World Health Organization

Policy brief one

Integrating maternal, newborn and child health programmes

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This year's World Health Report comes at a time when only a decade is left to achieve the MDGs. Poverty, inequality, war and civil unrest, and the destructive influence of HIV/AIDS have all played their part in the lack of progress towards better health for mothers and children, but the key obstacle is exclusion from good quality care.

TACKLING EXCLUSION

Rising demand and expectations ▸ Families in poor communities, and women in particular, know all too well that access to health care is important. They are increasingly demanding better care for their babies and children, and for themselves as well. They rightfully expect their governments to guarantee their access to care. These expectations now constitute a political reality and there are political costs for those who ignore the call.

Too many remain excluded ▸ The reasons for exclusion from access to care are multiple. Services may simply be unavailable, or women may find it difficult to access them because of their gender or because of barriers generated by poverty, race, language and culture, uncertainty about what care will cost them, or the awareness that it will be too expensive, deters many from accessing care that may prove vital. Even for people who do manage to use services, what is offered can be untimely, ineffective, unresponsive or discriminatory – and is often catastrophically expensive.

Too little progress ▸ The results are often fatal. Every year 529 000 women die from pregnancy-related causes, including a staggering 68 000 from unsafe abortion alone. 10.6 million children do not reach their fifth birthday. This number includes 4 million babies who die before they are one month old, but not the 3.3 million babies that are stillborn. Progress in tackling this situation is too slow and too patchy. In a few countries great improvements have been made, but in many others mortality rates have stagnated or taken a turn for the worse. Currently almost no measurable progress is being made in maternal health, and newborn health has until recently gone unnoticed as an important component of child health. The irony behind this lack of progress is that most of the deaths could be avoided since the life saving interventions are well known and can be implemented on a large scale, including in resource poor settings. The main problems are not technical, but operational: choosing the right strategies for programmes to go to scale with and overcome the constraints that hamper the development of effective health systems.

CHOOSING THE RIGHT PROGRAMME STRATEGIES

Building the continuum of care ▸ The core principle underlying the strategies to develop MNCH programmes is the "continuum of care". Confusingly, this expression has two meanings. First, it means care has to be provided as a continuum throughout the life cycle, including adolescence, pregnancy, childbirth and childhood. Second, it indicates that care has to be provided in a seamless continuum that spans the home, the community, the health centre and the hospital. Understanding these two dimensions of the continuum of care has profound consequences for the way programmes are organized.

Care during pregnancy ► Antenatal care is vital for both mother and baby. It has been a major success story, with rising demand and uptake of services throughout the world. Yet there continues to be a need for improving quality, responsiveness and coverage. More can be made of the potential of antenatal care by using it as a platform to promote healthy lifestyles and family planning as well as for programmes that tackle malnutrition, HIV/AIDS, sexually transmitted infections, malaria and tuberculosis. Antenatal care also has to lay the basis for continued care during and after childbirth, by building a relation of trust between mother and health services, by planning for giving birth in safe circumstances and by helping the family prepare for good parenting. But a good outcome of pregnancy starts before conception, among others by preventing early or unwanted pregnancies. There remains a huge unmet need for investment in information, in education and in access to family planning. The unacceptably high levels of unsafe abortion constitute a major public health problem. The deaths and disabilities that go with unsafe abortion can all be avoided: this is not only a question of how a country defines what is legal and what is not, but also of guaranteeing women access – to the fullest extent permitted by law – to good quality abortion and post abortion care.

Skilled, professional care at childbirth ► The countries that have successfully managed to make childbirth safer have one thing in common: they chose the path of providing access to professional skilled care before, at and after childbirth. As the complications that will occur during childbirth cannot be predicted and may very rapidly become fatal, all women and babies without exception need the care that only midwives, nurse-midwives, doctors or other professionals with midwifery skills can give. This means professional first level childbirth care has to be available 24 hours per day, every day, to attend to all mothers and newborns, with the back-up of a hospital that can provide referral level care 24 hours per day, every day for those who need it. Table 1. summarises what the World Health Report says is needed to provide such care to all mothers and their babies.

The days and weeks after birth ► Large gains in maternal health can be made by improving care during the postpartum, a period that has traditionally been neglected. The professionals attending to childbirth all too often neglect the fact that the hours, days and weeks after childbirth remain a critically dangerous period, for both mother and newborn. Child health programmes, on the other hand, have only recently begun to tackle the specific health problems of newborns. The importance of bridging the postnatal and postpartum gap cannot be overstated: it is a period during which up to 70 percent of all maternal deaths occur, and up to 40 percent of all deaths of children below the age of 5. The postnatal and postpartum period is the period where the continuum of care is most often interrupted, because there is often no clear delineation of professional responsibilities. In many settings there are simply no mechanisms for establishing communication and handover between maternal and child programmes. The adjustment of programmes to bridge this gap is then a priority. It requires a mix of approaches, from the improved care of newborns within the home, through home visits by health workers, better uptake of services in case of problems and referral when needed.

Integrated and holistic child care ► For all their impressive results, the inherent limitations of the vertical approaches of earlier decades have now become apparent, at a time when parents as well as health professionals realise that there is a need for a more comprehensive view of the needs of the child. Survival is the priority, but the aim is a healthy child that grows and develops harmoniously. The response to this new awareness is to integrate care – starting with limited integration such as through the Immunisation Plus strategy, or more ambitious integration

Table 1 District benchmarks for annual maternal-newborn care needs

Population	Typical district	100,000 - 120,000
Workload	Pregnancies to attend	3,000 - 3,600
	Births to attend	3,000 - 3,600
	Postpartum women to attend	3,000 - 3,600
	Women requiring back-up care (7%)	Approx 210 - 250
	Surgical cases (2 - 3%)	60 - 110
	Newborns to attend	3,000 - 3,600
	Newborns requiring back-up care (9 - 15%)	270 - 550
Resources needed	Professionals with midwifery skills	20 midwives organised 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

by packaging a set of simple, affordable and effective interventions for the combined management of the childhood illnesses and malnutrition under the label of "Integrated Management of Childhood Illness" (IMCI). IMCI combines interventions not only for preventing deaths, taking into account the changing profile of mortality causes, but also for improving children healthy growth and development. More than just adding more programmes to a single delivery channel it has sought to transform the way the health system looks at child care by shifting its focus from health centres alone to a continuum of care that implicates families and communities, health centres, and referral-level hospitals. IMCI has now been adopted by more than 100 countries, but its implementation is often still quite limited. The reality is that today many children do not benefit from such comprehensive and integrated care. As child health programmes continue to move towards integration, they also need to move from small-scale projects to universal access.

SCALING UP TO FULL COVERAGE OF EFFECTIVE CARE WILL REQUIRE EXTRA FUNDS

The World Health Report 2005 estimates that within 10 years it is feasible, in the 75 worst affected countries of the world, to reach all children and three quarters of all mothers and babies with the priority child health interventions and with the full range of the interventions that are effective during pregnancy, childbirth and the postpartum. In most of these countries, this would achieve or go beyond the MDG set for child health and reach or come close to the MDG set for maternal health. According to the latest available data, public expenditure on health in these countries is currently around US$ 97 Billion per year, i.e. approximately US$ 22 per inhabitant. To achieve the increase in coverage would require an extra expenditure of US$ 0.69 per inhabitant in 2006, increasing, as coverage expands, to US$ 2.66 in 2015 – a total of, on the average, US$ 9 billion per year over the coming 10 years. These sums are however a low-end estimate of what is needed and the efforts would need to continue to grow afterwards the initial 10-year period until universal coverage is reached for all women, newborns and children. The additional efforts required vary considerably from country to country, but on the whole will require substantial additional efforts from both countries and the international community.

POLICY RECOMMENDATIONS

Upgrade skills, delegate tasks and redefine responsibilities ► The shortage of human resources calls for pragmatic solutions. For example, a lack of obstetricians or anaesthesiologists for obstetric surgery can be corrected for by relying on purposefully trained general practitioners or mid-level technicians; or where nurses are in short supply, many of the priority interventions to treat children can be delegated to non-professional workers or volunteers – again after specific training and with the necessary back-up. But these providers also need to be able to practice in a regulated environment. All too often health professionals are or are not trained to their full potential, or when they are, not allowed to put the full range of their skills into action: allowing midwives or nurses to treat women with oxytocin, for example, which they are perfectly able to do, can save many lives. Governments need to put the legal and regulatory arrangements into place that can accelerate the scaling up of MNCH care. They have to do this in collaboration with professional organizations to keep all the professional constituencies on board.

Make skilled care the centrepiece of the MNCH strategy ► Where there is a large human resource base of health professionals, any remaining shortages should be corrected and skill mixes adapted to the needs. In some countries however, the shortages are such that the task ahead may seem overwhelming. The shortcut of relying on non-professionals may then seem attractive, particularly for child care where some of the tasks can be delegated to less skilled workers or trained non-professionals. Such shortcuts are faster in bringing care closer to the people, but may not lead to the expected results in mortality reduction. In any case it is important to focus on long term strategies built around skilled, professional care, and to make sure that investment in intermediate short term solutions will not be at the expense of investment in the future.

Roll out the whole MNCH continuum, district per district ► To maximise the synergies of empowerment, good home care, first-level services – such as those provided by midwives for pregnant women, or by multipurpose health workers for children – and hospital care, all these layers of care must be rolled out in parallel. To concentrate on one of these layers at the expense of the others is no longer acceptable. This often means building – and financing - integrated district health systems on a district per district basis.

Reconcile MNCH programmes with health system development ► All too often the world of MNCH programmes is far removed from that of health systems. Governments have to establish concrete and functional links between the programmes and the core health system development processes. To do this, the planning of MNCH scale up efforts has to be integrated in comprehensive health sector investment plans and budgets. First, to ensure that MNCH care and its specific requirements remain at the core of the health system's agenda. Second, to ensure that efforts to scale up MNCH are not limited to increase the supply of services, but that financial and other barriers to access are eliminated and that mothers and children are protected from catastrophic expenditure. Third, to make sure that synergies are developed with the wider agenda of the fight against gender discrimination, poverty and exclusion.

Take legal and regulatory measures to protect the rights of women and children ► Human rights treaties place legal obligations on countries to take measures to ensure that the rights of children and women are protected. For governments this means not only guaranteeing entitlements to care, but also introducing and implementing laws and policies to, for example, establish a minimum age for marriage, criminalise violence against women, prohibit female genital mutilation or enforce birth registration. It also means protecting pregnant women in the workplace and putting systems into place that protect women, their babies and their children against over-medicalisation and financial exploitation by unscrupulous providers.

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