citizens see. So coverage is low for even essential interventions and services are heterogeneous and patchy.

Nutrition is one example. Good nutrition is an essential component of programmes to improve both child and maternal health. But a 2002 nutrition sector review in Cambodia done by Helen Keller International—with the cooperation of 58 United Nations agencies and non-governmental organisations working in the country—revealed a jumbled mess of programmes, approaches, interventions, and coverage rates.¹ Some areas received vitamin A supplements and others iron tablets. Where breastfeeding information was available, it did not necessarily conform to international guidelines and was independent of complementary feeding advice. Some programmes targeted infants whereas others were restricted to women or school age girls. What is more, obvious synergies, such as distribution of bed nets alongside vitamin A capsules to children under 5—both of which need to be distributed every six months—

were being ignored, wasting resources and causing unnecessary health problems.

Wider problem

This situation, in which organisations set their own priorities in project areas and shout for their own causes, is symptomatic of a problem that affects many efforts to improve child and maternal health, says Flavia Bustreo, deputy director of the Partnership for Maternal, Newborn, and Child Health—a WHO hosted alliance of over 180 organisations, governments, and universities. The partnership aims to put an end to longstanding divisions that have held back progress in reducing mortality for these groups. Her organisation's first policy document, *Opportunities for Africa's Newborns*, published in November last year, emphasised the 4 million newborn deaths that occur every year—more deaths than caused by AIDS and malaria combined. But reducing this figure requires an integration of child and maternal health efforts, a process that means confronting a decades old divide.

Although it is counterintuitive for outsiders,

TANG CHHIN SOTHY/AFP/GETTY IMAGES

Health programmes have treated maternal mortality and health of newborn babies separately

but the way donors organise money can ruin that united front," she says.

Although the main thrust of the conflict is about competition for advocacy and resources, there are ideological aspects too. Some champions on the child side perceive the maternal side as a competition, and some on the maternal side have overly focused on obstetric care when their community approaches could include newborns and children too. It is less about individuals than about ideologies that have become entrenched.

Why did it happen?

This problem is not a new one. It was first articulated over two decades ago when Allan Rosenfield and Deborah Maine posed the question: "Where's the M in MCH?" in a comment article published in the *Lancet*.² They pointed out that most programmes that fall under the banner of "maternal and child health" did little to reduce maternal mortality and chided obstetricians for subspecialising in areas that prioritise high technology rather than basic public health.

"Thirty years ago there were a large number of child deaths and inspirational people like [former Unicef head] Jim Grant really

moved forward for child survival," explains Dr Lawn. The first primary healthcare revolution was also focused on the child, but success in that area brought the realisation that the mother had been forgotten. "That led maternal health people to start to think of the child as competition," says Dr Lawn.

But despite reams of articles that have since been written about the problem, numerous examples exist of the divide still being perpetuated. Dr Lawn explains that Unicef's main focus on the child means that many interventions for newborn babies, which require doing things with women, are not linked into their programming. And United Nations Population Fund programmes are linked to women so do not involve the child. Even the countdown for the child survival conference in 2005—part of a new effort to bring accountability—drew criticism for not including the mother, although it is meant to be adding maternal aspects for its second meeting in 2008.

The result of this division is that the increasing global interest in maternal and child health—sparked by the inclusion of specific targets in the millennium development goals, and maintained by a multitude of new initiatives and high profile

Mother and babies queue outside Kantha Bopha Hospital, Phnom Penh

health programmes have treated maternal mortality and health of newborn babies separately, thanks to distinct funding streams and convenience based administrative divisions in international organisations. The maternal and child health sectors are strong, but newborns fall into a void between the two. The result is that although mortality of children under 5 years has fallen in several African countries, deaths during the first month of life are virtually unchanged.

"One of the key problems is that some people are calling just for the mother and other people are calling just for the child. Combine that with other voices calling for malaria, HIV, and immunisation and you have the cacophony of calls," explains Joy Lawn, a South African based senior policy and research adviser for Saving Newborn Lives/Save the Children USA. "In a lot of African countries people have been trying to move forward for maternal and child health,

SEAN SPRAGUE/ALAMY

Immunisation clinic for babies at Chumpou Voan Kampot Province, Cambodia

“Instead of sitting in the corner and shouting for your own item, you could shout together”

campaigns by leading medical journals—is not being efficiently translated into better services for women and children on the ground. For example, explains Dr Bustreo, a lot of resources are going into HIV and AIDS and prevention of mother to child transmission, but these finances are not being used to fill the gaps in basic services for mothers at time of delivery or for newborn babies. “The way that advocacy translates into things on the ground is inefficient. The inefficiency of having separate drives is a key argument for looking at integrated service delivery—what we call the continuum of care,” says Dr Bustreo.

Wider publicity for the problem has resulted in some progress in tackling its roots. The World Health Organization has been working on forging stronger links between its division of reproductive health and department of child and adolescent health. According to Dr Lawn, the situation has improved since it was highlighted in the 2005 world health report, *Making Every Mother and Child Count*.³ “But”, she notes, “it would be fair to say that the newborn side has suffered because it has dropped between the two departments rather than being part of a strategic look at what would make the biggest difference.”

As Dr Bustreo emphasises, national and international policy and programmes are finally shifting towards a continuum of care that integrates maternal, newborn, and child health. But the progress has been shockingly slow, Dr Lawn explains. WHO’s integrated management of childhood illness strategy—looking at child health from the point of view of the individual rather than specific diseases—had nothing about neonates until last year. And its strategy on making pregnancy safer had nothing on the management of newborn illness.

Signs of hope

Two fundamental prerequisites for progress are still largely missing: a scientific evidence base for the right kind of integration and the money to make it happen. That is where Dr Bustreo’s partnership comes in. Bringing together the numerous diverse actors in child and maternal health, the Partnership for Maternal, Newborn, and Child Health pledges to intensify political advocacy and mobilisation of resources in addition to

advancing scientific analysis of integration. They have a few good examples to work from. “There have been countries that have already come up with national plans for an integrated approach to maternal, newborn, and child health,” she says. “For example, Pakistan launched one last year, Nigeria did it this year, and Tanzania is moving towards that direction. Next year we hope to produce a series of analysis articles asking whether these are the right way of doing integration in terms of improving coverage of services,” she explains.

Despite the uncertainty over technical details, there is a consensus that the benefits of a joint approach are potentially great. “Instead of sitting in the corner and shouting for your own item, you could shout together,” says Dr Lawn. “I think the amount of investment would go up. And by looking at total deaths in all three groups together you increase the public health burden, meaning you are more likely to have consistent investment. If you change policy every couple of years you won’t make any progress,” she adds.

A test of the new spirit of unity will come in this week’s Women Deliver conference in London, whose delegates include UN leaders and government officials. It will be a litmus test of whether newborn health issues have finally made it into mainstream thinking about maternal health, not least because previous gatherings have roundly failed to consider the issue.⁴ “The last time safe motherhood had a big public meeting in Sri Lanka they had 10 key messages and not one of the messages mentioned a baby. Not even by saying the mother and the baby would benefit,” recalls Dr Lawn.

She believes that the Women Deliver conference is a unique moment for maternal health advocates to make goals that are not in competition with child health and to give newborn health more than a token mention.

So with all this new momentum towards an integrated approach to maternal, child, and newborn health, is there any more hope that it will happen? Dr Bustreo thinks so, not least because there is no other way to reduce mortality now that the easy fixes have been made. Several years ago it was possible to have a large effect on mortality by boosting immunisation rates, for example. But there remains a bulk of deaths that

cannot be reduced without interventions at the time of delivery.

“I am quite optimistic,” she says. “I think the issues are converging, so there is no option but for the different camps to work together.” Even if you look at reducing child mortality alone, most deaths are occurring in young babies and neonates. So even partners that are interested only in children will have to accept that they can’t look just at post-neonatal mortality, she explains. “Biologically and psychologically they are together, and there is no way we can look separately.”

One unforeseen benefit of the long running conflict is that maternal and child health is emerging from the invisibility it has previously endured. But, says Dr Bustreo, to capitalise on this new high profile, the next important step must be clear and strategic mobilisation of resources to help fill the gaps. Maternal, newborn, and child health combined currently make up just 2% of development aid from countries in the Organisation for Economic Cooperation and Development. “We need to move to 4%,” asserts Dr Bustreo.

At the end of last month, Norway’s prime minister, Jens Stoltenberg, pledged \$1bn (£500m; €700m) for this cause and his Dutch counterpart, Jan Balkenende, added \$125m. But Dr Bustreo sees the contributions as just the initial steps in an ongoing increase in funding, through which she hopes to spur new initiatives that document good practice and measure changes in mortality. “To me, the real bottom line is the services that are provided to mothers and children and coverage of these services. So that is where we have to have our eyes,” she says. “Through the Countdown to 2015 process we have that. There is already some sign of progress but significant gaps remain. But if we keep our eyes on those issues, the differences should be minimised.”

Competing interests: None declared.

- 1 Helen Keller International. *An overview of nutrition sector services in Cambodia*. 2002. http://hkworld.org/research/pdf_zip_docs/Nutrition_Sector_Cambodia.pdf
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- 4 Starrs AM. Safe motherhood initiative: 20 years and counting. *Lancet* 2006;368:1130-2.

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