The World Health Report 2005

Make every mother and child count
Why this report?

• It is a disgrace that so many mothers and children remain excluded from the care they need and demand.
• The consequences are often fatal, and progress is too slow and too patchy.
• More can and should be done.
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- Mothers and children matter – so does their health
- Obstacles to progress: context or policy?

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- Newborns: no longer going unnoticed
- Redesigning child care: survival, growth and development

Part 3. System and policy implications
- Reconciling maternal, newborn and child health with health system development
1. The situation in 2005
This year

- Almost 11 million children under 5 will die, mostly from a handful of causes.
- 4 million of these will die within 28 days of birth.
- 3.3 million babies will be stillborn.
- ½ million women will die in pregnancy, during childbirth, or afterwards.
Evolution of maternal and child health

- For centuries regarded as a domestic affair.
- Became a public health priority in the 20th century.
- Increasing role of the state. National approaches, with international influence.
- Today, a moral and political imperative:
  - mother and child care seen as an entitlement …
  - … improving it is vital to increase equity and reduce poverty.
Progress is slowing down …

[Graph showing the mortality rate of children under 5 years of age per 1000 live births from 1970 to 2003 for different regions: Africa, Eastern Mediterranean, World, South-East Asia, South-East Asia without India, Western Pacific, Western Pacific without China, Americas, Europe.]
… and is unequally distributed

Child mortality

• **93** countries (40% of world's population): **on track towards 2/3 reduction by 2015 (MDG4).**

• **51** countries (48%): **slow progress.**

• **43** countries (12%): **stagnation or reversal.**

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Similar patterns for newborn mortality ...
... and for maternal mortality
Maternal mortality

- Little improvement.
- Pregnancy and childbirth are still the leading causes of death and disease in women of reproductive age in developing countries.
- Over 300 million women in developing countries suffer from illness due to pregnancy, abortion, childbirth; 529,000 die each year.
- Lifetime risk of maternal death: Africa, 1 in 16; rich countries, 1 in 2,800.
New awareness of the plight of newborns

- Newborn mortality has long been underestimated:
  - 40% of under-five deaths occur in the first month;
  - 98% of these deaths happen in developing countries.
- 3.3 million stillbirths every year.
- The gap between rich and poor is widening.
Unequal progress in reducing neonatal mortality between 1995 and 2000


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Neonatal deaths by cause and WHO region in 2000

- Diarrhoeal diseases
- Neonatal tetanus
- Congenital anomalies
- Other neonatal
- Asphyxia
- Severe infection
- Preterm

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Factors hindering progress

<table>
<thead>
<tr>
<th>Decline of child mortality</th>
<th>More than two years of humanitarian crisis since 1992</th>
<th>Adult HIV prevalence rate (weighted average)</th>
<th>GDP per capita (weighted average 1990–2002 in 1995 international dollars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>93 countries are on track\textsuperscript{a}</td>
<td>3/93 countries</td>
<td>0.3</td>
<td>20 049 (OECD) 4179 (non-OECD)</td>
</tr>
<tr>
<td>51 countries are making slower progress\textsuperscript{a}</td>
<td>10/51 countries</td>
<td>0.7</td>
<td>2657</td>
</tr>
<tr>
<td>14 countries are in reversal</td>
<td>8/14 countries</td>
<td>10.2</td>
<td>1627 (excluding South Africa)</td>
</tr>
<tr>
<td>29 countries have stagnating mortality</td>
<td>11/29 countries</td>
<td>4.1</td>
<td>896</td>
</tr>
</tbody>
</table>

\textsuperscript{a}Towards MDG4.
Exclusion from care: lack of access, insufficient uptake, discrimination

- Brazil 1996
- Marginalization
- Massive deprivation
- Ethiopia 2000
- ≥ 4 antenatal care visits
- Birth in a health facility
- Skilled attendance at birth

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2. Programme strategies
The two meanings of "continuum of care"

- A continuum that spans life's beginnings:
  - from before conception to childhood through pregnancy, childbirth and infancy.

- A continuum that goes from:
  - the home (empowering families);
  - through the health centre (bringing care closer to home);
  - and, when needed, to the hospital (facilitating referral).
Great expectations: making pregnancy safer

The most important things to do

• Prevent unwanted pregnancies.
• Tackle the public health priority of unsafe abortions.
• Provide antenatal care to improve the health of mother and baby.
• Provide social support and legal protection.
Not every pregnancy is welcome

- 87 million unintended pregnancies per year.
- 46 million induced abortions per year.
- More than 18 million in unsafe circumstances, leading to 68,000 deaths, countless disabilities and untold suffering.

- Invest in education, information and contraceptive services.
- Guarantee access, to fullest extent permitted by law, to good-quality and responsive abortion and post-abortion care.
Antenatal care is a success story: uptake and demand are on the increase
Antenatal care is also a platform

- For other programmes: nutrition, HIV/AIDS, sexually transmitted infections, malaria, tuberculosis.
- For promoting healthy lifestyles and breastfeeding.
- For establishing a birth plan.
- For improving parenting skills.
- For stronger links between mothers and health services during and after childbirth.
Complications of childbirth

• Complications cannot be predicted: all mothers must be attended.
• Midwives and other professionals with midwifery skills can avert, contain or solve many of the life-threatening problems that may arise during childbirth – but they need the back-up of a hospital.
Skilled attendance at birth saves mothers and babies
Neonatal mortality is lower when mothers benefit from antenatal and childbirth care

Data source: Demographic and Health Surveys.

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Newborn care

- Pregnancy care.
- Skilled care at birth.
- Care for newborns with complications.
- Parenting skills and care in the home.
- Bridging the handover between maternal and child health services.
# First-level and back-up care

<table>
<thead>
<tr>
<th></th>
<th>First-level maternal and newborn care</th>
<th>Back-up maternal and newborn care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Defining feature</strong></td>
<td>Close to client: demedicalized and with respect for birthing cultures, but provided by professionals</td>
<td>Referral-level technical platform to deal with surgical and other complications</td>
</tr>
<tr>
<td><strong>For whom?</strong></td>
<td>For all mothers and newborns</td>
<td>For mothers and newborns who present problems that cannot be solved by first-level care</td>
</tr>
<tr>
<td><strong>By whom?</strong></td>
<td>Best by midwives: alternatively by doctors or by doctors and nurses if correctly trained and skilled</td>
<td>By a team that includes gynaecologists-obstetricians and paediatricians; alternatively by appropriately trained doctors or mid-level technicians</td>
</tr>
<tr>
<td><strong>Where?</strong></td>
<td>Preferably in midwife-led facilities: also in all hospitals with maternity services</td>
<td>In all hospitals</td>
</tr>
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</table>
## Benchmarks for newborn and maternal care services

<table>
<thead>
<tr>
<th>Population</th>
<th>Typical district</th>
<th>100 000 – 120 000</th>
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<tbody>
<tr>
<td><strong>Workload</strong></td>
<td></td>
<td></td>
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<tr>
<td>Pregnancies to attend</td>
<td></td>
<td>3000 – 3600</td>
</tr>
<tr>
<td>Births to attend</td>
<td></td>
<td>3000 – 3600</td>
</tr>
<tr>
<td>Postpartum women to attend</td>
<td></td>
<td>3000 – 3600</td>
</tr>
<tr>
<td>Women requiring back-up care (7%)</td>
<td></td>
<td>210 – 250</td>
</tr>
<tr>
<td>Of which surgical cases (2 - 3%)</td>
<td></td>
<td>60 – 110</td>
</tr>
<tr>
<td>Newborns to attend</td>
<td></td>
<td>3000 – 3600</td>
</tr>
<tr>
<td>Newborns requiring back-up care (9 - 15%)</td>
<td></td>
<td>270 - 550</td>
</tr>
<tr>
<td><strong>Resources needed</strong></td>
<td>Professionals with midwifery skills</td>
<td>20 midwives organized into 2 - 3 teams, one of which at the district hospital</td>
</tr>
<tr>
<td>Doctors with obstetric/ gynaecological/ paediatric skills</td>
<td>Minimum 3 part-time to provide 24-hour cover at district hospital</td>
<td></td>
</tr>
<tr>
<td>Facilities</td>
<td>60 - 90 beds between hospital and birthing facilities</td>
<td></td>
</tr>
<tr>
<td>Enabling environment</td>
<td>Managerial support, drugs, lab tests, equipment, transport and communication systems</td>
<td></td>
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Scaling up coverage of maternal and newborn health care and services will cost

- US$ 39 billion over 10 years, in addition to current health expenditure on maternal and newborn health.
- US$ 1 billion in 2006; increasing to US$ 6.1 billion in 2015.
- An additional US$ 0.22 per inhabitant per year initially, expanding to US$ 1.18 in 2015.
Cost, additional to current expenditure, of moving towards universal coverage

- Renumeration of service providers
- Drugs, supplies and lab tests
- Investment in the health system
- Programme costs
Redesigning child care: survival, growth and development

- Single-issue programmes: great successes, great limitations (examples: EPI, ORT).
- Shift in focus now from diseases to children.
- Increased recognition of power of family actions and care for development.
- Move towards integration: of interventions and service delivery.
What do children die of today?

- Most deaths are due to a handful of conditions.
- Causes vary among regions.
- Effective, affordable interventions: available, but coverage too low.
- Need to move towards universal access to meet MDG4.

*Totals are more than 100% due to rounding.
Integrated Management of Childhood Illness (IMCI): a viable strategy

- Simple set of affordable, effective interventions that addresses main killers plus developmental needs.
- Integration at three levels of care (patient, point of delivery, system).
- Improves health worker skills, health system support, counselling and problem solving.
- Builds partnerships between parents and health workers to empower families.
Proportion of districts where training and system strengthening for IMCI had begun by 2003\textsuperscript{a}
Scaling up coverage of child health interventions will cost

- US$ 52 billion over 10 years, in addition to current child health expenditure.
- US$ 2 billion in 2006; increasing to US$ 8 billion in 2015.
- An extra outlay of around US$ 0.47 per inhabitant per year initially, expanding to US$ 1.48 in 2015.
- Single greatest cost: human resources.
Cost of scaling up child health interventions to full coverage, additional to current expenditure

- 21 countries with major constraints, long lead time
- 23 countries with fewer constraints, short lead time
- 18 countries that require no lead time
- 13 countries whose health systems allow for rapid scale up
- All countries
3. System and policy implications
Reconciling MNCH with health systems development

- Strategies that cross boundaries between maternal, newborn and child programmes.
- Synergies between MNCH programmes and environmental protection, gender equality and poverty reduction.
- Links between MNCH programmes and core health systems development processes with investment plans that:
  - overcome the systemic constraints on scaling up;
  - embed MNCH in an overriding project of ensuring universal coverage.
Universal coverage

- Universal access requires:
  - sufficient supply of services;
  - no financial barriers to uptake of services.
- Protection against financial consequences:
  - more than 100 million individuals in the world each year are pushed into poverty as a result of spending money on health care.
Organizing the financing of the health sector for universal coverage

• Shift from user fees to pre-payment and pooling.

• Consider all sources of funding:
  - Both domestic and international funding;
  - Need for increased public spending.

• Start to build national health insurance schemes (tax-based, social health insurance, mixed systems) from very early stage:
  - to develop institutional capacity;
  - to make funding more predictable and sustained.

• Keep MNCH at core of package of benefits.
The human resources crisis

• Shortages after years of insufficient production, downsizing, caps on recruitment, frozen salaries, losses to migration and HIV/AIDS, social and economic crises.
• Skill-mismatch mismatch.
Making up for the shortages

• In the next 10 years, 75 countries need:
  - at least 334 000 additional midwives (or professionals with midwifery skills);
  - upgrading of 140 000 existing professionals providing first-level care;
  - upgrading of 27 000 doctors and technicians to provide back-up care;
  - deployment of 100 000 multipurpose professionals backed up by millions of community health workers, plus specialized referral-level personnel to scale up child health care activities.
The human resources crisis is not just a question of numbers

- Inadequate pay and crisis of morale:
  - dual practice;
  - predatory behaviour.
- Fuels exclusion (diminishes trust).
- HRH fraction of scale-up costs (US$ 35 billion) needs to be multiplied by factor ??.
- Take immediate corrective measures.
Rehabilitating the workforce

• Prevent further harm – limit donor-related destabilization.
• Planned expansion of the workforce on the basis of a political consensus.
• Pool funding flows to ensure more sustained and predictable financing.
• Make the human resources crisis a national and global priority.
The report comes with a set of policy briefs to help prepare next steps.
A political agenda

• Build national consensus with:
  - mechanisms for predictable, sustained and increased funding;
  - MNCH at core of health entitlements;
  - human resources as national priority.

• Partnerships with civil society:
  - to establish accountability mechanisms;
  - to maintain political momentum.

• Accelerate scale-up towards universal coverage.

• WHR 2006 on human resources for health.