overview

The World Health Report 2005

Make every mother and child count

World Health Organization

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message from the director-general

Parenthood brings with it the strong desire to see our children grow up happily and in good health. This is one of the few constants in life in all parts of the world. Yet, even in the 21st century, we still allow well over 10 million children and half a million mothers to die each year, although most of these deaths can be avoided. Seventy million mothers and their newborn babies, as well as countless children, are excluded from the health care to which they are entitled. Even more numerous are those who remain without protection against the poverty that ill-health can cause.

Leaders readily agree that we cannot allow this to continue, but in many countries the situation is either improving too slowly or not improving at all, and in some it is getting worse. Mothers, the newborn and children represent the well-being of a society and its potential for the future. Their health needs cannot be left unmet without harming the whole of society.

Families and communities themselves can do a great deal to change this situation. They can improve, for example, the position of women in society, parenting, disease prevention, care for the sick, and uptake of services. But this area of health is also a public responsibility.

Public health programmes need to work together so that all families have access to a continuum of care that extends from pregnancy (and even before), through childbirth and on into childhood, instead of the often fragmented services available at present. It makes no sense to provide care for a child while ignoring the mother's health, or to assist a mother giving birth but not the newborn child.

To ensure that all families have access to care, governments must accelerate the building up of coherent, integrated and effective health systems. This means tackling the health workforce crisis, which in turn calls for a much higher level of funding and better organization of it for these aspects of health. The objective must be health systems that can respond to these needs, eliminate financial barriers to care, and protect people from the poverty that is both a cause and an effect of ill-health.

The world needs to support countries striving to achieve universal access and financial protection for all mothers and children. Only by doing so can we make sure that every mother, newborn baby and child in need of care can obtain it, and no one is driven into poverty by the cost of that care. In this way we can move not only towards the Millennium Development Goals but beyond them.

LEE Jong-wook
Director-General
World Health Organization
Geneva, April 2005

overview

This year's *World Health Report* comes at a time when only a decade is left to achieve the Millennium Development Goals (MDGs), which set internationally agreed development aspirations for the world's population to be met by 2015. These goals have underlined the importance of improving health, and particularly the health of mothers and children, as an integral part of poverty reduction.

The health of mothers and children is a priority that emerged long before the 1990s – it builds on a century of programmes, activities and experience. What is new in the last decade, however, is the global focus of the MDGs and their insistence on tracking progress in every part of the world. Moreover, the nature of the priority status of maternal and child health (MCH) has changed over time. Whereas mothers and children were previously thought of as targets for well-intentioned programmes, they now increasingly claim the right to access quality care as an entitlement guaranteed by the state. In doing so, they have transformed maternal and child health from a technical concern into a moral and political imperative.

This report identifies exclusion as a key feature of inequity as well as a key constraint to progress. In many countries, universal access to the care all women and children are entitled to is still far from realization. Taking stock of the erratic progress to date, the report sets out the strategies required for the accelerated improvements that are known to be possible. It is necessary to refocus the technical strategies developed within maternal and child health programmes, and also to put more emphasis on the importance of the often overlooked health problems of newborns. In this regard, the report advocates the repositioning of MCH as M*N*CH (maternal, *newborn* and child health).

The proper technical strategies to improve MNCH can be put in place effectively only if they are implemented, across programmes and service providers, throughout pregnancy and childbirth through to childhood. It makes no sense to provide care for a child and ignore the mother, or to worry about a mother giving birth and fail to pay attention to the health of the baby. To provide families universal access to such a continuum of care requires programmes to work together, but is ultimately dependent on extending and strengthening health systems. At the same time, placing MNCH at the core of the drive for universal access provides a platform for building sustainable health systems where existing structures are weak or fragile. Even where the MDGs will not be fully achieved by 2015, moving towards universal access has the potential to transform the lives of millions for decades to come.

PATCHY PROGRESS AND WIDENING GAPS – WHAT WENT WRONG?

Each year 3.3 million babies – or maybe even more – are stillborn, more than 4 million die within 28 days of coming into the world, and a further 6.6 million young children die before their fifth birthday. Maternal deaths also continue unabated – the annual total now stands at 529 000 often sudden, unpredicted deaths which occur during pregnancy itself (some 68 000 as a consequence of unsafe abortion), during childbirth, or after the baby has been born – leaving behind devastated families, often pushed into poverty because of the cost of health care that came too late or was ineffective.

How can it be that this situation continues when the causes of these deaths are largely avoidable? And why is it still necessary for this report to emphasize the importance of focusing on the health of mothers, newborns and children, after decades of priority status, and more than 10 years after the United Nations International Conference on Population and Development put access to reproductive health care for all firmly on the agenda?

Although an increasing number of countries have succeeded in improving the health and well-being of mothers, babies and children in recent years, the countries that started off with the highest burdens of mortality and ill-health made least progress during the 1990s. In some countries the situation has actually worsened, and worrying reversals in newborn, child and maternal mortality have taken place. Progress has slowed down and is increasingly uneven, leaving large disparities between countries as well as between the poor and the rich within countries. Unless efforts are stepped up radically, there is little hope of eliminating avoidable maternal and child mortality in all countries.

Countries where health indicators for mothers, newborns and children have stagnated or reversed have often been unable to invest sufficiently in health systems. The health districts have had difficulties in organizing access to effective care for women and children. Humanitarian crises, pervasive poverty, and the HIV/AIDS epidemic have all compounded the effect of economic downturns and the health workforce crisis. With widespread exclusion from care and growing inequalities, progress calls for massively strengthened health systems.

Technical choices are still important, though, as in the past programmes have not always pursued the best approaches to make good care accessible to all. Too often, programmes have been allowed to fragment, thus hampering the continuity of care, or have failed to give due attention to professionalizing services. Technical experience and the successes and failures of the recent past have shown how best to move forward.

MAKING THE RIGHT TECHNICAL AND STRATEGIC CHOICES

There is no doubt that the technical knowledge exists to respond to many, if not most, of the critical health problems and hazards that affect the health and survival of mothers, newborns and children. The strategies through which households and health systems together can make sure these technical solutions are put into action for all, in the right place and at the right time, are also becoming increasingly clear.

Antenatal care is a major success story: demand has increased and continues to increase in most parts of the world. However, more can be made of the considerable potential of antenatal care by emphasizing effective interventions and by using it as a platform for other health programmes such as HIV/AIDS and the prevention and treatment of sexually transmitted infections, tuberculosis and malaria initiatives, and family

planning. Health workers, too, can make more use of antenatal care to help mothers prepare for birthing and parenting, or to assist them in dealing with an environment that does not always favour a healthy and happy pregnancy. Pregnant women, adolescents in particular, may be exposed to violence, discrimination in the workplace or at school, or marginalization. Such problems need to be dealt with also, but not only, by improving the social, political and legal environments. A case in point is how societies face up to the problem of the many millions of unintended, mistimed and unwanted pregnancies. There remains a large unmet need for contraception, as well as for more and better information and education. There is also a real need to facilitate access to responsive post-abortion care of high quality and to safe abortion services to the fullest extent allowed by law.

Attending to all of the 136 million births every year is one of the major challenges that now faces the world's health systems. This challenge will increase in the near future as large cohorts of young people move into their reproductive years, mainly in those parts of the world where giving birth is most dangerous. Women risk death to give life, but with skilled and responsive care, at and after birth, nearly all fatal outcomes and disabling sequelae can be averted – the tragedy of obstetric fistulas, for example – and much of the suffering can be eased. Childbirth is a central event in the lives of families and in the construction of communities; it should remain so, but it must be made safe as well. For optimum safety, every woman, without exception, needs professional skilled care when giving birth, in an appropriate environment that is close to where she lives and respects her birthing culture. Such care can best be provided by a registered midwife or a health worker with midwifery skills, in decentralized, first-level facilities. This can avert, contain or solve many of the life-threatening problems that may arise during childbirth, and reduce maternal mortality to surprisingly low levels. Skilled midwifery professionals do need the back-up only a hospital can provide, however, for women with problems that go beyond the competency or equipment available at the first level of care. All women need first-level maternal care and back-up care is only necessary for a minority, but to be effective both levels need to work in tandem and both must be put in place simultaneously.

The need for care does not stop as soon as the birth is over. The hours, days and weeks that follow birth can be dangerous for women as well as for their babies. The welcome emphasis, in recent years, on improving skilled attendance at birth should not divert attention from this critical period, during which half of maternal deaths occur as well as a considerable amount of illness. There is an urgent need to develop effective ways of organizing continuity of care during the first weeks after birth, when health service responsibilities are often ill-defined or ambiguous.

The postpartum gap in providing care for women is also a postnatal gap. Although the picture of the unmet need in caring for newborns is still very incomplete, it shows that the health problems of newborns have been unduly neglected and underestimated. Newborn babies seem to have fallen between the cracks of safe motherhood programmes on one side and child survival initiatives on the other. Newborn mortality is a sizeable proportion of the mortality of children under five years of age. It has become clear that the MDG for child mortality will not be reached without substantial advances for the newborn. Although modest declines in neonatal mortality have occurred worldwide (for example, vaccination is well on the way to eliminating tetanus as a cause of neonatal death), in sub-Saharan Africa some countries have seen reversals that are both unusual and disturbing.

Progress in newborn health does not require expensive technology. It does however require health systems that provide continuity of care starting from the beginning of pregnancy (and even before) and continuing through professional skilled care at birth into the postnatal period. Most crucially, there is a need to ensure that the delicate and often overlooked handover between maternal and child services actually takes place. Newborns who are breastfed, loved and kept warm will mostly be fine, but problems can and do occur. It is essential to empower households – mothers and fathers in particular – so that they can take good care of their babies, recognize dangers early, and get professional help immediately when difficulties arise.

The greatest risks to life are in its beginning, but they do not disappear as the newborn grows into an infant and a young child. Programmes to tackle vaccine-preventable diseases, malnutrition, diarrhoea, or respiratory infections still have a large unfinished agenda. Immunization, for example, has made satisfactory progress in some regions, but in others coverage is stagnating at levels between 50% and 70% and has to find a new momentum. These programmes have, however, made such inroads on the burden of ill-health that in many countries its profile has changed. There is now a need for more integrated approaches: first, to deal efficiently with the changing spectrum of problems that need attention; second, to broaden the focus of care from the child's survival to its growth and development. This is what is needed from a public health point of view; it is also what families expect.

The Integrated Management of Childhood Illness (IMCI) combines a set of effective interventions for preventing death and for improving healthy growth and development. More than just adding more subsets to a single delivery channel, IMCI has transformed the way the health system looks at child care – going beyond the mere treatment of illness. IMCI has three components: improving the skills of health workers to treat diseases and to counsel families, strengthening the health system's support, and helping households and communities to bring up their children healthily and deal with ill-health when it occurs. IMCI has thus moved beyond the traditional notion of health centre staff providing a set of technical interventions to their target population. It is bringing health care closer to the home, while at the same time improving referral links and hospital care; the challenge now is to make IMCI available to all families with children, and create the conditions for them to avail themselves of such care whenever needed.

MOVING TOWARDS UNIVERSAL COVERAGE: ACCESS FOR ALL, WITH FINANCIAL PROTECTION

There is a strong consensus that, even if all the right technical choices are made, maternal, newborn and child health programmes will only be effective if together, and with households and communities, they establish a continuum of care, from pregnancy through childbirth into childhood. This continuity requires greatly strengthened health systems with maternal, newborn and child health care at the core of their development strategies. It is forcing programmes and stakeholders with different histories, interests and constituencies to join forces. The common project that can pull together the different agendas is universal access to care. This is not just a question of fine-tuning advocacy language: it frames the health of mothers, babies and children within a broader, straightforward political project, responding to society's claim for the protection of the health of its citizens and for access to care – a claim that is increasingly seen as legitimate. The magnitude of the challenge of scaling up services towards universal access, however, should not be underestimated.

Reaching all children with a package of essential child health interventions necessary to comply with and even go beyond the MDGs is technically feasible within the next decade. In the 75 countries that account for most of child mortality this will require US$ 52.4 billion, in addition to current expenditure, of which US$ 25 billion represents additional costs for human resources. This US$ 52.4 billion corresponds to an increase as of now of 6% of current median public expenditure on health in these countries, rising to 18% by 2015. In the 21 countries facing the greatest constraints and where a long lead time is likely, current public expenditure on health would have to grow by 27% as of 2006, rising to around 76% in 2015.

For maternal and newborn care, universal access is further away. It is possible to envisage various scenarios for scaling up services, taking into account the specific circumstances in each of the same 75 countries. At present, some 43% of mothers and newborns receive some care, but by no means the full range of what they need even just to avoid maternal deaths. Adding up the optimistic – but also realistic – scenarios for each of the 75 countries gives access to a full package of first-level and back-up care to 101 million mothers (some 73% of the expected births) in 2015, and to their babies. If these scenarios were implemented, the MDG for maternal health would not be reached in every country, but the reduction of maternal and perinatal mortality globally would be well on the way. The costs of implementing these 75 country scenarios would be in the region of US$ 39 billion additional to current expenditure. This corresponds to a growth of 3%, in 2006, rising to 14% over the years, of current median public expenditure on health in these countries. In the 20 countries with currently the lowest coverage and facing the greatest constraints, current public expenditure on health would have to grow by 7% in 2006, rising to 43% in 2015.

Putting in place the health workforce needed for scaling up maternal, newborn and child health services towards universal access is the first and most pressing task. Making up for the staggering shortages and imbalances in the distribution of health workers in many countries will remain a major challenge for years to come. The extra work required for scaling up child care activities requires the equivalent of 100 000 full-time multipurpose professionals, supplemented, according to the scenarios that have been costed, by 4.6 million community health workers. Projected staffing requirements for extending coverage of maternal and newborn care assumes the production in the coming 10 years of at least 334 000 additional midwives – or their equivalents – as well as the upgrading of 140 000 health professionals who are currently providing first-level maternal care and of 27 000 doctors who currently do not have the competencies to provide back-up care.

Without planning and capacity-building, at national level and within health districts, it will not be possible to correct the shortages and to improve the skills mix and the working environment. Planning is not enough, however, to put right disruptive histories that have eroded workforce development. After years of neglect there are problems that require immediate attention: first and foremost is the nagging question of the remuneration of the workforce.

In many countries, salary levels are rightfully considered unfair and insufficient to provide for daily living costs, let alone to live up to the expectations of health professionals. This situation is one of the root causes of demotivation, lack of productivity and the various forms of brain-drain and migration: rural to urban, public to private and from poorer to richer countries. It also seriously hampers the correct functioning of services as health workers set up in dual practice to improve their living conditions or merely to make ends meet – leading to competition for time, a loss of resources for

the public sector, and conflicts of interest in dealing with their clients. There are even more serious consequences when health workers resort to predatory behaviour: financial exploitation may have catastrophic effects on patients who use the services, and create barriers to access for others; it contributes to a crisis of trust in the services to which mothers and children are entitled.

There is an urgent need to invent and deploy a whole range of measures to break the vicious circle, and bring productivity and dedication back to the level the population expects and to which most health workers aspire. Among these, one of the most challenging is rehabilitating the workforce's remuneration. Even a modest attempt to do so, such as doubling or even tripling the total workforce's salary mass and benefits in the 75 countries for which scenarios were developed, might still be insufficient to attract, retain and redeploy quality staff. But it would correspond to an increase of 2% rising, over 10 years, to 17% of current public expenditure on health, merely for payment of the MNCH workforce. Such a measure would have political and macroeconomic implications and is something that cannot be done without a major effort, not only by governments but by international solidarity as well. On the eve of a decade that will be focused on human resources for health, this will require a fundamental debate, in countries as well as internationally, on the volume of the funds that can be allocated and on the channelling of these funds. This is all the more important because rehabilitating the remuneration of the workforce is only one part of the answer: establishing an atmosphere of stability and hope is also needed to give health professionals the confidence they need to work effectively and with dedication.

At the same time, ensuring universal access is not merely a question of increasing the supply of services and paying health care providers. For services to be taken up, financial barriers to access have to be eliminated and users given predictable financial protection against the costs of seeking care, and particularly against the catastrophic payments that can push households into poverty. Such catastrophic payments occur wherever user charges are significant, households have limited ability to pay, and pooling and prepayment is not generalized. To attain the financial protection that has to go with universal access, countries throughout the world have to move away from user charges, be they official or under-the-counter, and generalize prepayment and pooling schemes. Whether they choose to organize financial protection on the basis of tax-generated funds, through social health insurance or through a mix of schemes, two things are important: first, that ultimately no population groups are excluded; second, that maternal and child health services are at the core of the health entitlements of the population, and that they be financed in a coherent way through the selected system. While it can take many years to move from a situation of a limited supply of services, high out-of-pocket payments and exclusion of the poorest to a situation of universal access and financial protection, the extension of health care supply networks has to proceed in parallel with the construction of such insurance mechanisms.

Financing is the killer assumption underlying the planning of maternal, newborn and child health care. First, increased funding is required to pay for building up the supply of services towards universal access. Second, financial protection systems have to be built at the same time as access improves. Third, the channelling of increased funds, both domestic and international, has to guarantee the flexibility and predictability that make it possible to cope with the principal health system constraints – particularly the problems facing the workforce.

Channelling increased funding flows through national health insurance schemes – be they organized as tax-based, social health insurance, or mixed systems – offers the best avenue to meet these three challenges simultaneously. It requires major capacity-

building efforts, but it offers the possibility of protecting the funding of the workforce in public sector and health sector reform policies and in the forums where macroeconomic and poverty-reduction policies are decided. It offers the possibility of tackling the problem of the remuneration and the working conditions of health workers in a way that gives them long-term, credible prospects, which traditional budgeting or the stopgap solutions of project funding do not offer.

While the financing effort seems to be within reasonable reach in some countries, in many it will go beyond what can be borne by governments alone. Both countries and the international community will need to show a sustained political commitment to mobilize and redirect the considerable resources that are required, to build the institutional capacity to manage them, and to ensure that maternal, newborn and child health remains at the core of these efforts. This decade can be one of accelerating the move towards universal coverage, with access for all and financial protection. That will ensure that no mother, no newborn, and no child in need remains unattended – because every mother and every child counts.

CHAPTER SUMMARIES

Chapter 1. Mothers and children matter – so does their health

This chapter recalls how the health of mothers and children became a public health priority during the 20th century. For centuries, care for mothers and young children was regarded as a domestic affair, the realm of mothers and midwives. In the 20th century this purely domestic concern was transformed into a public health priority. In the opening years of the 21st century, the MDGs place it at the core of the struggle against poverty and inequality, as a matter of human rights. This shift in emphasis has far-reaching consequences for the way the world responds to the very uneven progress in different countries.

The chapter summarizes the current situation regarding the health of mothers, newborns and children. Most progress has been made by countries that were already in a relatively good position in the early 1990s, while countries that started with the highest mortality rates are also those where improvements have been most disappointing.

Globally, mortality rates in children under five years of age fell throughout the latter part of the 20th century: from 146 per 1000 live births in 1970 to 79 in 2003. Towards the turn of the millennium, however, the overall downward trend started to falter in some parts of the world. Improvements continued or accelerated in the WHO Regions of the Americas, South-East Asia and Europe, while the African, Eastern Mediterranean and Western Pacific Regions experienced a slowing down of progress. In 93 countries, totalling 40% of the world population, under-five mortality is decreasing fast. A further 51 countries, with 48% of the world population, are making slower progress: they will only reach the MDGs if improvements are accelerated significantly. Even more worrying are the 43 countries that contain the remaining 12% of the world population, where under-five mortality was high or very high to start with and is now stagnating or reversing.

Reliable data on newborns are only recently becoming available and are more difficult to interpret. The most recent estimates show that newborn mortality is considerably higher than usually thought and accounts for 40% of under-five deaths; less than 2% of newborn deaths currently occur in high income countries. The difference between rich and poor countries seems to be widening.

Over 300 million women in the world currently suffer from long-term or short-term illness brought about by pregnancy or childbirth. The 529 000 annual maternal deaths, including 68 000 deaths attributable to unsafe abortion, are even more unevenly spread than newborn or child deaths: only 1% occur in rich countries. There is a sense of progress, backed by the tracking of indicators that show increases in the uptake of care during pregnancy and childbirth in all regions except sub-Saharan Africa during the 1990s, but the overall picture shows no spectacular improvement, and the lack of reliable information on the fate of mothers in many countries – and on that of their newborns – remains appalling.

Chapter 2. Obstacles to progress: context or policy?

This chapter seeks to explain why progress in maternal and child health has apparently stumbled so badly in many countries. Slow progress, stagnation and reversal are clearly related to poverty, to humanitarian crises, and, particularly in sub-Saharan Africa, to the direct and indirect effects of HIV/AIDS. These operate, at least in part, by fuelling or maintaining exclusion from care. In many countries numerous women and children are excluded from even the most basic health care benefits: those that are important for mere survival.

The specific causes, manifestations and patterns of exclusion vary from country to country. Some countries show a pattern of marginal exclusion: a majority of the population enjoys access to service networks, but substantial groups remain excluded. Other countries, often the poorest ones, show a pattern of massive deprivation: only a small minority, usually the urban rich, enjoys reasonable access, while an overwhelming majority is excluded. These countries have low density, weak and fragile health systems.

The policy challenges vary according to the different patterns of exclusion. Many countries have organized their health care systems as health districts, with a backbone of health centres and a referral district hospital. These strategies have often been so under-resourced that they failed to live up to expectations. The chapter argues that the health district model still stands as a rational way for governments to organize decentralized health care delivery, but that long-term commitment and investment are required to obtain sustained results.

Chapter 3. Great expectations: making pregnancy safer

This chapter reviews the three most important ways in which the outcomes of pregnancies can be improved: providing good antenatal care, finding appropriate ways of preventing and dealing with the consequences of unwanted pregnancies, and improving the way society looks after pregnant women.

Antenatal care is a success story: coverage throughout the world increased by 20% during the 1990s and continues to increase in most parts of the world. Concern for a good outcome of pregnancy has made women the largest group actively seeking care. Antenatal care offers the opportunity to provide much more than just pregnancy-related care. The potential to promote healthy lifestyles is insufficiently exploited, as is the use of antenatal care as a platform for programmes that tackle malnutrition, HIV/AIDS, sexually transmitted infections, malaria and tuberculosis and promote family planning. Antenatal consultations are the ideal occasion to establish birth plans that can make sure the birth itself takes place in safe circumstances, and to help mothers prepare for parenting.

The chapter sets out critical directions for the future, including the need to improve the quality of care and to further increase coverage.

Even in societies that value pregnancy highly, the position of pregnant women is not always enviable. In many places there is a need to improve the social, political and legal environments so as to tackle the low status of women, gender-based violence, discrimination in the workplace or at school, or marginalization. Eliminating sources of social exclusion is as important as providing antenatal care.

Unintended, mistimed or unwanted pregnancies are estimated to number 87 million per year. There remains a huge unmet need for investment in contraception, information and education to prevent unwanted pregnancy, though no family planning policy will prevent it all. More than half of the women concerned, 46 million per year, resort to induced abortion: that 18 million do so in unsafe circumstances constitutes a major public health problem. It is possible, however, to avoid all of the 68 000 deaths as well as the disabilities and suffering that go with unsafe abortions. 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 and responsive abortion and post-abortion care.

Chapter 4. Attending to 136 million births, every year

This chapter analyses the major complications of childbirth and the main causes of maternal mortality. Direct causes of maternal mortality include haemorrhage, infection, eclampsia, obstructed labour and unsafe abortion. Childbirth is a moment of great risks, but in many situations over half of maternal deaths occur during the postpartum period. Effective interventions exist to avoid most of the deaths and long-term disabilities attributable to childbirth. The history of successes in reducing maternal and newborn mortalities shows that skilled professional care during and after childbirth can make the difference between life and death for both women and their newborn babies. The converse is true as well: a breakdown of access to skilled care may rapidly lead to an increase of unfavourable outcomes.

All mothers and newborns, not just those considered to be at particular risk of developing complications, need skilled maternal and neonatal care: close to where and how they live, close to their birthing culture, but at the same time safe, with a skilled professional able to act immediately when complications occur. Such birthing care can best be provided by a registered midwife or a professional health worker with equivalent skills, in midwife-led facilities. These professionals can avert, contain or solve many of the largely unpredictable life-threatening problems that may arise during childbirth and thus reduce maternal mortality to surprisingly low levels. But they do need the back-up only a hospital can provide to help mothers who present problems that go beyond their competency or equipment. All women need first-level maternal care, and only in a minority of cases is back-up care necessary, but to be effective both need to work in tandem, and have to be extended simultaneously. In many countries uptake of postpartum care is even lower than of care at childbirth. This is an area of crucial importance with much scope for improvement.

Chapter 5. Newborns: no longer going unnoticed

Until recently, there has been little real effort to tackle the specific health problems of newborns. A lack of continuity between maternal and child health programmes has allowed care of the newborn to fall through the cracks.

Each year nearly 3.3 million babies are stillborn, and over 4 million more die within 28 days of coming into the world. Deaths of babies during this neonatal period are as numerous as those in the following 11 months or those among children aged 1–4 years. Skilled professional care during pregnancy, at birth and during the postnatal period is as critical for the newborn baby as it is for its mother. The challenge is to find a better way of establishing continuity between care during pregnancy, at birth, and when the mother is at home with her baby. While the weakest link in the care chain is skilled attendance at birth, care during the early weeks of life is also problematic because professional and programmatic responsibilities are often not clearly delineated.

The chapter presents a set of benchmarks for the needs in human resources and service networks to provide first level and back-up maternal and newborn care to all. In many countries there are major shortages in facilities and, crucially, human resources. Using a set of scenarios to scale up towards universal access to both first-level and back-up maternal and newborn care in 75 countries, it seems realistic for coverage to increase from its present 43% (with a limited package of care) to around 73% (with a full package of care) in 2015. Implementing these scenarios would cost US$ 1 billion in 2006, increasing, as coverage expands, to US$ 6 billion in 2015: a total of US$ 39 billion over ten years, in addition to present expenditure on maternal and newborn health. This corresponds to an extra outlay of around US$ 0.22 per inhabitant per year initially, increasing to US$ 1.18 in 2015. A preliminary estimate of the potential impact of this scaling up suggests a reduction of maternal mortality, in these 75 countries, from a 2000 aggregate level of 485 to 242 per 100 000 births, and of neonatal mortality from 35 to 29 per 1000 live births by 2015.

Chapter 6. Redesigning child care: survival, growth and development

Increased knowledge means that technically appropriate, effective interventions for reducing child mortality and improving child health are available. It is now necessary to implement them on a much larger scale.

This chapter explains how in the 1970s and 1980s vertical programmes have undeniably allowed fast and significant results. The Expanded Programme on Immunization and initiatives to implement oral rehydration therapy, for example, with a combination of state-of-the-art management and simple technologies based on solid research, were adopted and promoted to great effect.

For all their impressive results, however, the inherent limitations of vertical approaches became apparent. At the same time, it became clear that a more comprehensive approach to the needs of the child was desirable, both to improve outcomes and to respond to a genuine demand from families. The response was to package a set of simple, affordable and effective interventions for the combined management of the major childhood illnesses and malnutrition, under the label of Integrated Management of Childhood Illness (IMCI). IMCI combined interventions designed to prevent deaths, taking into account the changing profile of mortality causes, but it also comprised of interventions and approaches to improve children's healthy growth and development. More than just adding extra programmes to a single delivery channel, IMCI has gone a step further and has sought to transform the way the health system looks at child care, spanning a continuum of care from the family and community to the first-level health facility and on to referral facilities, with an emphasis on counselling and problem-solving.

Many children still do not benefit from comprehensive and integrated care. As child health programmes continue to move towards integration it is necessary to progress towards universal coverage. Scaling up a set of essential interventions to full

coverage would bring down the incidence and case fatality of the conditions causing children under five years of age to die, to a level that would permit countries to move towards and beyond the MDGs. This will not be possible without a massive increase of expenditure on child health. Implementing scenarios to reach full coverage in 75 countries would cost US$ 2.2 billion in 2006, increasing, as coverage expands, to US$ 7.8 billion in 2015: a total of US$ 52.4 billion over 10 years, in addition to present expenditure on child health. This corresponds to an extra outlay of around US$ 0.47 per inhabitant per year initially, expanding to US$ 1.48 in 2015.

Chapter 7. Reconciling maternal, newborn and child health with health system development

This last chapter looks at the place of maternal, newborn and child health within the broader context of health system development. Today, the maternal, newborn and child health agendas are no longer discussed in purely technical terms, but as part of a broader agenda of universal access. This frames it within a straightforward political project: responding to society's demand for the protection of the health of citizens and access to care, a demand that is increasingly seen as legitimate.

Universal access requires a sufficiently dense health care network to supply services. The critical challenge is to put in place the health workforce required for scaling up. The most visible features of the health workforce crisis in many countries are the staggering shortages and imbalances in the distribution of health workers. Filling these gaps will remain a major challenge for years to come. Part of the problem is that sustainable ways have to be devised of offering competitive remuneration and incentive packages that can attract, motivate and retain competent and productive health workers. In many of the countries where progress towards the MDGs is disappointing, very substantial increases in the remuneration packages of health personnel are urgently needed, a challenge of a magnitude that many poor countries cannot face alone.

Universal access, however, is more than deploying an effective workforce to supply services. For health services to be taken up, financial barriers to access have to be reduced or eliminated and users given predictable protection against the costs of seeking care. The chapter shows that by and large the introduction of user fees is not a viable answer to the underfunding of the health sector, and institutionalizes exclusion of the poor. It does not accelerate progress towards universal access and financial protection; this can be guaranteed only through generalized prepayment and pooling schemes. Whichever system is adopted to organize these schemes, two things are important. First, ultimately no population groups should be excluded; second, maternal, newborn and child health services should be at the core of the set of services to which citizens are entitled and which are financed in a coherent way through the selected system.

With time, most countries move towards universal coverage, widening prepayment and pooling schemes, in parallel with the extension of their health care supply networks. This also has consequences for the funding flows directed towards maternal, newborn and child health. In most countries, financial sustainability for maternal, newborn and child health can best be achieved in the short and middle term by looking at all sources of funding: external and domestic, public and private. Channelling funds towards generalized insurance schemes that both fund the expansion of health care networks and provide financial protection, offers most guarantees for sustainable financing of maternal, newborn and child health and of the health systems on which it depends.

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Children are the future of society and their mothers are guardians of that future. Yet this year, almost 11 million children under five years of age will die from causes that are largely preventable. Among them are 4 million babies who will not survive the first month of life. On top of that 3.3 million babies will be stillborn. At the same time, about half a million women will die in pregnancy, childbirth or soon after.

The World Health Report 2005 – Make Every Mother and Child Count, published by the World Health Organization, examines why these deaths continue to occur on such a scale, and how the annual toll can be reduced. The report contains both an expert analysis of the obstacles to progress in maternal, neonatal and child health, and a comprehensive series of recommendations aimed at overcoming them. It says that today the interventions already exist to transform the lives of millions of mothers and children and to prevent millions of tragically premature deaths.

To put an end to widespread exclusion, countries have to guarantee access to care for each and every mother and child – through a continuum that extends from pregnancy through childbirth, the neonatal period and childhood. The report makes detailed projections of the efforts – and the corresponding costs – needed to scale up towards universal access within the coming decade.

Universal access for mothers and children requires health systems to be able to respond to the needs and demands of the population, and to offer them protection against the financial hardship that results from ill-health. To make this possible, investments in health systems and in the human resources for health need to be stepped up. The report argues that maternal, newborn and child health should constitute the core of the health entitlements protected and funded through public funds and social health insurance systems.

The World Health Report 2005 is essential reading for everyone with an interest in improving the health of every mother, newborn and child, and making them count.