Scaling up access to health care for mothers and children: reducing the toll of child and maternal deaths

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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. 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. 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. The report makes detailed projections of the efforts – and the corresponding costs – needed to scale up towards universal access within the coming decade. It shows that universal access for mothers and children requires investments in health systems and in the human resources for health need to be stepped up. The report finally 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. What follows is an overview of the content of the report, which has been launched on April 7th 2005, World Health Day.

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

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.

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,

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. 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 75 countries gives access to a full package of first-level and backup care to 101

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 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 channeling 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

Channeling 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 stop-gap 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.