
Policy and Advocacy Side Event at the International Maternal New-Born Health Conference (IMNHC) 2026

Title of Side Event: Shaping the Future of MNCH: Country-Led Policy & Financing Dialogue

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Closing Remarks

By

Professor Joseph Akinkugbe Adelegan
Executive Director & Chief Executive Officer
Partners in Population and Development (PPD)
Dhaka, Bangladesh
E-mail: jadelegan@ppdsec.org
WhatsApp: +6596662403



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Closing Address: Advancing Maternal, New-born and Child Health through South-South and Triangular Cooperation and Transformative Financing

By

Professor Joseph Akinkugbe Adelegan
Executive Director & Chief Executive Officer
Partners in Population and Development (PPD)
Dhaka, Bangladesh
E-mail: jadelegan@ppdsec.org
WhatsApp: +6596662403

Distinguished Ministers of Health and Finance, Excellencies, Ambassadors and Diplomats, esteemed policymakers, development partners, donors, colleagues, ladies and gentlemen, I stand before you today at this Policy and Advocacy Side Event at IMNHC 2026, convened under the leadership of the SMART Advocacy for Strategic Action (SASA) Alliance, with a profound sense of urgency but also with a firm conviction that this room holds the leadership, the influence, and the responsibility to change the trajectory of maternal, new-born, and child health globally.

Let me begin by commending the SASA Alliance and its partners, PPD Africa Regional Office, Pathfinder Nigeria, Jhpiego Kenya, HENNET and SAMASHA for convening this critical and action-oriented dialogue. What we have witnessed today is not just discussion, it is the foundation for decisions that must translate into lives saved.

Distinguished colleagues, Maternal, new-born, and child health (MNCH) is not simply a sectoral issue. It is the clearest reflection of the performance of our health systems and the equity of our societies. It is also one of the most sensitive indicators of whether our health systems can deliver across the continuum of care from pre-pregnancy, to antenatal care, to intrapartum care, to postnatal care, and onward to new-born survival, child health, nutrition, immunization, and early childhood development. And yet, the reality remains stark and unacceptable.

Every year, nearly 287,000 women die from preventable causes related to pregnancy and childbirth. Every year, approximately 2.3 million new-borns die within their first month of life, and another 1.9 million babies are stillborn. Sub-Saharan Africa alone accounts for nearly 70% of global maternal deaths, and neonatal mortality rates remain highest in our regions.

These are not just numbers. They represent lives lost to postpartum haemorrhage, hypertensive disorders of pregnancy including pre-eclampsia and eclampsia, puerperal sepsis, obstructed labour, and unsafe delivery conditions. They represent new-borns dying from birth asphyxia, prematurity and its complications, neonatal sepsis, low birth weight, and infections that are entirely preventable with timely, quality care.

Let us be clear: the majority of these deaths are preventable. And this is what makes the situation not only tragic but unacceptable. We are not facing a knowledge gap. We are facing a delivery, quality, equity, and financing gap.

We know that skilled birth attendance (SBA) can prevent the majority of maternal deaths. We know that access to Basic Emergency Obstetric and New-born Care (BEmONC) and Comprehensive Emergency Obstetric and New-born Care (CEmONC) is essential. We know that antenatal care (ANC), postnatal care (PNC), integrated RMNCAH services, and strong referral systems save lives. We know that essential new-born care, kangaroo mother care, neonatal resuscitation, management of preterm birth, partograph use, infection prevention and control, and timely access to oxytocin, magnesium sulphate, antibiotics, blood, and safe surgery are fundamental to survival.

We know that strong primary healthcare systems, universal health coverage (UHC), and a well-trained midwifery and nursing workforce are indispensable. And yet, millions still lack access to these services. Why? Because systems remain underfunded. Because resources are not reaching the frontline. Because financing is fragmented, insufficient, and unsustainable.

The Financing Reality: Available Resources, SDG Needs, and the Widening Gap

Distinguished Ministers, Excellencies, Allow me to speak with clarity and precision on the financing reality because this is where urgency must translate into action. Today, total financing directed toward maternal, new-born, and child health across low- and middle-income countries is estimated at approximately US\$18-22 billion annually.

However, to achieve the SDG targets particularly reducing maternal mortality to less than 70 per 100,000 live births and ending preventable neonatal and under-five deaths. Countries require at least US\$40-45 billion annually in sustained, system-wide investments. This leaves a financing gap of US\$20-25 billion every single year.

Distinguished colleagues, this is not a marginal gap. This is a structural deficit. And the situation is worsening. Development assistance for MNCH has stagnated and declined by approximately 10-15% in real terms, with some countries experiencing reductions of up to 20-30% in external support.

At the same time, domestic fiscal pressures are increasing, and out-of-pocket expenditure remains above 40% in many countries, placing an unsustainable burden on households. This means that millions of women and children are either unable to access care or are pushed into poverty when they do.

Let me be clear: This is not just a financing gap. It is a gap between life and death. Because these numbers translate directly into: Health facilities without essential equipment. Health workers who are overstretched and underpaid. Stock-outs of life-saving commodities such as oxytocin, magnesium sulphate, antibiotics, resuscitation equipment, and essential new-born supplies. Weak referral transport for obstetric emergencies. Interrupted access to ANC, skilled delivery, emergency obstetric care, neonatal intensive support, immunization, nutrition, and child survival services. And communities left without access to basic maternal and new-born care.

Distinguished Ministers, Excellencies, We must confront another difficult truth. Global health financing is tightening. Development assistance for health is stagnating and in some areas declining in real terms. Competing global priorities, economic pressures, and shifting donor landscapes are placing increasing constraints on external funding. At the same time, countries face growing domestic fiscal pressures and debt burdens, competing development priorities, and limited fiscal space. The result is a widening MNCH financing gap estimated in the tens of billions of dollars annually. This gap is not theoretical, it is the reason why systems fail and lives are lost.

Distinguished colleagues, If we do not address this financing gap decisively, we risk reversing hard-earned gains. We risk failing an entire generation. This is why the discussions we are having today under the leadership of the SASA Alliance are not just important. They are urgent. And this is why I want to emphasize, with clarity and conviction, that business as usual is no longer an option.

From Financing Crisis to Financing Transformation

We need transformation. Transformation in how we cooperate. Transformation in how we finance. Transformation in how we lead. At Partners in Population and Development, we believe this transformation must be anchored in three pillars: South-South and Triangular Cooperation; Innovative and catalytic financing; And strengthened domestic resource mobilization.

Excellencies, South-South Cooperation is no longer optional, it is essential. Countries of the Global South are not lacking solutions. Across Africa and Asia, we have examples of countries reducing maternal mortality through community health worker programs, scaling midwifery-led continuity of care, improving referral systems, expanding task-sharing, integrating sexual and reproductive health with MNCH, and strengthening primary healthcare delivery.

Through South-South Cooperation, these solutions can be rapidly adapted and scaled. Triangular Cooperation strengthens this by bringing in financing, technical expertise, implementation support, and global partnerships. This is not just cooperation, it is accelerated problem-solving at scale.

This matters greatly for MNCH because the interventions are known, but their success depends on coverage, quality, timeliness, and equity. South-South and Triangular Cooperation enable countries to learn not only *what* works, but *how* to operationalize it, how to strengthen maternal death surveillance and response, how to improve perinatal audits, how to scale respectful maternity care, how to reduce the three delays in seeking, reaching, and receiving care, and how to institutionalize high-impact practices within public systems.

But cooperation without financing will not deliver results. Let me be very direct: The current financing model for MNCH is not fit for purpose. It is fragmented. It is overly dependent on external aid. It is not aligned with long-term sustainability.

A Strong Case for Financing Transformation

First - Domestic Resource Mobilization

Distinguished Ministers of Finance and Health, this is where leadership must be most visible. Countries that have achieved reductions in maternal and child mortality have done so by increasing domestic investment.

We must: Move toward the Abuja target of allocating at least 15% of national budgets to health. Prioritize primary healthcare and MNCH services. Strengthen public financial management systems. Reduce out-of-pocket spending above 40%, which remains a major barrier to access.

But let us go further. Domestic resource mobilization must deliberately finance the full MNCH package: quality ANC, skilled birth attendance, BEmONC and CEmONC, new-born care corners, special new-born care units, nutrition services, routine immunization, postnatal follow-up, family planning, adolescent

sexual and reproductive health services, and the commodities, data systems, and workforce needed to sustain them.

Domestic resource mobilization is not optional, it is the foundation of sustainability and national ownership. It is also the clearest expression of political commitment to women, new-borns, and children.

Second - Innovative Financing

We must unlock new capital. Blended finance can leverage public resources to crowd in private investment. Results-based financing can link funding to measurable MNCH outcomes. Health bonds and impact investments can mobilize large-scale resources. Innovative financing expands fiscal space, improves efficiency, and strengthens accountability.

But in MNCH, innovative financing must be tied to real technical outcomes: increased fourth ANC visit and eight-contact ANC uptake, greater facility-based deliveries, improved EmONC functionality, higher postnatal coverage within 48 hours, lower maternal case fatality rates, improved new-born resuscitation readiness, increased contraceptive uptake postpartum, and stronger continuity between facility and community care.

Innovative financing should not be treated as an abstract financial instrument. It must be designed to solve real health system bottlenecks and improve measurable maternal, perinatal, neonatal, and child health outcomes.

Third - Catalytic Financing

Catalytic financing is the lever for transformation. It enables countries to pilot, scale, and sustain high-impact interventions. A catalytic investment in midwifery can reduce maternal mortality at scale. A catalytic investment in digital systems can improve ANC and PNC coverage. A catalytic investment in supply chains can eliminate preventable deaths.

Catalytic financing creates a multiplier effect, turning millions into billions of impact. For MNCH, catalytic financing can help countries scale midwifery education and deployment, strengthen maternal and perinatal death surveillance and response systems, expand oxygen systems and neonatal care capacity, improve transport and referral networks, deploy digital tracking for high-risk pregnancies, and close the implementation gap in the most underserved districts. This is precisely where catalytic financing becomes indispensable: it de-risks innovation, demonstrates proof of concept, unlocks co-financing, and moves us from pilot to national scale.

The Strategic Role of PPD and South-South Cooperation

Distinguished colleagues, In a resource-constrained world, efficiency and collaboration are critical. This is where PPD plays a central role. Through South-South and Triangular Cooperation, PPD enables countries to: Share cost-effective MNCH solutions; Accelerate policy adoption; Scale innovations across similar contexts; And mobilize partnerships and financing. This model reduces duplication, maximizes impact, and ensures sustainability.

But let me add this clearly: PPD's comparative advantage is not simply in convening dialogue. It is in connecting governments to governments, institutions to institutions, and policy to implementation. PPD can help countries exchange practical experience on health financing reform, midwifery regulation, EmONC scale-up, community health systems, reproductive health commodity security, maternal death review mechanisms, and integrated RMNCAH programming. In this way, South-South and Triangular Cooperation become not just diplomatic concepts, but operational mechanisms for accelerating MNCH results.

Distinguished colleagues, Let me be clear: We do not need more fragmented pilots. We do not need more short-term projects. We need scaled, sustained, system-wide solutions. And these solutions must be: Country-led. Financed sustainably. Delivered equitably.

But financing alone is not enough. We must strengthen health systems. Invest in the health workforce, especially midwives, nurses, skilled birth attendants, anaesthetic personnel, pediatric and neonatal care staff. Strengthen infrastructure, especially maternity wards, operating theatres, blood banks, newborn care units, and rural facilities. Ensure reliable supply chains for uterotonics, anticonvulsants, antibiotics, contraceptives, vaccines, and neonatal commodities.

Strengthen health information systems for maternal and perinatal surveillance, disaggregated data, and evidence-based decision-making. Improve quality of care, including respectful maternity care, infection prevention and control, and adherence to clinical protocols because access without quality does not save lives. We must also strengthen the links between maternal nutrition, family planning, adolescent health, immunization, child survival, and primary healthcare. MNCH outcomes do not improve in silos. They improve when health systems function as integrated systems.

And above all, we must prioritize equity. Because progress is measured by who we reach—not who we average. It is whether we reach: The woman in a remote village facing the first delay in deciding to seek care. The adolescent girl with no access to contraception or skilled support.

The mother with severe pre-eclampsia arriving too late for emergency obstetric care. The premature new-born who needs warmth, feeding support, oxygen, and infection management. The family facing catastrophic health expenditure for a complication that should have been prevented or treated early. If they are left behind, then we have failed.

Distinguished Ministers, Excellencies, partners, We stand at a moment of choice. We can continue with incremental progress. Or we can choose transformation. We can continue to operate within constraints. Or we can redefine what is possible. We can continue to underfinance lifesaving services.

Or we can build financing systems equal to the scale of the challenge. We can continue to discuss maternal mortality, neonatal mortality, stillbirths, and preventable child deaths as statistics. Or we can finally treat them as the urgent policy failures they are.

Let us choose transformation. Let us leverage South-South and Triangular Cooperation. Let us close the financing gap through domestic, innovative, and catalytic financing. Let us build resilient, equitable health systems. Let us invest in midwives, emergency obstetric care, neonatal survival, community systems, and primary healthcare. Let us ensure that no woman dies from postpartum haemorrhage because oxytocin was unavailable.

That no mother dies from eclampsia because magnesium sulphate was not stocked. That no new-born dies because there was no bag-and-mask for resuscitation, no warmth for a preterm baby, no antibiotics for sepsis, and no referral when complications arose.

Because ultimately, MNCH is about dignity, justice, and the future of our nations. Behind every maternal death is a preventable tragedy. Behind every stillbirth is a silenced life. Behind every new-born death is a lost future. And behind every missed opportunity is a decision we failed to make.

Let us not leave this room with declarations alone. Let us leave with commitments. With financing decisions. With policy reforms. With stronger South-South and Triangular Cooperation. With investments that close the gap between evidence and delivery. And with action.

Distinguished colleagues, The future of maternal, new-born, and child health will not be determined by what we say. It will be determined by what we do. Let us act boldly, urgently, technically, and collectively. Because the time for action is now.

Thank you very much.