

The World Health Report 2005

**Make every mother
and child count**



World Health Organization

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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- 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.

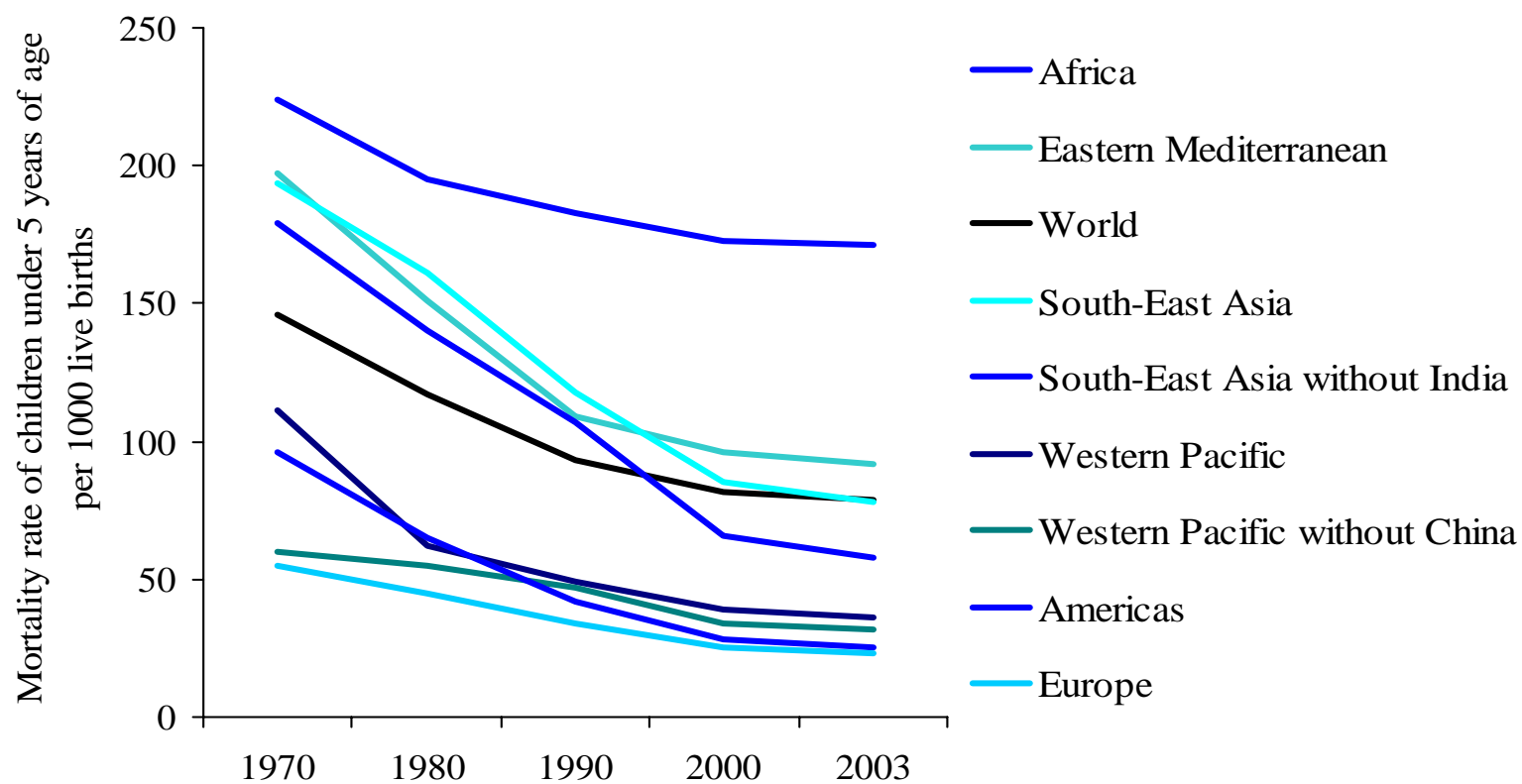


Evolution of maternal and child health

- 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 ...



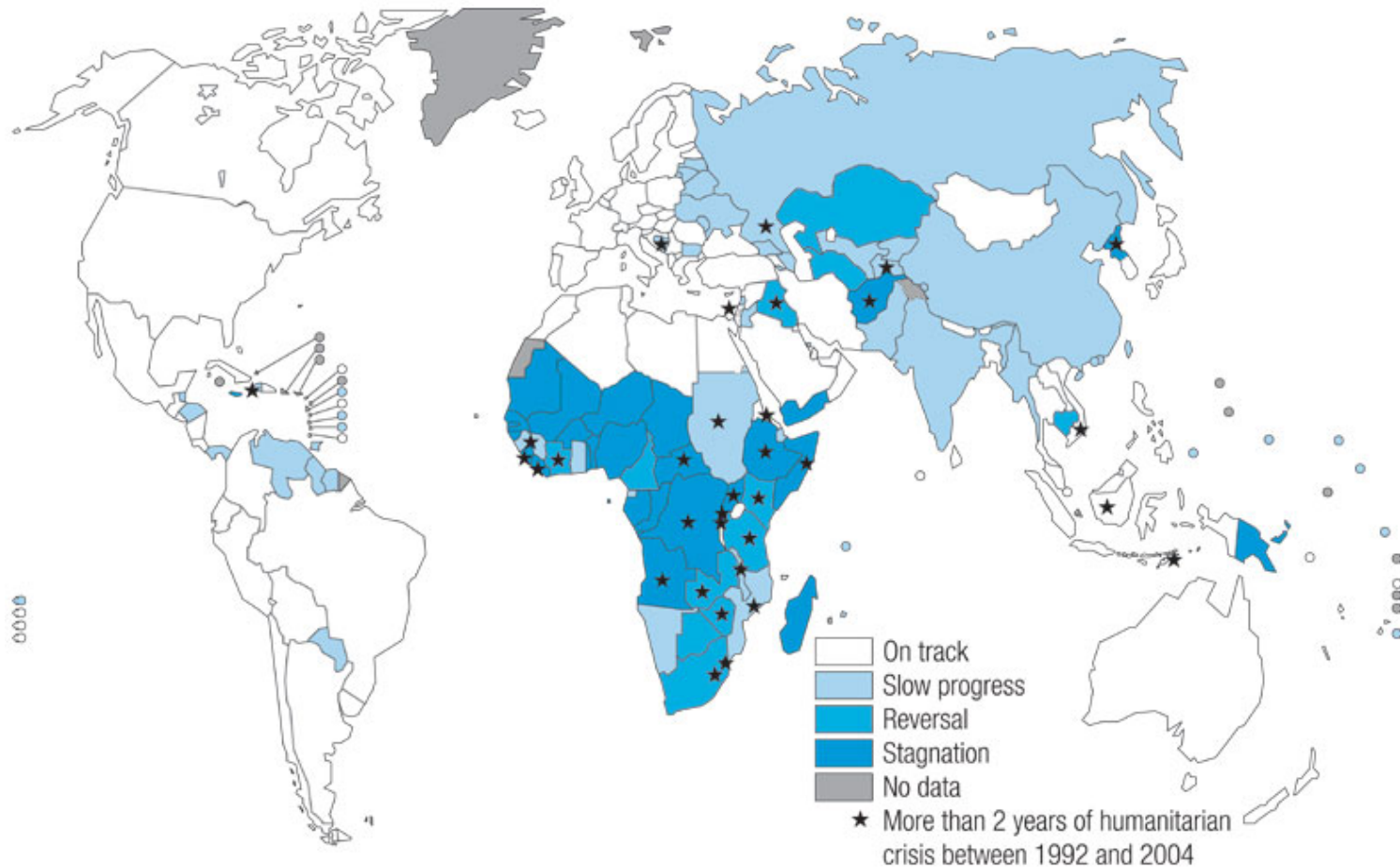
... and is unequally distributed

Child mortality

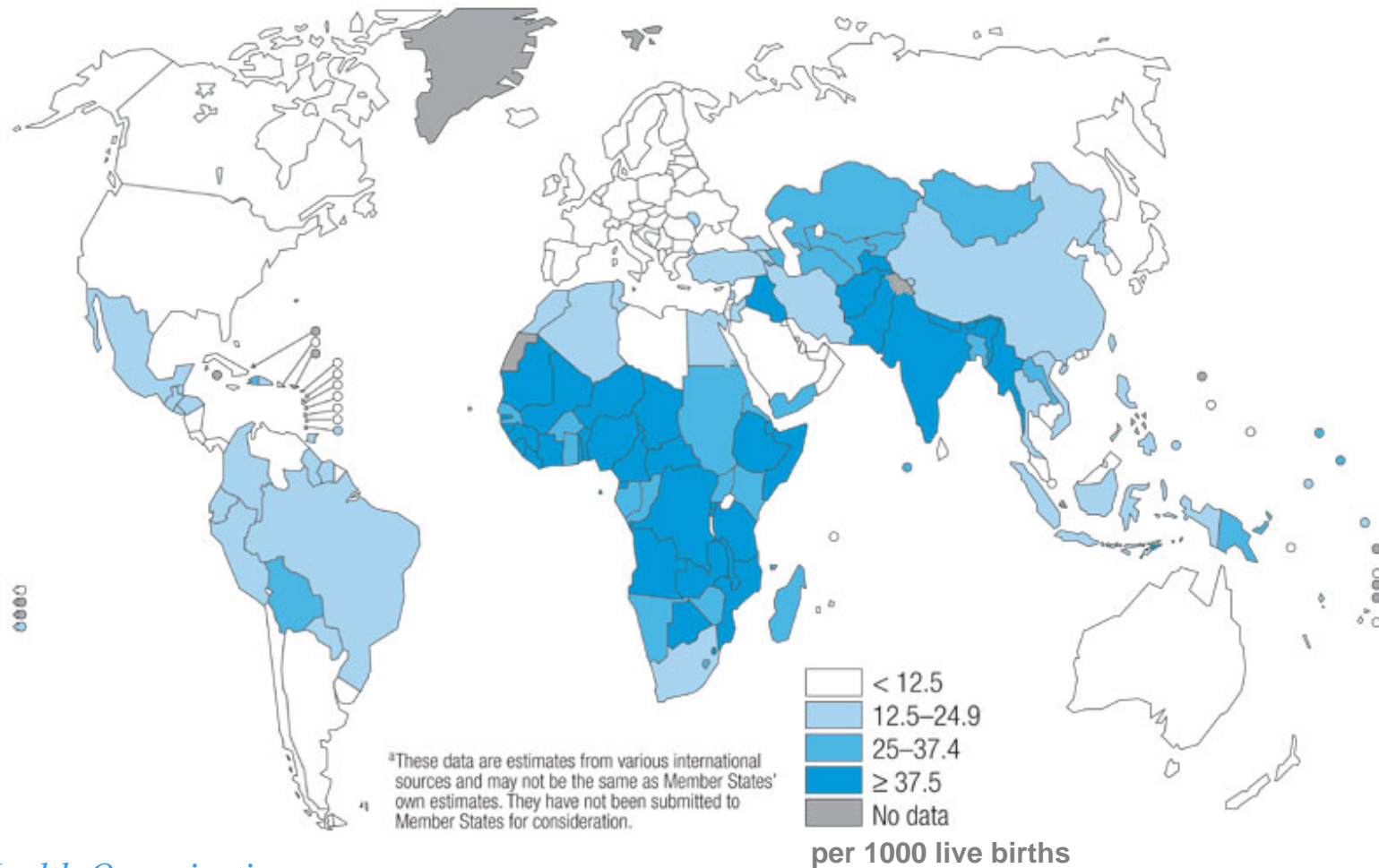
- 93 countries (40% of world's population): on track towards 2/3 reduction by 2015 (MDG4).
- 51 countries (48%): slow progress.
- 43 countries (12%): stagnation or reversal.



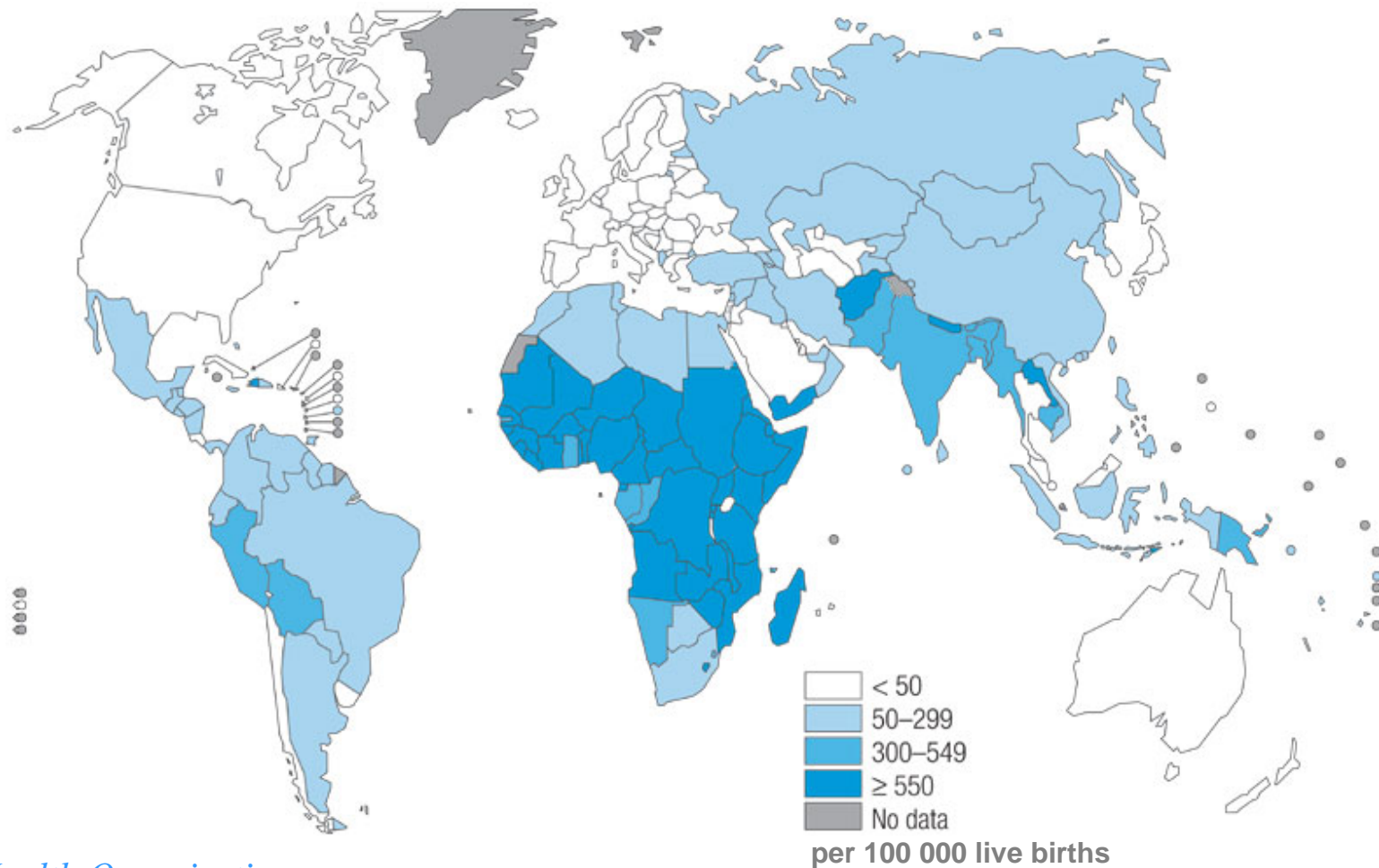
Reduction of under-5 mortality, 1990–2003



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 2800.

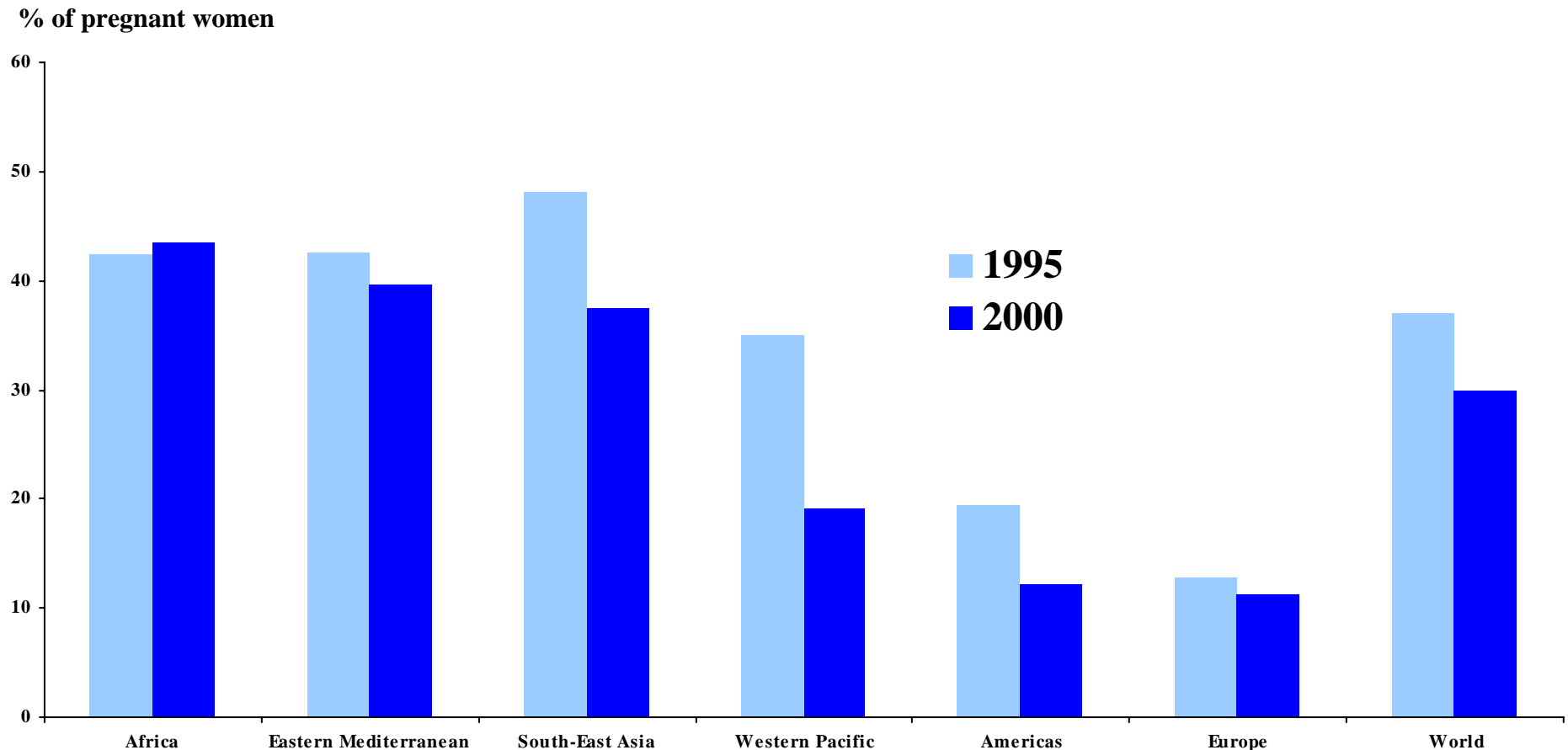


New awareness of the plight of newborns

- 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.



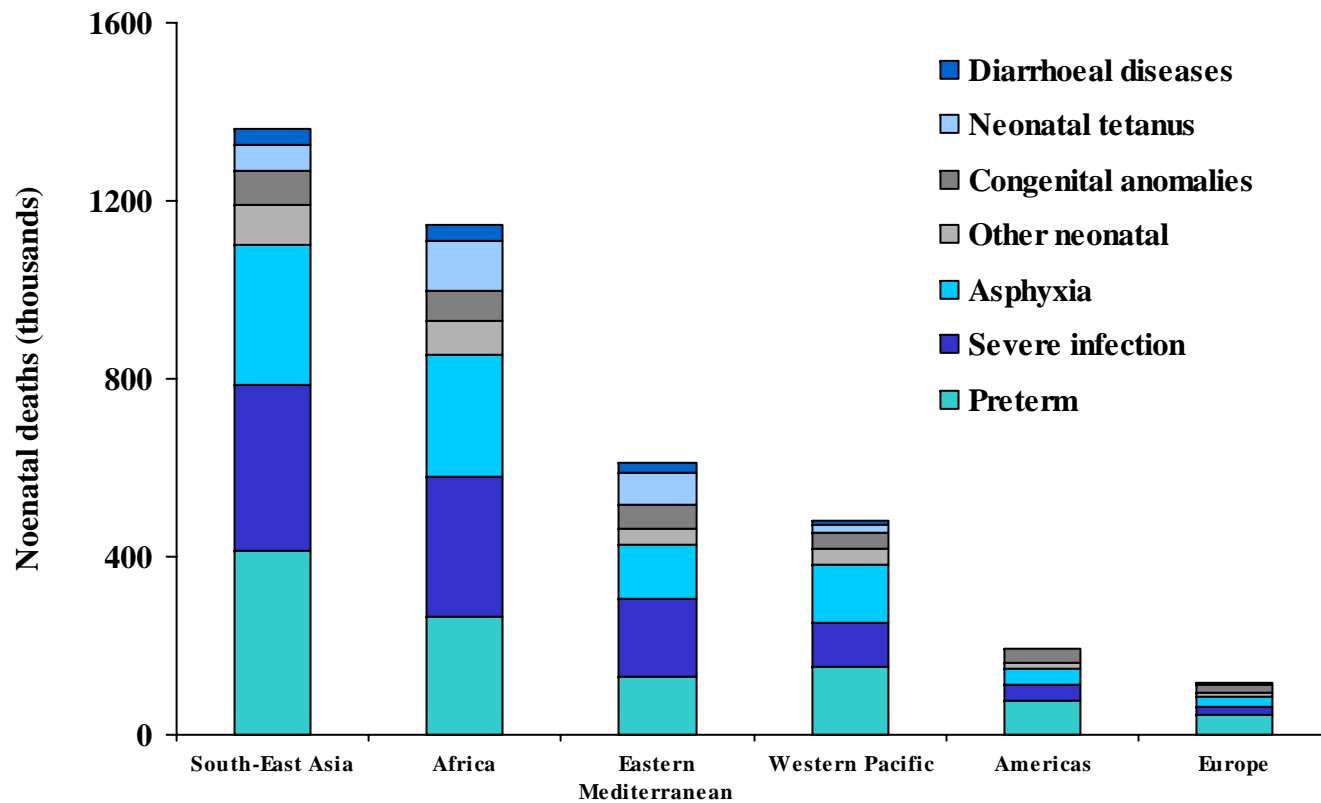
Unequal progress in reducing neonatal mortality between 1995 and 2000^a



^a Methods of calculation differed slightly in 1995 and 2000.



Neonatal deaths by cause and WHO region in 2000



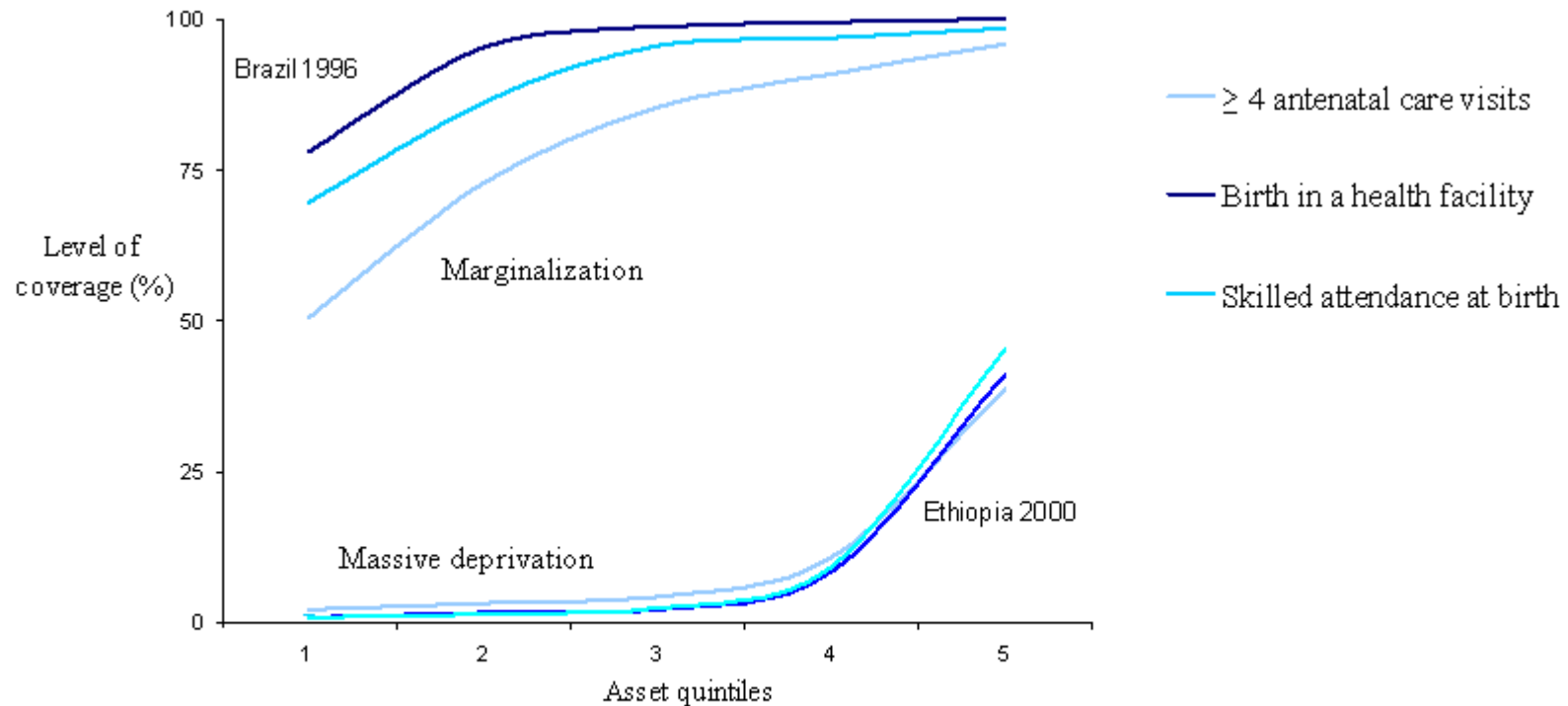
Factors hindering progress

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

^a Towards MDG4.



Exclusion from care: lack of access, insufficient uptake, discrimination



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.

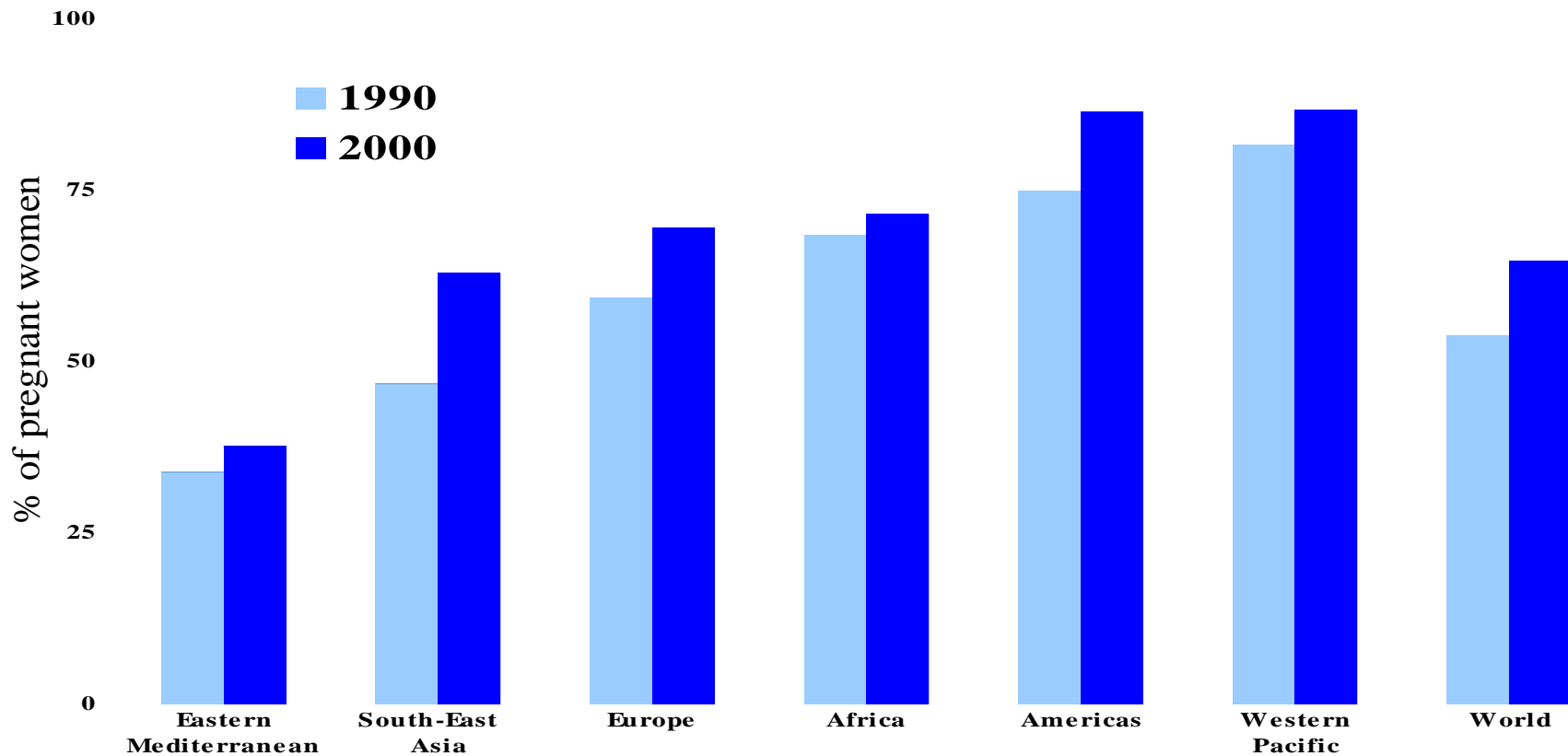


Not every pregnancy is welcome

- 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.

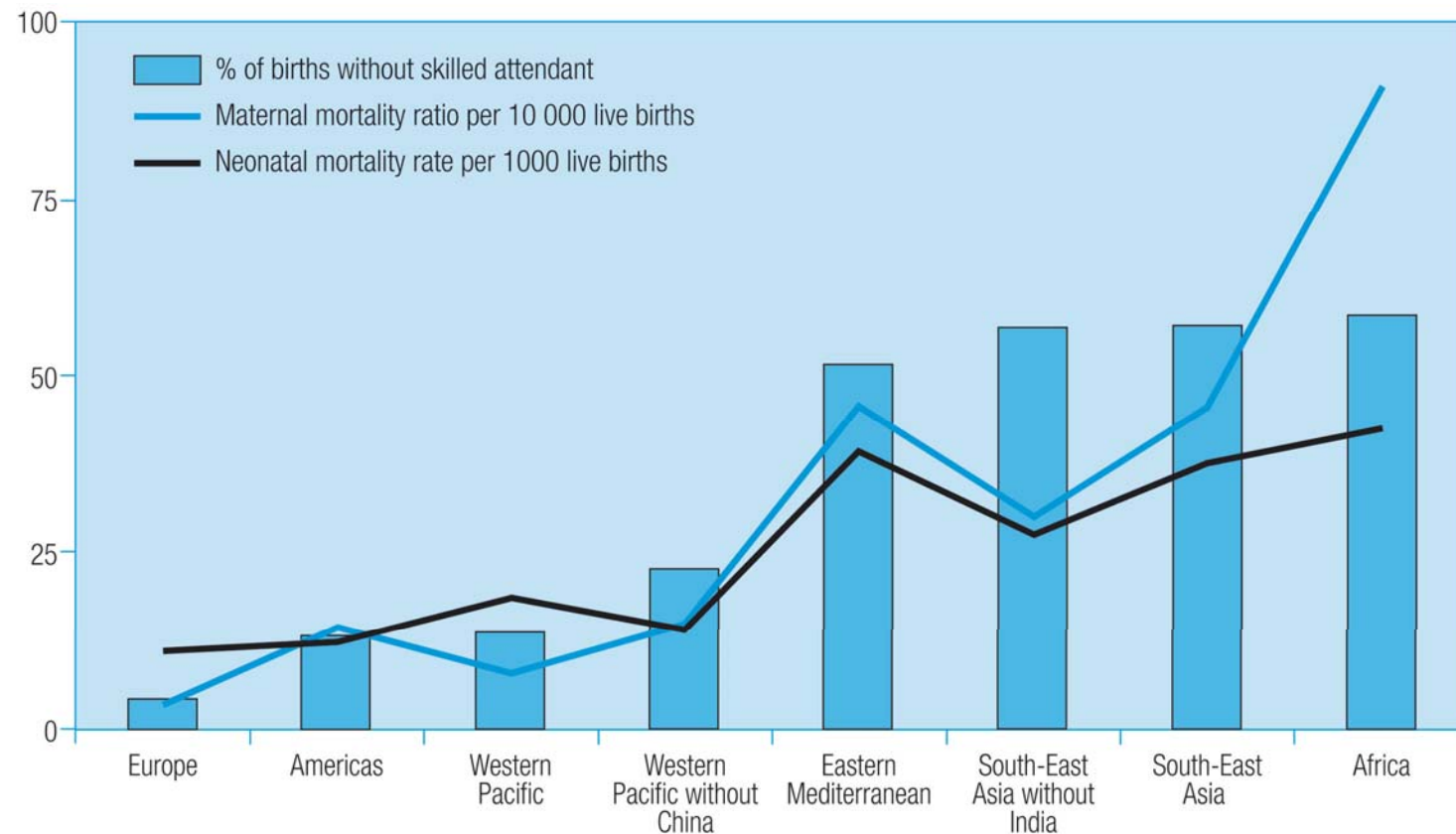


Complications of childbirth

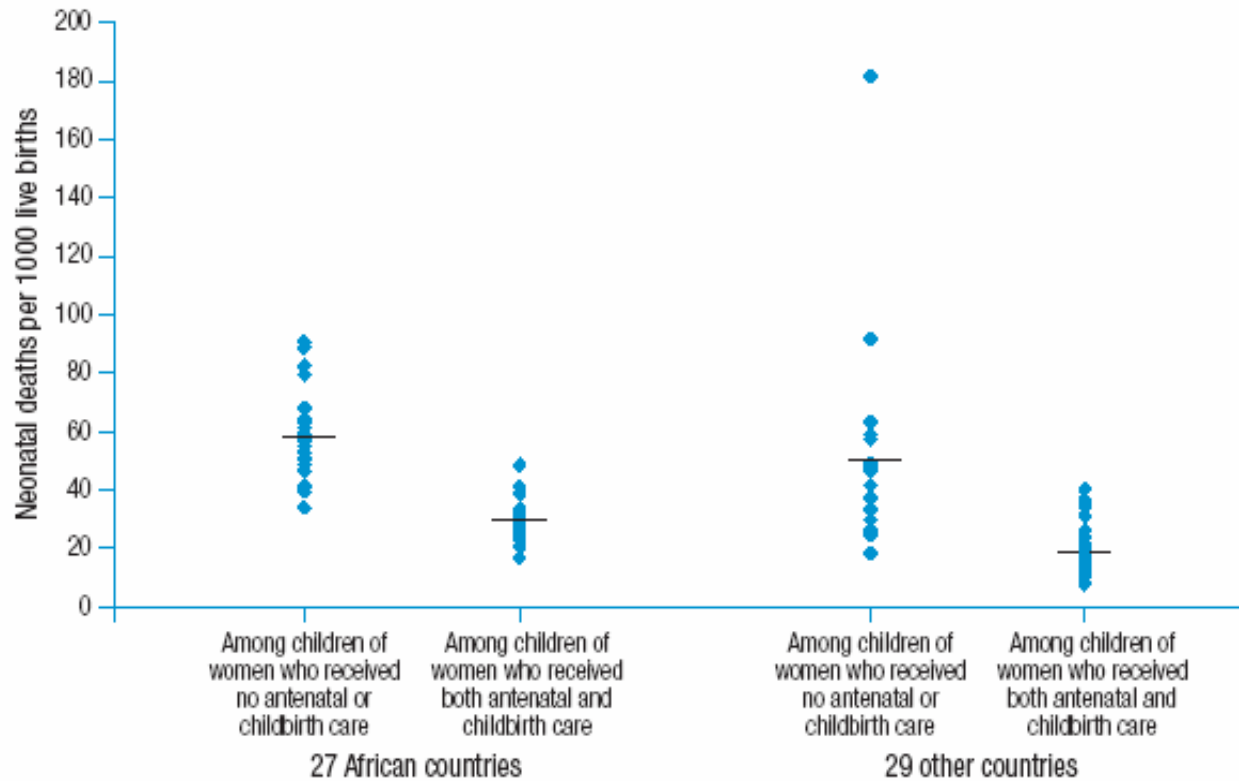
- Complications cannot be predicted: all mothers must be attended.
- Midwives and other professionals with midwifery skills can avert, contain or solve many of the life-threatening problems that may arise during childbirth – but they need the back-up of a hospital.



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.



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

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



Benchmarks for newborn and maternal care services

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

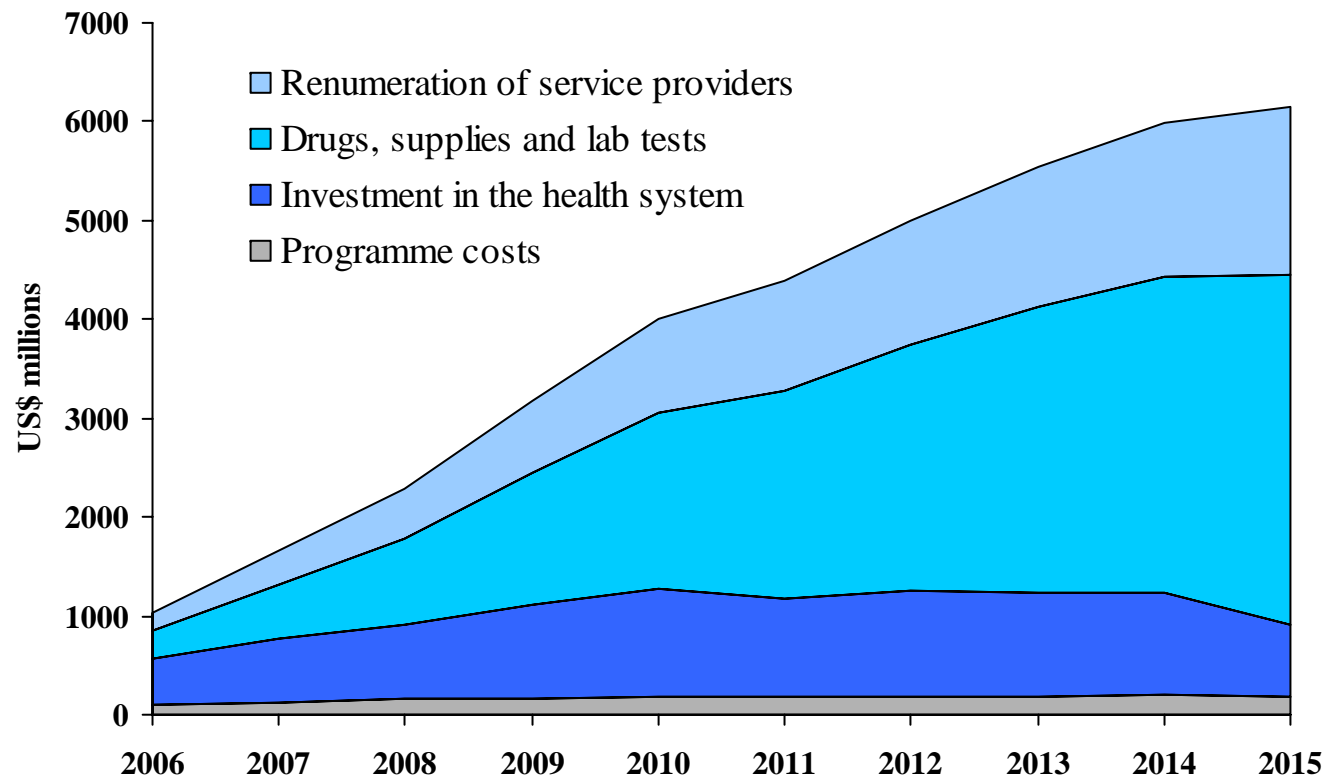


Scaling up coverage of maternal and newborn health care and services will cost

- 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



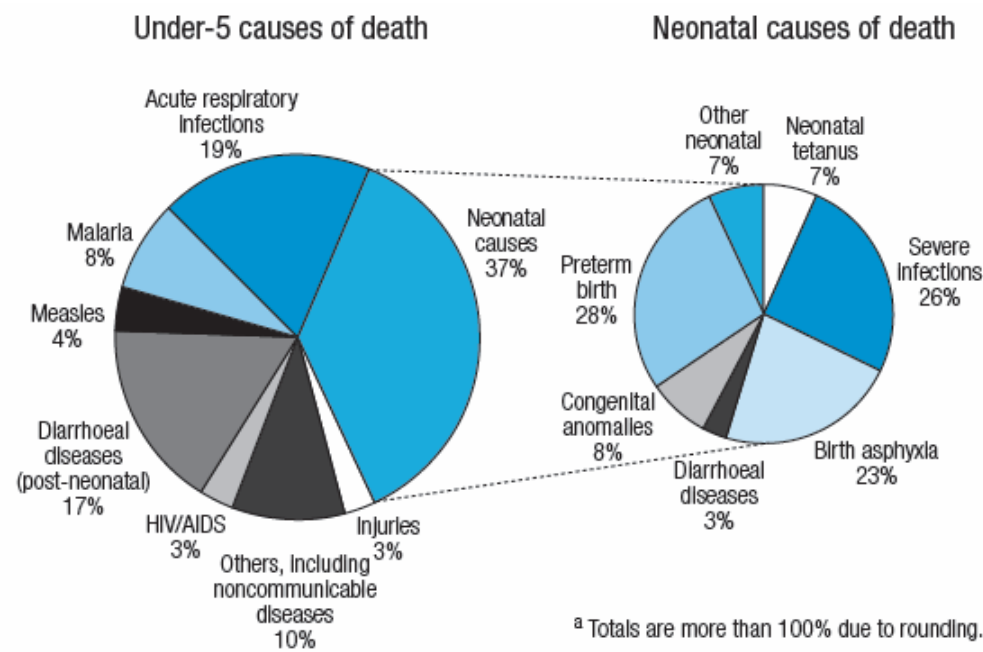
Redesigning child care: survival, growth and development

- 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.



^a 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.

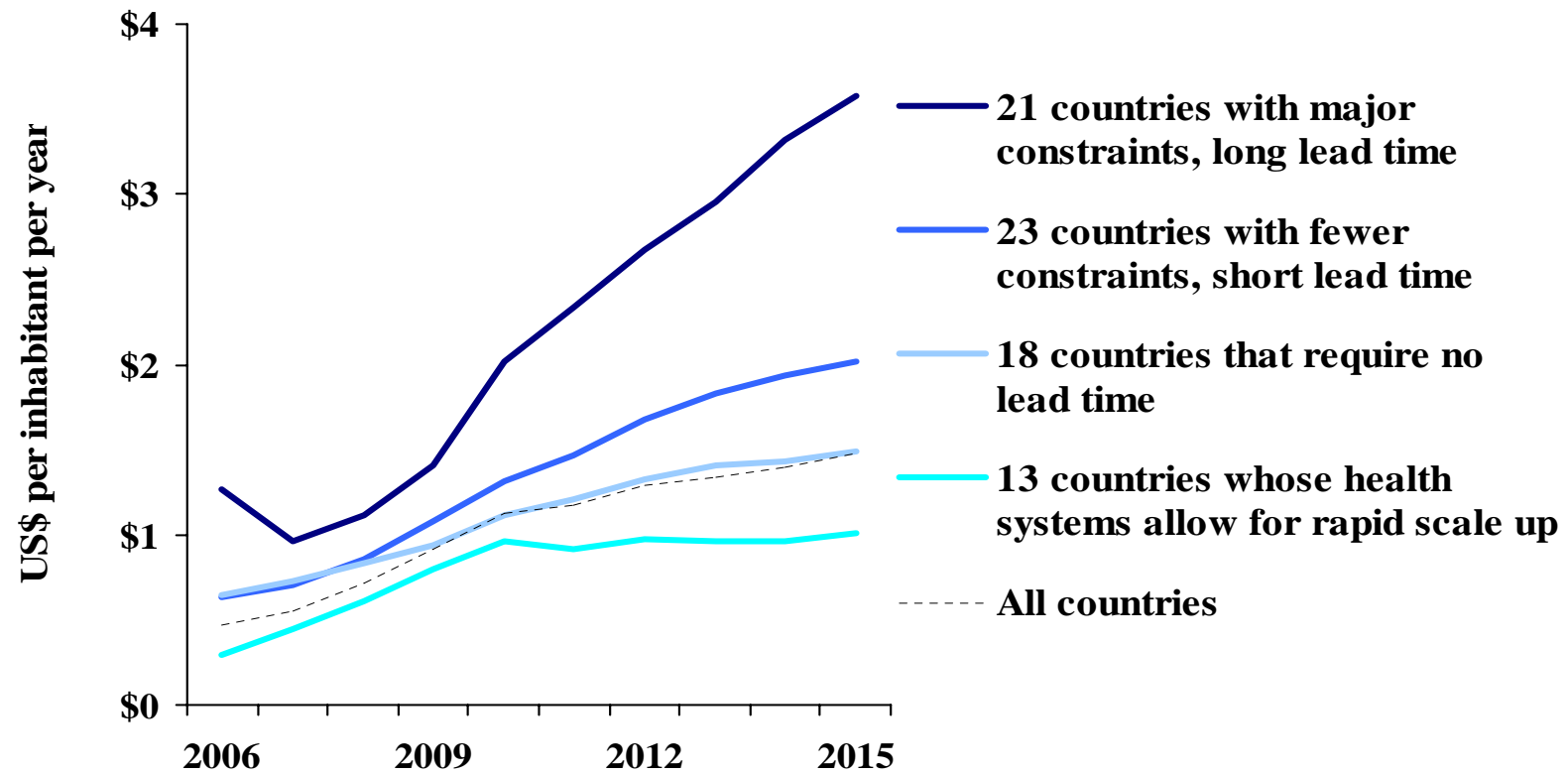


Scaling up coverage of child health interventions will cost

- 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



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.



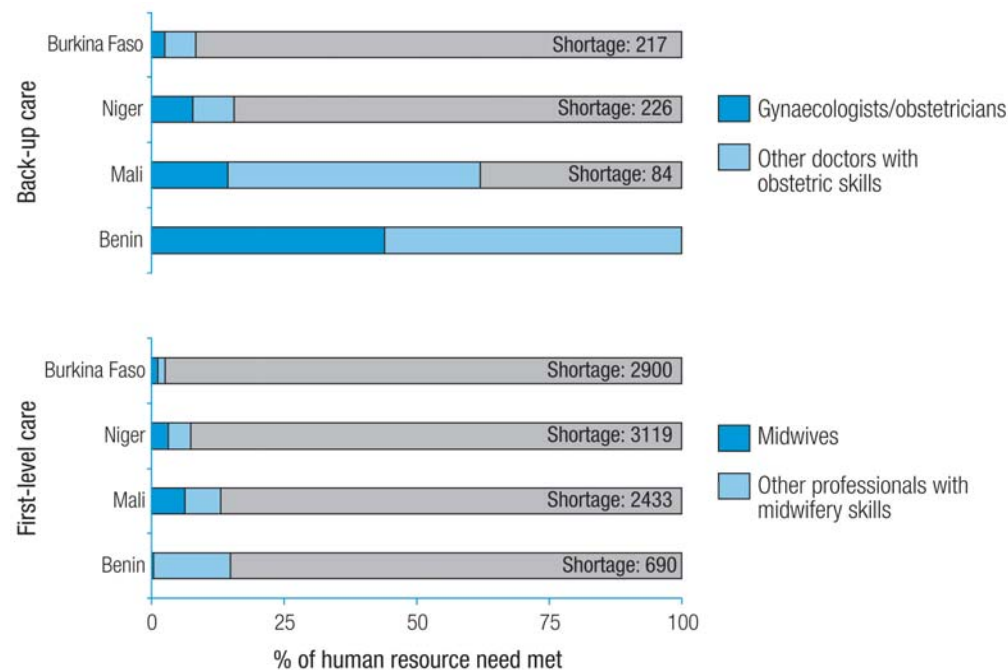
Organizing the financing of the health sector for universal coverage

- 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-mix 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.

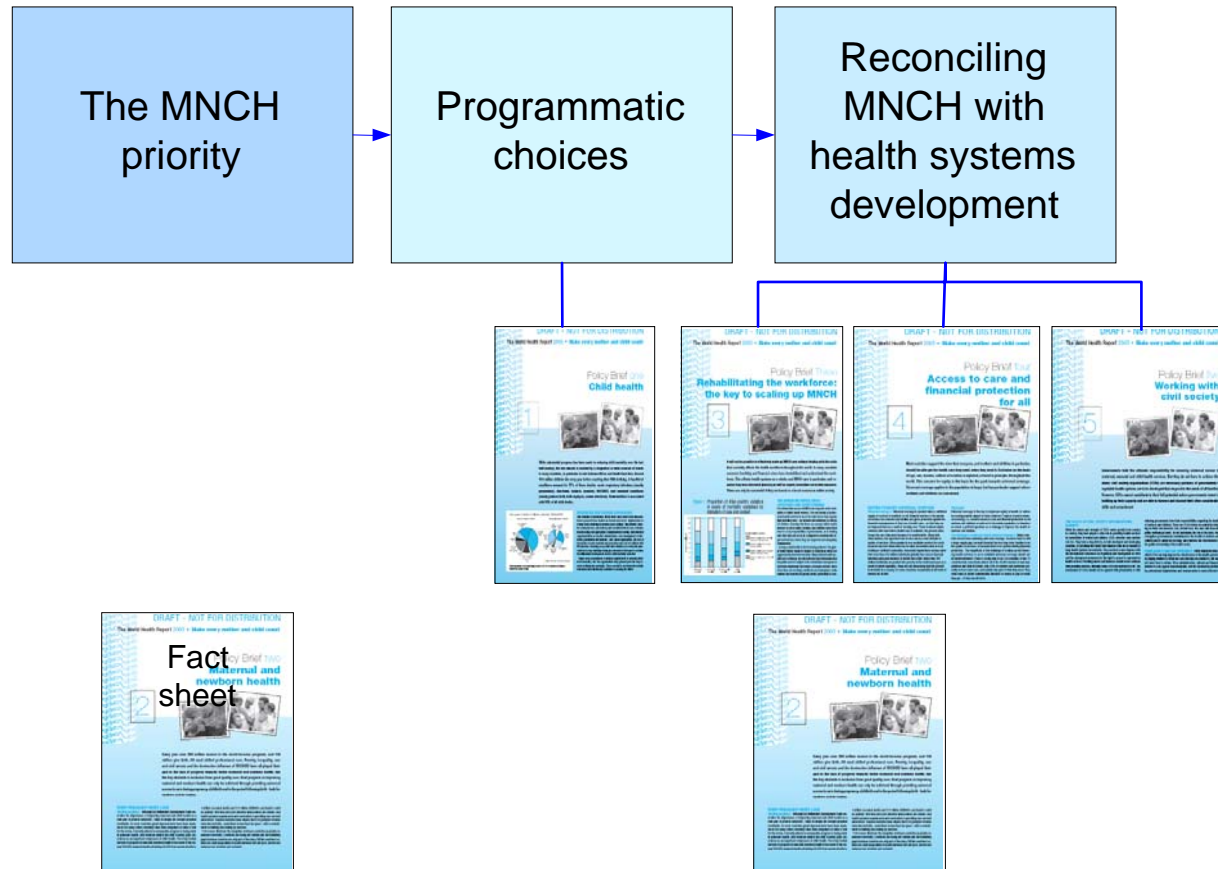


Rehabilitating the workforce

- 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.**

